IMPACT OF PARENTING PRACTICES AND FAMILY FUNCTIONING ON PSYCHOLOGICAL ADJUSTMENT OF ADOLESCENTS WITH ADHD: ROLE OF EARLY MALADAPTIVE SCHEMAS

BY

Romana Iqbal

NATIONAL UNIVERSITY OF MODERN LANGUAGES

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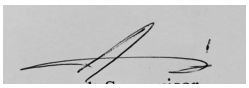

Prof. Dr. M. Anis-ul-Haque
Name of Research Supervisor

_____
Signature of Research Supervisor

Prof. Dr. Khalid Sultan
Name of Dean (FSS)

_____
Signature of Dean (FSS)

Brig. Syed Nadir Ali
Director General

_____
Director General

_____

Dated

AUTHOR'S DECLARATION

I Romana Iqbal

Daughter of Iqbal Ahmed

Registration # 1717-MPhil/Psy/S-19

Discipline Psychology

Candidate of **Master of Philosophy** at the National University of Modern Languages do hereby declare that the thesis **"Impact of Parenting Practices and Family Functioning on Psychological adjustment of Adolescents with ADHD: Role of Early Maladaptive Schemas"** submitted by me in partial fulfilment of M.Phil degree, is my original work, and has not been submitted or published earlier. I also solemnly declare that it shall not, in future, be submitted by me for obtaining any other degree from this or any other university or institution.

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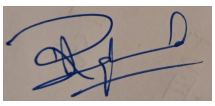

Signature of Candidate

Romana Iqbal

Name of Candidate

17/12/2022

Date

ABSTRACT

Title: Impact of Parenting Practices and Family Functioning on Psychological Adjustment of Adolescents with ADHD: Role of Early Maladaptive Schemas

This study's primary purpose was to measure the impact of Early Maladaptive Schemas in Parenting Practices, Family Functioning, and Psychological Adjustment of adolescents with ADHD. The study also measured the indirect and direct relationship between parenting practices and family functioning. The study also explored gender differences on study variables and differences based on age group. For this purpose, using a cross-sectional research design, a sample of 100 (Male=50, Female=50) adolescents was selected from different special education institutions, schools and colleges of government and private sector in Islamabad and Rawalpindi. The age range varied from 12 to 20 years (M=14.73, SD=1.82). The data was collected using Alabama Parenting Questionnaire, Family Assessment Device, Young's Schema Questionnaire, and Personality Assessment Questionnaire. A simple mediation analysis confirmed the significant partial mediation. The direct effect of Healthy family functioning was nonsignificant, while the indirect effect was significant. The direct effect of positive dimensions of parenting practices was significant, while the indirect effect was also significant. The negative dimensions of Parenting practices also found to have significant direct and indirect effect on Psychological adjustment. The results also confirm significant gender-based differences among ADHD adolescents on subdomains of study variables. The results suggest broader treatment strategies, considering the parents and family for the ADHD adolescents.

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CHAPTER 1

INTRODUCTION

Adolescents dealing with specific incapacitating developmental issues and disorders may face difficulty while undergoing rapid cognitive, hormonal and physical changes, lack of rewarding opportunities, academic and social challenges, exposure to violence, depression and anxiety (Richter, 2006; Blum et al., 2017). In adolescents diagnosed with ADHD, this change may apace with increased sensitivity due to cognitive difficulties to process such complicated emotions and demands from the external world (Krueger & Kendall, 2001). Additionally, research indicates that teenagers with ADHD struggle to control their emotions, are more aggressive, and have poor adjustment. ADHD has also been linked to a number of adjustment issues, including persistent behavioural, academic, and emotional (Arora et al., 2016; Palaniappan, 2013; Wüstner et al., 2019).

Furthermore, studies have shown that young adults with ADHD have problems with their psychological adjustments. These young adults had more psychosocial problems, used mental health services more frequently, dropped out of high school, and had run-ins with the law (Hansen et al.,1999). Not only that, but ADHD has a negative impact on academic performance, social adaptive skills, and general functioning (Baumgaertel, 1995). Likewise, a study by Garg and Arun (2013) indicated persistent and significant family and social adjustment problems in ADHD adolescents. Similarly, in another study Jusyte et al. (2017) highlighted the interpersonal adjustment problems and the impaired emotional expressions across all emotional categories. A study also shown that having an ADHD diagnosis in young people affected several facets of their functioning. According to findings, the recruits in military services were found to be medically unfit, having been diagnosed with personality disorders, anxiety, obesity, and being ineligible for military combat duties at the time of enrollment if they had prior

diagnosis of ADHD (Fruchter et al., 2019). Similarly, high risk of suicide, low self-esteem and depression have been reported in a sample of young Korean military soldiers who were diagnosed with ADHD (Kim et al., 2015). As for the social life, children with ADHD often have difficulty maintaining peer relations due to intrusive and aggressive behaviours (Saylor, 2016). Since children with severe ADHD have a difficult time adjusting to a conventional classroom environment during their academic years of life, it is frequently essential that these kids should be provided with special facilitation and guideline in educational systems (Barkely et al., 1990). According to a research, 20% of children with attention deficit and lower IQ experience these issues. The prevalence of ADHD has also been linked to co-occurring learning challenges in children, such as difficulties with math, reading, or spelling (Czamara et al., 2013; Schuchardt et al., 2015). Due to the limitation of generalizability and insufficient work on this area in Pakistan, the current study will focus on understanding the impact of parenting practices, family function on the psychological adjustment of adolescents with ADHD and evaluating the mediating role of early maladaptive schemas. This study will bridge the gap to highlight problems related to ADHD adolescents within Pakistan.

1.1 Rationale of the Study

Previous researches indicate significance of parenting practices in terms of lack of parental warmth (Khaleque, 2013), Parenting acceptance (Carrasco et al., 2019) and decreased psychological adjustment in non-ADHD children. Parental acceptance-rejection has also been indicated as a strong predictor for psychological adjustment and poor response to treatment in nine to ten years old children, diagnosed with ADHD (Guzel, 2018). It has also been indicated that Parenting styles are strongly related to increased difficulties in psychological adjustment among children and adolescents with ADHD. These researches measure overall stress among mothers of ADHD children and

adolescents (Muñoz-Silva et al., 2017) or explore parental perspective on perceived difficulties and stress (Theule, 2013), parental emotional socialization and psychological adjustment in non-clinical samples (Jin et al., 2017), and psychosocial adjustment in gifted children (Yazdani & Daryei, 2016), however there are limitations in the generalizability across cultures due to single parent respondents or a lack of child's perspective in this area (Qiu, 2021; León, 2015). Family functioning has been suggested to have a strong association with psychological distress among parents of children with ADHD that influence a child's well-being (Moen et al., 2016). Additionally, family functioning also been suggested to plays an important role in the psychological adjustment of adolescents and patients diagnosed with anorexia nervosa (De Los Reyes & Ohannessian, 2016; Sbicigo & Dell'Aglio, 2012; Yu et al., 2022; Ciao, 2015). Similarly, an online qualitative survey during pandemic suggested a significant relation of family conflicts and psychological adjustment among adolescents using normal population (Postigo-Zegarra et al., 2021).

Recent literature also indicates the association of early maladaptive schemas with higher levels of perceived stress, lower levels of wellbeing, and an increase in the symptoms of depression in adults with ADHD and non-clinical adult population (Philipsen et al., 2017; Miklosi et al., 2016). Parenting styles including authoritarian and permissive styles have been suggested as strong predictor for early maladaptive schemas in undergraduate students (Esmali Kooraneh & Amirsardari, 2015). According to the finding of studies in Pakistan early maladaptive schemas also predict negative emotional regulation, self-care problems in Patients diagnosed with HIV (Seyed et al., 2020) and post-traumatic stress disorder in patients with brain injuries (Zaman et al., 2021). Furthermore, only a handful of studies have been conducted to actively observe the interactive effects of such variables (Bibi et al., 2022; Batool et al.,2017; Jabeen et

al.,2013; Zahra & Saleem, 2022; Batool & Najam, 2009), however, most of these included adults and children from non- ADHD population and university students with no formal ADHD diagnosis.

1.2 Statement of the Problem

The problem to be addressed through this study is to find out the impact of parenting practices and family functioning on psychological adjustment of adolescents with ADHD, and mediating role of early maladaptive schemas between these variables. Fundamentally, the findings of aforementioned studies lack generalizability and explicitly highlight the need to explore such variables while primarily keeping in view the ADHD adolescent's population of Pakistan. In conclusion, since this topic of research is scarcely pursued, not much is known about the interactive relationships between these variables and the mediating role of early maladaptive schemas. This research provides an opportunity to bridge the gap and delve into the area to gain some insight into the development of this critical age group. While taking early maladaptive schemas as mediating factors, the aim is to study the direct and interactive relationship of Parenting practices and family functioning on the psychological adjustment of adolescents with ADHD. More importantly a clear insight in this area can provide a good prognosis and clarity of treatment choices for the professionals, help teachers to choose effective learning strategies in the class room, and facilitates parents to know the illness in a better context and facilitate one at home suffering from this illness. Further, adolescents will also get a better insight into their condition and learn better ways to manage their problems in different life contexts.

1.3 Research Objectives

The objectives of the present study are:

1. To examine the impact of parenting practices and family functioning on psychological adjustment among adolescents with ADHD.
2. To investigate the mediating role of early maladaptive schemas in the relationship between parenting practices, family functioning and psychological adjustment, adolescents with ADHD.
3. To explore gender differences concerning family functioning, parenting practices, psychological adjustment, and early maladaptive schemas among adolescents with ADHD.

1.4 Research Questions

Q 1. What is the impact of parenting practices and family functioning on the psychological adjustment of adolescents with ADHD?

Q 2. Do early maladaptive schemas mediate the relationship between parenting practices and family functioning on the psychological adjustment of adolescents with ADHD?

1.5 Null Hypotheses

Following are the null hypotheses, according to the study objectives mentioned above:

H1. Healthy family functioning leads to psychological adjustment among adolescents with ADHD.

H2. Unhealthy family functioning leads to psychological maladjustment among adolescents with ADHD.

H3. Poor monitoring leads to psychological maladjustment among adolescents with ADHD.

H4. Inconsistent discipline leads to psychological maladjustment among adolescents with ADHD.

H5. Corporal punishment leads to psychological maladjustment among adolescents with ADHD.

H6. Parental involvement leads to psychological adjustment among adolescents with ADHD.

H7. Positive reinforcement leads to psychological adjustment among adolescents with ADHD.

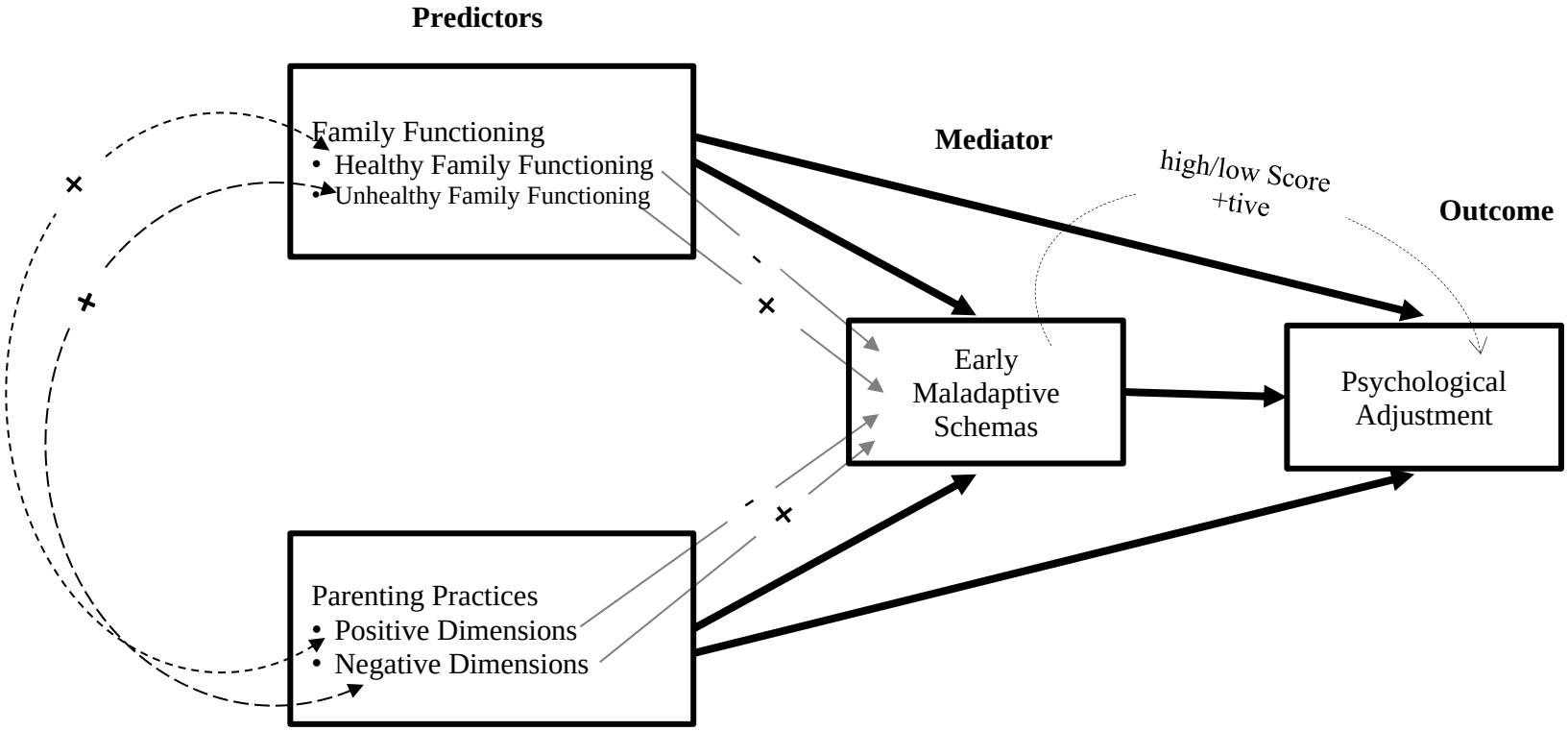
H8. Early maladaptive schemas mediate the relationship of parenting practices and family functioning with psychological adjustment among adolescents with ADHD.

H9. There are gender differences on family functioning, parenting practices, psychological adjustment, and early maladaptive schemas among adolescents with ADHD.

1.6 Conceptual Framework

Figure 1.

Schematic representation of the effect of Family Functioning and Parenting Practices on Psychological adjustment trough Early Maladaptive Schemas in Adolescents with ADHD.



Note: This model is based on clinical sample from Islamabad and Rawalpindi . In parenting practices positive dimensions includes parental involvement and positive reinforcement, negative dimension includes poor monitoring, corporal punishment and inconsistent discipline.

1.7 Significance of the Study

The present study provides a new perspective in understanding ADHD in adolescents in the context of Pakistan. It also develops understating of the importance of family functioning and parenting practices in the psychological adjustment in adolescents through early maladaptive schemas. The present study benefits the following in particular;

The study will spread awareness in community on recognizing ADHD as an important concern for the mental health of adolescentes and need to improve their psychological adjustment in the context of Pakistan.

Through this research, academic institutions and administrators may promote programs and advocacies regarding ADHD that can help the adolescents deal with their ADHD issues.

The result of this research will provide valuable information for the advocates to further their campaign on spreading awareness on how to deal with various mental health issues including ADHD and how to stop related stigmatization of individuals with ADHD.

This research may convince parents to consider programs involving training that may help the adolescents deal with their ADHD issues at home.

Students will be directly benefited from this research as its findings may encourage them to consider the importance of timely treatment that may help to increase their psychological adjustment by taking schema-based therapies and behavioural treatments.

This study covers information involving psychological adjustment in adolescents with ADHD the context of Pakistan. Thus, the result of this study can be used for future discussions on the role of factors other than family, parenting and early maladaptive schemas that can contribute to mental health concerns of adolescents with ADHD.

The finding of this study also provides a foundation for mental health professionals for the formulation of treatment plans for the adolescents with ADHD by involving families to enhance the outcomes for the increased psychological adjustment.

1.8 Methodology

The study was conducted in three phases. The participants were accessed through different sources including , personal visits, institutes, google forms, and facilitation through WhatsApp to complete the questionnaires. As it was difficult to keep ADHD children to stay on task, the procedure for data collection from each participant was based on distributed practice, which involved on average 2-3 sessions for completing the questionnaire by each participant. In addition, movement breaks like stretching, and a chanced to move around were also made part of data collection. The participants were also provided with incentives at the end of task. In case where parents or guardians facilitated the process, they were instructed to follow the same procedure.

1.9 Delimitations

The researcher limited the study to 100 (50 Boys and 50 Girls) adolescents diagnosed with ADHD. The participants were accessed through different sources including , personal visits, institutes, google forms, and facilitation through WhatsApp to complete the questionnaires. The selected participants were form different institutions including hospitals, special education institutes located in Islamabad and Rawalpindi area to prevent bias and gather objective responses. The age of participants of this study was limited to 12 to 20 years, as only this age group comes under the criteria of adolescents. The formal diagnosis of ADHD by clinician or psychiatrist was also confirmed at the time of screening and selection for all participants. The data was gathered after taking formal permissions

from concerned authorities and informed consent by the parents/guardians. Due to COVID-19 lockdown data was collected using google forms, WhatsApp, personal visits, and institutional visits during intermittent lifting of lockdowns by the government.

1.10 Operational definitions

1.10.1 Family Functioning

Family Functioning refers to rendering a favorable environment to develop all family members' psychological, physical, and biological aspects (Dai & Wang, 2015). In the present study, subscales (Problem-solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning) of the McMaster Family Assessment Device (FAD) (Epstein et al., 1983) measures family functioning, where high scores on the scales show poor family functioning (Cottrell et al., 2018).

1.10.2 Parenting practices

Parenting practices are specific patterns of parents' child-rearing goals and attitudes that constitute a relatively stable environment for parent-child relationships across life situations (Darling & Steinberg, 1993). In the present study, subscales (Poor Monitoring/Supervision, Inconsistent Discipline, Corporal Punishment, Positive Parenting, and Involvement) of the Alabama Parenting Questionnaire (APQ) (Frick, 1991) measures Parenting practices. The high score on positive or negative dimensions shows positive or negative parenting. There is no requirement of reverse scoring of the items.

1.10.3 Early maladaptive schemas

Early maladaptive schemas refer to self-perpetuating, dysfunctional cognitive structures during childhood. These structures develop by dysfunctional relations with

significant others in childhood and lead to psychopathology (Young, 1990, 1999). In the present study, (Abandonment/ instability, Mistrust/abuse, Emotional deprivation, Defectiveness/shame, Social isolation/ alienation, Dependence/ incompetence, Vulnerability, Enmeshment/ undeveloped self, Failure, Entitlement/grandiosity, Insufficient self-control/ self-discipline, Subjugation, Self-sacrifice, Approval-seeking/ recognition-seeking, Negativity/pessimism, Emotional inhibition, Unrelenting standards, Punitiveness) of Young Schema Questionnaire for adults (YSQ-3) (Young, 2006) measures early maladaptive schemas, where 2 or more score on the form is meaningful and high score shows maladjustment.

1.10.4 Psychological adjustment

Psychological adjustment refers to psychological features that lead one to display meaningful and consistent behaviors (Costa & McCrae, 1985). Psychological adjustment is defined as an individual's affective, cognitive, perceptual, and motivational dispositions to respond and actual observable behaviors of responding in various life situations, parental acceptance or rejection, as perceived by the child, has been shown to have consistent effects on the child's psychological adjustment (Rohner,1991). The psychological adjustment in IPARTheory refers to an individual's position on the constellation of seven personality dispositions central to IPARTheory's personality subtheory (Khaleque & Rohner, 2007). The questionnaire, based on IPARTheory, Personality Assessment Questionnaire (PAQ) measures psychological adjustment using seven subscales: Hostility/aggression, dependency, emotional unresponsiveness, emotional instability, negative self-esteem, negative self-adequacy and negative view of the world (Rohner, 1991). A higher composite score on the test indicates greater emotional and behavioral impairment in functioning of an individual (Rohner, 1978).

1.10.5 Attention, Deficit Hyperactivity Disorder

Attention, Deficit Hyperactivity Disorder refers to pronounce problems of inattention and hyperactivity-impulsivity. According to National Institute of Mental Health (NIMH, 2021) these ongoing patterns interfere with normal functioning or development. In the present study, the sub-domains including inattention, hyperactivity/impulsivity of Swanson Nolan and Pelham (SNAP-IV) measures ADHD. If the scores are higher on the scale, it indicates the worst symptoms of ADHD on SNAP-IV.

CHAPTER 2

REVIEW OF THE RELATED LITERATURE

2.1 Attention deficit/hyperactivity disorder (ADHD)

The Diagnostic Statistical Manual (DSM-5) defines attention deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by impairing levels of inattention, disorganization, or hyperactivity-impulsivity. Inattention and disorganization implicate difficulty staying on the task, listening when spoken directly, losing materials, and organizing tasks not consistent with age appropriate developmental level. Hyperactivity–impulsivity comprises overactivity, fidgeting, inability to stay seated, intruding into other people's activities, and inability to wait—excessive symptoms, inappropriate for that age or developmental level (Willcutt, 2012; Berger, 2011). Even though ADHD is typically diagnosed in children, issues with inattention, impulsivity, and mood dysregulation can persist into adulthood, impairing social, academic, and occupational functioning in those who have the disorder (Skirrow et al., 2012; American Psychiatric Association [APA], 2013).

The DSM-5 identifies three main nominal subtypes of ADHD, differentiating each presentation based on the symptoms and severity level on two dimensions of inattention and hyperactivity-impulsivity. The first presentation characterizes maladaptive levels of inattention in individual taping predominantly inattentive type (ADHD-I). The second presentation describes maladaptive levels of hyperactivity-impulsivity in individuals taping predominantly hyperactive-impulsive type (ADHD-H). Finally, the third presentation characterizes mixed symptoms of inattention and hyperactivity-impulsivity in combined type (ADHD-C) (Berger, 2011).

ADHD symptoms might manifest before the age of twelve. Only five symptoms are needed for diagnosis in adults and adolescents aged 17 and older as opposed to six symptoms for younger children (APA, 2013). Also, ADHD has been reported to prevail with other externalizing and internalizing problems (Schiweck et al., 2021; Tung et al., 2016) including comorbid disorders like learning disabilities depression, anxiety disorders, bipolar disorder, substance use disorders, and personality disorders (Katzman et al., 2017).

2.2 Definition of Adolescence

Adolescents' age is a spurt of growth in all significant areas, including biological, psychological, social, and emotional. Societies may vary in the definition of adolescence and may include the transcendent meaning of maturation's physical, social, psychological, and moral aspects. However, according to World Health Organization (WHO), the adolescence period falls between 10 to 19. This age range falls within WHO's definition of *young people*, which refers to individuals between ages 10 and 24 (Singh et al., 2019). Many factors (environmental and genetic) affect the normal developmental pathways during adolescents (Brinksma et al., 2021).

2.3 Psychological Adjustment

Psychological adjustment is defined as an individual's affective, cognitive, perceptual, and motivational dispositions to respond and actual observable behaviors of responding in various life situations, parental acceptance or rejection, as perceived by the child, has been shown to have consistent effects on the child's psychological adjustment (Rohner,1991). Interpersonal acceptance-rejection theory (IPARTheory) represents a global perspective on the significant causes and consequences of interpersonal acceptance-rejection that contribute to psychological adjustment among children, adolescents, and

adults (Rohner, 1980, 1986, 2004; Rohner & Lansford, 2017). It conceptualizes the significant role of socialization and parenting style as a variable that moderates parenting practices and developmental outcomes (Darling & Steinberg, 1993). The theory's focus is the investigation of the origins, effects, and correlates of children's perceptions of parental acceptance and rejection, as well as how these perceptions are maintained into adulthood. The theory conceptualizes all people as sharing a common trait, which is the need to be loved and cared for by significant others, regardless of ethnicity, culture, age, gender, or any other attribute (Rohner, 2016). The theory is divided into three sub-theories: the coping sub theory, sociocultural sub theory, and personality sub theory (Rohner et al., 2009). The present study incorporated the personality subtheory to evaluate the psychological adjustment of adolescents with ADHD. To comprehend the fundamental tenets of this theory, a concise summary is provided below.

The Coping subtheory identifies those children and adults who have better emotional coping with the frequent cynical cycle of rejections in daily life**.** The theory underlines the factors that develop emotional resilience in those individuals. In IPARTheory, coping refers to instrumental and affective coping. Such as, the affective coper manages to maintain emotional well-being and mental health despite adverse dynamic exposures. Whereas, instrumental copers, on the other hand, have impaired mental health, but somehow, they perform well in school, in their professions, occupations, and other task-oriented activities (Rohner, 1986, 2004; Rohner et al., 2009; Rohner, 2016).

Similarly, the sociocultural subtheory explains the social and cultural factors that provide a context to parental acceptance or rejection. It suggests that variations in race, language, culture, gender and other similar defining features may not sufficiently override

the pronounced universal tendency to develop psychological maladjustments in those individuals who experience rejection by significant figures in their life (Rohner, 2004).

According to the personality subtheory, a person's relatively persistent set of predispositions, such as their motivational, perceptual, affective, and cognitive dispositions, determine how they will react to different life situations. In addition, more obvious changes occur as a result of internal and external factors, which affect responses and patterns of behaviour during the maturational transition and may lead to adjustment problems in later life (Rohner, 2005a; Hopwood et al., 2011). Since parenting practices and developmental outcomes are moderated by a strong determinant known as parenting style, which has a major influence in the socialization of children (Darling & Steinberg, 1993). The initial assumption of the personality subtheory is that people have a constant need for acceptance throughout biocultural evolution (Rohner, 1975; Baumeister & Leary, 1995; Leary, 1999; Bjorklund & Pellegrini, 2002). As referred by William James (1920), who describes this "craving to be appreciated" (a desire to be recognized and admired) as a part of human nature. It emphasizes on the quality of this bond between the attachment figure, parents, and the child substantially affects the child's sense of well-being and psychological adjustment (Mónaco et al., 2019). Moreover, the importance of acceptance and rejection by the parents is a crucial element for the development and adjustment of a child (Hong & Park, 2012). In addition, the consequent perception of the quality of emotional security and attachment effects the well-being and intimate relations. Therefore, it has a significant influence on adolescents' personality and psychological adjustment (Yahya et al., 2021; Tian et al., 2020).

To investigate these psychological adjustment issues, the personality subtheory postulates the following areas: immature dependence, emotional unresponsiveness,

impaired self-esteem, impaired self-adequacy, emotional instability, and pessimistic worldview (Rohner, 2016). The importance placed on the quality of this bond between the attachment figure, parents, and child has a significant impact on the child's sense of well-being and psychological adjustment (Mónaco et al., 2019). Parental influence affects a child's development in several ways. It can foreshadow negative cognitive patterns and emotional issues like rejection, isolation, and disrupted boundaries (Pellerone et al., 2017).

This warmth dimension of interpersonal relationships creates a continuum that makes it easier to assess how much acceptance or rejection people encounter throughout their lives. The continuum reveals warmth on two dimensions, one with warmth and affection, love, comfort, or interpersonal acceptance. The other shows absence, withdrawn feelings, display of hurtful behaviors or expressions or rejection from the caregiver (Rohner, 2016). The theory provides a thorough understanding of the factors and outcomes of parental acceptance and rejection on psychological adjustment of an individual.

2.4 Parenting Practices

Parenting practices are those behaviors that parent display during the process of child socialization and can be observed in their interaction with the child. Throughout history, the parent-child bond has remained a focus for theory and research. According to Lock (1970), the Concept of parenting and child-rearing is critical in a child's life and development (Crain, 2014). Similarly, Rousseau (1962) pointed out the importance of the home environment and the parents, with whom they interact and learn rather than learn from books. In a review Wright (1957) suggested that child misconduct can result from his/her perceived unacceptance by the social circle. In failure to get the required attention, the child struggles to acquire power, revenge, and a feeling of inadequacy (Goddard &

Dennis, 2003). History of research on parenting yields the importance of relationship and unique bond between the child, influencing the development through the life span, academic success and decline (Spera, 2005). A brief review of the few important theories in this domain is provided below.

The attachment theory developed by Bowlby and Ainsworth (1991) represents one of a classic type . The assumption of love as a bond, nourishment, and consequences in the relationship predict the parent-child behavior as a behavioral system adapted to promote survival and competence in the child (Easterbrook et al., 2013). The parents attend to the safety needs of offspring, thus providing comfort and warmth. These in turns facilitate the child to develop competence in learning to overcome the environment, practice autonomy, develop self-efficacy in cognitive and social spheres (Holden, 2010). Moreover, Ainsworth pointed out that a child can develop four types of attachments with the caregiver including secure attachment, avoidant attachment, ambivalent attachment and disorganized attachment (Sincero, 2012).

The behavioural theory adopted a much mechanical perspective for child rearing. The concept of reinforcements, for instance, in training appropriate behaviors to children, either positive reinforcement, negative reinforcement, or even with the application of punishment where the shaping of desirable behaviors is required (Watson, 1920; Holden, 2010). Similarly, proponent of social learning theory emphasized the role of modeling and observational learning in acquiring new behaviours (Bandura, 2001, 2018). However, according to social relational theory, Bell (1979) held the view that parents are key figures to control and regulate the behaviour of children by setting lower and upper limits for the acceptable behaviour of their children (Kuczynski & De Mol, 2015). Another similar view called social role theory explores roles, status, expectations regarding behaviors and the

consequences, emphasizing on the parental participation. According to Vygotsky (1994) parents play a significant role in child's cognitive development during their interaction with their social environment. The positive parental behavior in learning more appropriate and mature behavior leads the child to a " zone of proximal development", where the child performs the task independently and successfully without any help (Laff & Ruiz, 2021).

In addition, self-determination theory explores the reasons for an individual's actions (Deci & Ryan, 2012). It further posits three basic needs, emphasizing a child's agency, that motivates individuals to act: autonomy, competence, and to relate to others. According to (Farkas & Grolnik, 2010), parenting qualities include taking interest or getting involved with the child, providing an environment to explore and learn skills and become competent, and supporting the child to grow and become an adult autonomous individual is inevitable for parenting (Holden, 2010). However, Bowen (1966) emphasizes the fundamental concept of co-parenting, which refers to parents' mutual and cooperative involvement as parents in child-rearing, highlighting emotional functioning as a critical process in a family (MacHale & Lindahl, 2011; Brown, 1999). Similarly, emotional security theory hypothesized that perceived conflict between parents can trigger distress in a child when they see separation, divorce or other disputes between parents (Davies & Cummings, 1994).

Another influential contribution comes from the views of Baumrind (1967), who classified different parenting styles known as "Baumrind's Parenting Typology" and pioneered the research specific to this area. Baumrind theory signifies two dimensions of parenting with two possible aspects described as responsiveness vs. unresponsiveness and demandingness vs. un-demandingness. The parenting practices classification includes permissive, authoritarian, and authoritative styles of parenting (Kuppens & Ceulemans,

2019). Afterward, Maccoby and Martin (1983) added a fourth type by providing a distinct category of two dimensions: neglectful, permissive, authoritative, and authoritarian parenting style (Collins et al., 2002). It is evident that parent's quality of interaction with the child affects a child's behavior (Liem et al., 2010; Timpano et al., 2010).

According to Darling and Steinberg (1993) parenting style is a pattern of parents' attitudes and behaviors toward children and a dynamic environment in which they express their behaviors . While, parenting practices are those behaviors that parent display during the process of child socialization. For example, parents' interactions with their children are observable when they show their involvement, attend meetings to get their child's progress and monitor the child at home. Moreover, in order to interact with their children, parents engage in certain behaviours (for example, initiating play, expressing appreciation, or supervising homework) (Kuppens & Ceulemans, 2019). Furthermore, parenting practices have a significant impact on children and their socialization, with the impact being greatest in late childhood and leading to emotional and social adjustment problems later in life (Maccoby & Martin, 1983). Furthermore these hurdles extend to other areas of maladjustment including impulsivity, substance abuse (Benchaya et al. 2019) crime or child-to-parent violence, development of low self-esteem, depression, and anxiety in children (Cortese et al., 2016; Gámez-Guadix et al., 2012; Milevsky et al., 2007; Oliva et al., 2008; Steinberg, 2001). Parenting practices can be fundamental in forming early childhood experiences and psychological adjustment in general (Rohner, 2016).

It has been shown that good parenting practices lays the groundwork for effective family functioning. Despite low family income, which is strongly linked to poor outcomes in developing children, the presence of positive parental engagement and harmonious family functioning lowers the risk factors for behavioural issues in younger children. On

the other hand, mothers' emotional distress might make children' behaviour issues worse (Linver, 2002).

2.5 Family Functioning

Family functioning characterizes the global family environment, including the structural and social interaction of a family, specific modes of conflict, cohesion, adaptability, organization, and communication quality. Healthy family functioning occurs within a family environment with clear communication, well-defined roles, cohesion, and good affect regulation (Lewandowski et al., 2010). In contrast, Unhealthy family functioning occurs within families of low-income, high conflict levels, disorganization, and poor affective and behavioral control (Alderfer et al., 2008). There are various theories that attempt to explain different dimension of a family to understand its structure and function.

For example, according to bioecological model a family context and setting, including, economy, peer, and sociocultural beliefs, can influence a child's and adolescents development process (Bronfenbrenner & Moriss, 2006). The Model describes its five subsystems; first is "microsystem" that incorporates the quality of the relationship between a parent and child. The second is "mesosystem" that evaluates the interaction between multiple settings in an individual's surroundings, where they do not operate directly. Thus, assessing how a parental experience from work can influence the interaction with the child. The third is "exosystem" that includes institutions on a larger scale, including organizations, mass media, hospitals and agencies. The impact from these institutions flow towards smaller organizations and ultimately to the individual level. The fourth is "macrosystem" that includes the culture, tradition, religion and politics of a society provide

a context that explains the individual's behavior and relationships. Lastly the fifth is “chronosystem” that evaluates the pattern of development across time and the influence of the environment on a child's development (Bronfenbrenner, 1995).

Next the Functionalism’s perspective endorses families as a substantial institution that provides the foundation for stability in society. This approach considers the crucial roles adopted by family members during family occasions or activities. These active role performances facilitate the growth of a family as a healthy functional unit in society. According to Murdock (1949) a family provides socially acceptable and healthy intimate relationships in marriage and reproduction (Davis, 2015). According to Lee (1985), the family then provides the training required for survival through adulthood. The families play the role of a primary agent of socialization and cultural adaptions for the children. The children inherit their ancestors' cultural norms, beliefs, values, attitudes, thinking patterns, and civic behavior (Crano & Aronoff, 1978). Similarly, symbolic interactionism inspects the world in the form of symbols and meanings associated with them (LaRossa & Reitzes, 2009). They try to understand these symbols in the context of the world. For example, a family represents a symbol of unison, compassion and respect. During past years, the changing parent-child relationship due to remarriage, adoption, and guardianship roles changed the meaning of a " parent" from a biological and emotional connection to a caregiver responsible for raising the child. A family characterizes a group of " actors", or role players responsible for playing their part to constitute a family unit, bond with the child and facilitate a child's emotional, social, and intellectual growth in modern days (Laff & Ruiz, 2021).

The Beavers system model attempted to study health and pathology in families by integrating family system theory and developmental theories (Franklin et al., 2004). This

model describes family competence and family-style as two important dimensions (Beavers & Hampson, 2000). Family competence pertains to the availability of information and structural adaptability to communicate and maintain that structure parallel to the external world and help achieve family goals (Drumm et al., 2008). Extreme styles hypothesize to occur in more dysfunctional families, while a more blended and flexible style occurs in healthier families. In addition, Olson's circumplex model is also based on system theory, this model of family functioning presents a typology (Anderson & Gavazzi, 1990; Craddock, 2001), including cohesion, flexibility, and communication. Where cohesion is defined as 'the emotional bonding that family members have toward one another (Olson, 2011; Fristad, 1989). leadership contains quality of flexibility in organization, role, relationships, and related rules in negotiations. Communication represents the positive communication skills utilized in the couple or family system (Anderson & Gavazzi, 1990; Dai & Wang, 2015).

Yet another systemic approach, the McMaster model of family functioning, focuses on family processes. It is assumed that the reciprocation process and organizational structures of a family influence the behaviour of its members. The theory also implies that understanding a family structure as a whole requires consideration of its subunits. Because all members of a family are interconnected (Laff et al., 2021). This model identifies various dimensions that are necessary for dealing with clinically presenting families. The family function model assesses the family along with this dimension to evaluate the extent of effectiveness of its function. The healthy and unhealthy patterns in a family structure and organization can be assessed along with these six dimensions (Miller et al., 2008; Dai & Wang, 2015).

The dimension of problem-solving refers to the family ability to maintain its optimal level of functioning by resolving problems that threaten its integrity and functional capacity. This dimension perceives the problem as a situation for which a family is trying to find a solution (Deci & Ryan, 2012). However, some problems remain unresolved and a threat to the capacity of a family to function well. These are instrumental and affective types—everyday mechanical problems, such as earning and managing money. Similarly, affective problems are those related to feelings and emotional experience.

Similarly, within a family, communication is a means of information exchange. There are two types of communication regions: instrumental and emotional. The main objective of instrumental communication is to precisely and successfully "transmit" an intended message (explicit content), where the achievement of a goal is the main priority. While, affective communication (implicit content) deals with family members' disclosure of their feelings and emotions within the family (Miller, 2008; Dai & Wang, 2015).

Roles are recurrent behavior patterns of family members that are displayed to perform family tasks. These tasks include routine chores such as garbage disposal to cooking. These tasks are further divided into sub-areas: crucial functions to maintain balanced functioning, including affective, instrumental or combination of the two, are said to be necessary tasks. Other tasks arise during routine functioning and can be of varying degrees but not necessary for effective functioning. However, there is a need to address all essential areas of equal importance to be addressed (Miller et al., 2008; Dai & Wang, 2015).

Affective responsiveness refers to the family members' capacity to respond to various stimuli with the right emotional state and to express a variety of emotions according to the circumstance. In addition, affective involvement shows the ability of a family to

ensure the needs of each other in terms of showing interests in activities of the rest of family members, showing concern, care, and understanding for others (Miller et al., 2008; Dai & Wang, 2015).

Moreover, behavior control refers to a family's adopted set of habits for handling particular circumstances. These courses of action are utilized when a family needs to prevent physical injury, when behaviour control is needed to express psychobiological needs (such as eating, sleeping, and aggressiveness), and when social skills are needed to interact with people both inside and outside the family (Choksomngam et al., 2022; Chacko et al., 2014; Aduen et al., 2018).

In conclusion, Mc master Model identifies dysfunctional transactional patterns in a family, in addition to six dimensions. These dysfunctional patterns can interfere with any of the mentioned dimensions of families (Miller et al., 2008). The theory focuses on the family's subsystems capable of self-regulation and self-reorganization as independent units and conceptualizes families as organized wholes (Cox and Paley, 1997, 2003; Minuchin, 1985). Self-regulation helps to maintain the pattern of interaction between a family during the escalating conflict and then to recover the previous sate of low conflict, for instance, economic crisis and shifting of rolls for earnings and providing members of the family (Schermerhorn & Cummings, 2008). A family system needs to be studied as an organized and cohesive emotional unit, affecting and projecting shared emotions and behavior rather than dyads or individuals (Mchale & Fivaz-Depeursinge, 1999).

2.6 Early Maladaptive Schema

Originally Early Maladaptive schema is defined as "a broad pervasive theme or pattern composed of emotions, bodily sensations, cognitions, and memories, about oneself

and one's relationships with others". These patterns develop during childhood and evolve into more complex and dysfunctional through adolescents. These EMS can be incapacitating in many life areas, affecting one's optimal functioning throughout life (Young et al, 2003; Rafaeli et al., 2010).

The schema is referred to as a fundamental organizational principle in the construction of these mental structures. As for its utility, it is established that schema connects cognitions to perception, emphasizing its mediating role in the process (Katunar & Eterovic, 2018; Andrew & Wuerth, 2020). This same lens in mind helps to see and interpret the world around us (Mcvee et al., 2005). Bartlett emphasized the organizational value of social and cultural factors in explaining the subjective sense of the world (Fulbrook, 2020). While Piaget (1952) describes the schemas as functions to assimilate and adapt to the environment. For example, human beings use schemas of space, time, causation, and time to process information within their surroundings. He regarded schemas as a mental framework to represent the complex world's varieties of objects, events, and relations. This framework is distributed into the sensory-motor, symbolic, and operational schemas (Scaglia, 2018).

Similarly, the work of Vygotsky's (1934) presents the sociocultural constituent of the schema as an influential and dynamic agent in seeding and shaping thoughts through social interaction (Vygotsky, 1978,1986; McLeod, 2018; Mcvee et al., 2005). In the Space model Gavelek and Raphael (1996), based on work of Vygotsky, explains in numerous ways that the intrapsychological and interpsychological interact to process and construct schemas during learning. According to Robbins these interactional processes reflect the transformation that originates from internalization. The space model describes the stages of transition that represents the cognitive growth in creating and evaluating the schemas. For example,

the stage of "appropriation" represents the process of acquiring thinking styles with interaction with others. The second stage of "transformation" that is the process of transforming and taking hold of appropriated ways of thinking. The third staged "publication" is the process of expressing through talk or actions in front of others. The final stage of "conventionalization" refers to the process of making these ways of thinking into a standard way of thinking for oneself and others. This model facilitates comprehending the genesis, growth, and transformation of schemas that extend to individuals to interact with society and culture (Mcvee et al., 2005).

In addition, according to Rumelhart and Ortony (1977), schemas have certain characteristics, including variables or multiple nodes of concepts, which provides a plethora of information regarding the world and its implementation. It posits that schemas provide a dynamic network of intaking, processing and extending meaningful knowledge. Moreover, Beck (1967), initiated to use concept of schema in cognitive therapy and based his techniques on understanding underlying processes that permeate the negative schemas and malfunction in self and interaction with others. According Beck schemas are the processes used to screen, code, and evaluate the stimuli that influence the organism. Beck and Freeman (1990) identifies core beliefs (schemas) and underlying assumptions (conditional beliefs) for therapeutic procedures. Beck posits the importance of emotions to trace maladaptive schemas during therapy. Beck and colleagues also developed schemas checklist and Dysfunctional Attitude Scale to tap the underlying maladaptive schemas that trigger and then maintain depression. They posit that replacing these maladaptive schemas with more effective and adaptive schemas with appropriate therapeutic techniques is imperative (Beck et al., 1990; Padesky, 1994). In addition, Young (1999) devised a schema model and suggested that maladaptive schemas are crucial for schema therapy (Cecero & Young, 2001). Their viewpoint is based on Beck's (1967) brilliant work in the area of

cognitive therapy. It supported the view that early maladaptive schema believe that early experiences served as a basis for current pathological behaviour (Cecero et al., 2004).

Originally, early maladaptive schema (EMS) is defined as" a broad pervasive theme or pattern composed of emotions, bodily sensations, cognitions, and memories, about oneself and one's relationships with others". These behaviours start in childhood and become more complex and dysfunctional as teenagers get older. These EMS can significantly impair one's ability to operate in certain areas of life (Young et al., 2003; Rafaeli et al., 2010). The schema refers to a fundamental organizational principle in constructing these mental structures. As for its utility, it is established that schema connects cognitions to perception, emphasizing its mediating role in the process (Katunar & Eterovic, 2018; Brook et al., 2020). In the context mentioned earlier, the schemas represent the beliefs about oneself, the world and the people around us. These beliefs, unconsciously, affect the perspective we make about ourselves, our world, the quality of our relationship and future hopes. According to Young et al. (2003) since behaviours are a reaction to schemas rather than being a component of them, schemas do not include particular behaviours. Early maladaptive schemas develop in childhood as a result of traumatic life events hence these schemas are planted on a foundation of unmet demands in early childhood.

According to young (1999) every child has five distinct core needs that must be met by their caregivers: the need for secure attachment (safety, stability, nourishment, and acceptance), the need for autonomy, competence, and identity, the freedom to express reasonable needs and emotions, play and spontaneity, and the ability to exercise self-control and realistic boundaries. Therefore, the type of the interaction between the child and the caregiver affects how the child develops (Young, 2003; Arntz et al., 2022). If the

caregiver fails to set attainable boundaries, then children are unable to enjoy and regulate their own behaviors independently. Consequently, these needs remain unmet or caregivers fail to satisfy those core needs (Sikirica et al., 2015).

In addition, Young et al. (2003) found 18 early maladaptive schemas and divided them into five domains including: Disconnection and Rejection, Impairment of Autonomy and Performance, Impairment of Limits, Other Directedness, and Over-vigilance and Inhibition. Schema of disconnection and rejection is the first domain that exhibits insecure attachment with the caregiver. It emerges when the caregiver does not provide the early developmental needs of love, belongingness, support, and direction to the developing child. Consequently, they continue to hold on to the idea that others won't comply with their demands. Children who grow up in abusive, cold, and isolated families get ingrained with this schema (Dattilio, 2002). The schema of abandonment, mistrust, deprivation, defectiveness/shame, and social isolation are included in this domain.

The dread of abandonment and chronic worry over losing those relationships are both represented by the notion of abandonment as the perceived instability and unpredictability in a relationship. Additionally, using this schema causes the person to become envious, needy, dependent, and controlling as well as cause them to get angry and depressed (Rezaei et al., 2016). The continuous fear that one will suffer abuse or maltreatment at the hands of others is known as mistrust. Because they believe others will take advantage of them, manipulate them, or cheat them, the person with this schema exhibits mistrust in other relationships. Such people may behave abusively and show mistrust when interacting with partners as a result of growing up in an abusive environment (Patterson, 2020; Kebritchi & Mohammadkhani, 2016). Deprivation is a different schema that causes people to disregard their emotional demands. They also think that these things

are irrelevant or that people who are strong and independent do not have these wants. Psychological symptoms including depression, sadness, and loneliness are frequently displayed by them, along with even physical symptoms (Brown, 2021). People with this schema act tough and avoid expressing their emotions (Young et al., 2003). Defectiveness or shame is the unshakable idea that someone has a specific flaw or defect linked to their appearance, character, or manner of social interaction. The ongoing sense of shame and unworthiness generates a fear of having these defects exposed. People with low self-esteem, self-consciousness, humiliation, and self-doubt frequently feel insecure in comparison to other people (Lucke et al., 2017; McKay et al., 2020). Children reared in socially isolated families tend to have social isolation schema. As a result, individuals experience social awkwardness or think they don't fit in anywhere. People with this schema consequently want to stay alone and maintain a distance from social interactions (Oshima et al., 2021).

Impaired Autonomy and Performance is the second domain, including four maladaptive schemas. This domain reflects the belief about one's unstable self-perception, self-agency and autonomy as an independent being. The overprotective family environment, over-involvement or carelessness in child development leads to the child's inability to function as a confidant and autonomous individual (Pellerone et al., 2017; Koemans et al., 2015). People who hold the maladaptive dependence/incompetence belief have a low sense of sufficiency and are judgmental. For them, making decisions in their own everyday life is difficult. Before making any decisions in life, they feel the need to speak with others in order to resolve their daily problems (Terrighena, 2020; Thiessen, 2019). Children whose parents don't allow them make decisions are unable to acquire the life skills needed to live independently (Petrocelli, 2001).

Fear and apprehensions about getting sick or experiencing harm as a result of the vulnerability to harm or illness schema arise. A person with this syndrome believes they have been the victim of crime or a disaster more often than they actually have been (Ghamkhar Fard, 2014). The over-involvement of parents in every aspect of the child's emotional and social development leads to the emergence of enmeshment and undeveloped self-schema. As a result, they cannot think of themselves as independent entities from the "enmeshed figure". This dependency causes social life deficits and feelings of emptiness in the individual (Kivisto, 2015). People who have this failure schema feel a great sense of loss, insufficiency, and lack of intellectual and professional potential in comparison to those around them. In addition, a lack of commitment, attention, or discipline might also aid in keeping this schema (Bertrams, 2020).

The third domain is Impaired limits that reflects inability to set limits for oneself and leads to the impaired personal and interpersonal boundaries. This schema triggers difficulty in taking responsibilities, abiding by rules, controlling impulses, and maintaining goal-directed activities. Consequently, they face problems achieving attainable goals. Parents with undecided limitations and reasonable supervision may develop an inability in their child to learn self-discipline. Children fail to feel accountable for what they say or do in an unsupervised family environment (Esmali Kooraneh & Amirsardari., 2015; Louis et al., 2021). People with the schema of entitlement/grandiosity perceive themselves as flawless and exceptional. This schema may lead them to be above the rules and regulations set for other people around them. Moreover, they try to fulfil their unrealistic and unreasonable desires and pay no consideration to the needs of others (Corral & Calvete, 2014). In addition, Individuals with schema of insufficient self-control/self-discipline have poor self-discipline and emotional intolerance. Moreover, they tend to be impulsive

disorganized and unreliable. . Their sense of poor control over behavior causes problems in their life (Terrighena, 2020). During the development period, parents do not set limits for the children to succeed in life objectives, resulting in disorganization (Hendriks, 2019).

The fourth domain of Other directedness represents one's belief about conditional relationships, where the person feels accepted by others only when they satisfy the demands/needs of others. Moreover, they engage in activities that seem to approve them as acceptable at the cost of their own emotions. This schema may emerge in response to the need to integrate the sense of belongingness and approval from others (Balsamo et al., 2015). This domain consists of three maladaptive schemas. Individuals with this schema of subjugation believes themselves to be unimportant and keep suppressing their personal opinions and emotions as they fear the rejection of others, whose approval they seek, while not doing so may lead to something catastrophic. In contrast with the schema of self-sacrifice, people tend to subdue one's needs for others as they feel it is justified. The associated empathy- to protect others from pain- reflects a positive inclination, but too much effort results in exhaustion and stress (Skurat, 2021). As in approval-seeking / recognition-seeking, people weigh their worth in the approval and reactions of other people. This schema leads to a struggle for the outlook of one's lifestyles, social and financial status. In general, parents prioritizing their children to focus on fulfilling social standards and ignoring their own desires inspires the children to maintain this schema in life (Ricardo-Ruy & Valle-Mena, 2016).

The fifth and last domain in the schema therapy model is over-vigilance and inhibition. This domain characterizes the inflexible personalized values, rigid moral standards and a tendency to focus on their feelings and emotions to the extent of losing their social relationships. They safeguard in response to the subconscious worry and fear

of going wrong. Furthermore, such schemas trigger strict, demanding, and perfectionist family environments in children (Dattilio, 2002). In addition to this, domain negativity / pessimism schema emerges in response to childhood sufferings, hardships. Individuals tend to evaluate their experiences with the negativity in their affairs, mainly sorrows, pain and live-in apprehension of the worst (Kivisto et al., 2015). Individuals with emotional inhibition schemas exert robust control on the expression of their emotions and inhibit their natural spontaneity for both positive, that is, playfulness, and negative emotions, that is, aggression (Petrocelli, 2001). In most of the time-restricted environments where children are prohibited or disapproved to express themselves naturally may exhibit this schema to avoid embarrassment (Louis et al., 2021). Having a schema of unrelenting standards / hyper criticalness, people develop internalized, inflexible rules and standards. They display a highly critical approach towards themselves and others due to their obsessive perfectionism (Young et al., 2003). The schema of punitiveness displays one's preference to choose punishment over forgiveness while dealing with mistakes. Adults with this schema are intolerant to failure and follow inevitable punishment standards for themselves and others (Pilkington et al., 2020).

Moreover, EMS is often out of cognitive awareness and plays a significant factor in increasing susceptibility towards poor psychological health and mental conditions, including depressive/anxiety and personality disorders (Young et al. 2003; Brotchie et al., 2004; Pinto-Gouveia et al., 2006; Reeves & Taylor, 2007). These ingrained basic ideas, or schemas, act as a lens through which people view the world and are mirrored in the automatic ideas that people have about a circumstance or event (Beck & Dozois, 2011; Young et al., 2003). These dysfunctional automatic thoughts are an essential target for

treatment because they are linked to unhelpful coping strategies (Torrente et al., 2014) and may raise the risk of depression (Oddo et al., 2016).

2.7 Related Researches

ADHD is most prevalent neurodevelopmental disorder that has been associated with many cognitive, social and academic limitations . In Pakistan there is no valid study that provides the prevalence rates of ADHD in population including children, adolescents or adults. However, previous researches other than Pakistan shows a gradual increase in this condition. As a meta-analysis on ADHD have reported pooled prevalence estimates in adult ADHD of 2.5% (Simon, 2009), whereas, in children and adolescents, the pooled estimate was 7.2% (Willcutt, 2012; Thomas et al., 2015). Epidemiological studies report a worldwide prevalence of attention-deficit hyperactivity disorder (ADHD), including a range of countries in Europe, Asia, America, Iraq, of approximately 2.2% overall, as estimated in children and adolescents below 18 years of age. The mean prevalence of ADHD was about 2.8% overall in adults of 18 to 44 years old (Fayyad, 2017). A recent meta-analysis of 12 studies showed a pooled prevalence of ADHD 7.47% in children and adolescents and a greater prevalence in boys (10.60%) than in girls (5.28 %). However, the most common type was predominately inattention type (ADHD-I, 2.95%), followed by hyperactive-impulsive type (ADHD-HI, 2.77%) and the combined type (ADHD-C, 2.44%) (Ayano, 2020).

Attention deficit-hyperactivity disorder (ADHD), is the most prevailing neurodevelopmental disorder in children and adolescents that interferes with normal functioning in school, life, emotional regulation, decision making and maintaining social interactions (Posner et al., 2020; Magnus, 2022). Longitudinal research on ADHD have

found that younger age of the child, severity of parental mental health, aggressive behaviour, migration, and presence of generalized anxiety symptoms are risk factors in the development of complex ADHD symptoms (Wüstner et al., 2019; Murray et al., 2020). According to the present literature on ADHD in children and adolescents with ADHD, there are significant rates of co-occurring externalising and internalizing problems. Oppositional defiant disorder (ODD) and conduct disorder are examples of externalising disorders, which are those in which discomfort is conveyed outwardly and are prevalent with ADHD (Cosgrove et al., 2011).

It is evident that adolescents dealing with specific incapacitating developmental issues and disorders may face difficulty coping with their rapidly shaping sophisticated cognitions, struggling with hormonal and physical changes (Pingault, 2015). Family environment and parental interaction provide a foundation for making primary and then refining the cognitions about oneself and their world, leading to the psychological adjustment or maladjustment. In adolescents, this change may apace with increased sensitivity in those suffering from cognitive difficulties to process such complicated emotions and demands from the external world. One such disorder, attention-deficit/hyperactivity disorder (ADHD), is the most prevailing neurodevelopmental disorder in children and adolescents (Jokiranta-Olkoniemi et al., 2019). In adolescents with ADHD, intense and frequent feelings of rejection accompany the intense feelings of aggression or resentment and characterize destructive and painful emotions (Dodson, 2022). A study on ADHD in adolescents, reported use of maladaptive emotion regulation methods (such as self-blame, catastrophizing, and ruminating) more frequently than controls and using adaptive emotion regulation strategies (such as positive reappraisal) less frequently (Mayer et al., 2022; Bara et al., 2021). A study conducted in fourteen North

American and European countries. A number of 108 participants were evaluated for their various life domains, including social and routine life, using a focused group. It was found that participants' statements about the presentation of symptoms, impact of ADHD throughout life, childhood experiences, addictive and risk-taking behavior, work and productivity, relationships, and psychological health impacts were similar across all respondents (Brod et al., 2012). The severity of the ADHD symptoms and depressive symptoms were also found to be linked with rejection sensitivity at later age in adolescents (Mrug et al., 2012).

The psychological adjustment of adolescents with ADHD is closely correlated with parental acceptance or rejection (Modesto-Lowe et al., 2008). Children and adults with ADHD are more likely to become angry, resentful, and experience other negative emotions when they suffer major rejection (Yoo et al., 2021). The differences in links between mother rejection, family, cognitive characteristics, and aggression in home and school contexts were explored in a study on a sample of 476 school-age (up to 15 years old) children with a diagnosis of ADHD. The emergence of violent behaviour in ADHD was discovered to be influenced by other genetic and environmental variables (Ercan et al., 2014; Retz and Rösler, 2009; Brinksma et al., 2021).

Maternal rejection in children with ADHD has a strong association with poor psychological adjustment (Guzel et al., 2018). According to a global cross-sectional survey carried out in Pakistan, adolescent violence is linked to the parent-child relationship. The results showed that physical aggressiveness is more common in male adolescents than in female adolescents. Additionally, the distinction was more noticeable for teenagers who had strained parent-child relationships. Additionally, the results revealed the potential

significance of gender and parent-child relationships as indicators of physical aggressiveness in adolescents with ADHD (Lakhdir et al., 2020).

Parental bonding is a necessary element in the social adjustment of children and adolescents (Raudino et al., 2013). A study conducted by Gau and Chang (2013) compared ADHD and Non-ADHD samples to find association between children's maternal bonding and behavioral problems. The results indicated that mothers with neurotic traits, depressive symptoms and ADHD symptoms have overprotective behavior and more control while having less affection and care. The mother's neurotic/depressive symptoms and overprotection significantly associate with increased inattention, hyperactivity impulsivity, and comorbidity in children with ADHD (Meyer et al., 2022). In addition, parenting practices, including warm, consistent and calm parenting, enhance the socio-emotional adjustment of children with ADHD (Bhide et al., 2019).

Additionally, there is a reciprocal impact of parenting and child engagement (Zhang et al., 2020). According to studies, there is a direct link between increased parental involvement and improved academic performance. In contrast, a child's poor academic achievement is linked to harsh parenting. Unique setting, demographics, and child development factors, however, can explain these impacts in a variety of ways (Yan & Ansari, 2016). According to Barkley (2019) the disputes between an ADHD teen and their parents highlight the significance of ODD and ADHD co-morbidity and the escalating difficulties between parents and teenagers. Teenagers also deal with difficulties in self-regulation, executive functioning deficits, and interactions with other family members during this time. Additionally, cognitive, behavioural, emotional, social, and developmental function abnormalities as well as decreased academic performance are linked to ADHD symptoms (Rader et al., 2009).

Numerous researches have investigated the relationship between parenting practices and the characteristics (comorbidity, gender, age) of children and mothers with ADHD. The results demonstrated a strong link between the application of a mother's strict discipline, less involvement, and an increase in oppositional defiance in children with ADHD (Cöp et al., 2017; Li et al., 2018a). Additionally, research has demonstrated a strong link between comorbid depressive symptoms and frequent arguments and conflicts amongst the parents of children with ADHD. Disagreements concerning homework, personal cleanliness, and bedtime rituals are frequently cited as the root of disputes between parents and adolescent (Garcia et al., 2019). In addition, the issues related to the organization of personal tasks hinder due to symptoms of impulsivity or inattention in children with ADHD. In turn, it also aggravates the parental monitoring of academic and daily activities of the child, triggering more distress among parents and use of punishment and negligence (Teixeira et al., 2015; Cappe et al., 2017). Similarly, another study evaluated the interaction of parenting practices, distress of mothers with symptoms of ADHD in children (Gau, 2007). The results revealed that mothers' lack of affection, overprotection and control was significant in boys. Moreover, such children show more issues in communication and interaction with parents and behavioral problems at home.

As Gau and Change (2013) found a substantial correlation between ADHD children's hyperactivity and impulsive symptoms and mothers' reduced bonding. The study links the influence of depressed mothers, who exercise inconsistent or strict control over their children and show less affection to them, to children's increased inattention and comorbid disorders. According to the study, impulsivity and hyperactivity are highly correlated with neurotic features in mothers. Additionally, mothers' excessive overprotection or participation has a major impact on symptoms of children with ADHD.

According to a similar study that evaluated father and child interaction in the ADHD population of Taiwan. The study revealed the strong correlation between authoritarian control and overprotection between fathers and their children. Such children were reported to have more behavioral issues at home. Moreover, traits like depression and neuroticism and lack of support in families can significantly impair the child's behavioral problems (Chang et al., 2013).

Other researches also investigated how teens and children were affected by digitalization and its effects on their symptoms of ADHD. Given that parents have ample time to spend with their children throughout the epidemic, their function in determining the psychological well-being is significantly more effective. However, how parents give their children access to these digital devices varies depending on their parenting style (Shuai et al., 2021; Hung, 2022). In addition, parents of children with ADHD and children without the disorder were compared in a study. Participants aged 7 to 12 made up the study's sample. The study's findings suggested that the parents' education and gender have an impact on how they interact with their children. The employment of an authoritarian approach was more prevalent in children with ADHD than in non-ADHD children. Thus, it is essential to provide knowledge about how to deal effectively with children and foster better relationships between families (Moghaddam, 2013).

In addition, IQ, social position, geography, career, and employment status may all be related to how warm and supportive parents are to their children. According to studies on mild to severe cases of ADHD, parents showed significantly more warmth and support for older children with mild ADHD and less severe social adjustment issues than they did for parents of younger children with severe cases of ADHD (El-Deen et al., 2021). Parents have a crucial role in fostering a positive social environment. However, children with

ADHD may have poor outcomes if their family is dysfunctional and their parents use negative parenting techniques. The manifestation of behavioural issues, social maladjustment, and increased ADHD symptoms are risk factors for a child's unhealthy development that are connected to poor parenting techniques and an unfavorable family environment (Huang et al., 2019 ; Pires et al., 2013).

The application of parent-child centered therapies can be highly helpful to raise positive parenting to the highest level and lessen associated parental depression. In children and adolescents with ADHD, these interventions can enhance their academic, social, behavioural, and neuropsychological outcomes. These interventions can also benefit the transactional nature of parent-child wellbeing (Tarver et al., 2015). Previous research studies have highlighted the importance of evidence-based interventions. Healthcare practitioners must also be aware of the efficacy of these interventions. Since the issues with a child's adjustment may continue to affect other aspects of their lives. In this situation, parents and primary caregivers continue to be important factors in the emergence and maintenance of such issues. It is crucial to intervene soon to utilize effective interventions to prevent adversity in these problems later in life because the root of mental health issues, social problems, and behavioural problems are thought to relate to younger ages in life. Interventions can also improve family dynamics and the quality of life for both parents and children (Ryan et al., 2017).

In Taiwan, a research of 666 parent-child dyads looked at the association between children's mental health problems and parenting. According to self-report gender disparities, boys saw parenting as more Chinese culture centered and authoritarian. Parents, on the other hand, scored higher on Chinese parenting. Fathers were viewed as authoritative, whereas mothers were perceived as authoritarian. In comparison to fathers,

mothers scored higher on authoritative parenting. Understanding the origins of mental health symptoms in children requires an understanding of the child's view of parental practices (Huang, 2019). Children and teenagers are frequently referred to mental health facilities or counselling services for conduct issues like violence, disobedience, and breaking rules (Kazdin, 1995). These issues are linked to impairment in a number of spheres of life, such as decreased academic performance, impaired socialization, and legal system participation (Lahey, et al., 1997). The most well-documented risk factor associated with is being exposed to poor parenting practices (Dadds, 2003; Dishion et al., 1991; Vuori et al., 2015). A wide range of factors have been found as being associated with the development and persistence of these conduct disorders. These parenting techniques include strict and inconsistent rules, poor supervision and monitoring of children, low levels of positive involvement with children, and excessive use of corporal punishment (Frick et al., 1992).

Morgan et al. (2016) analyzed multi-informant ratings by the end of middle school using a longitudinal sample of 7,456 children who were tracked from kindergarten to eighth grade. Children from low socioeconomic backgrounds, those whose mothers struggled with mental illness or substance abuse, or those who were spanked as a form of punishment in kindergarten were significantly more likely to later display severe levels of conduct disorder symptoms related to ADHD in eighth grade. Low academic accomplishment was observed to increase the likelihood of both mild and severe ADHD manifestations in a distinctive way. Similarly, in a research, 45 children under the age of 18 who presented with mixed ADHD and ODD were assessed twice (at the age of 6 and 18). It was discovered that dysfunctional disciplining techniques and the severity degree of ADHD as reported at time one screening were predictive of oppositional symptoms and cognitive issues in the

follow-up. In contrast to the effective parenting group, children with dysfunctional parenting showed an increase in oppositional conduct between times 1 and 2 evaluation (Colomer-Diago et al., 2014).

The parental involvement and positive parenting domains have been found to be very effective in monitoring children and adolescents with ADHD. According to a cross-sectional study, conducted in India 38 children and adolescents between age of 8 and 16 diagnosed with ADHD. According to the parental report of their children's behaviour as being positive fell under the domain of positive discipline, while being attentive , engaged, and interested were included under the domain of parental involvement. However, children with comorbid ODD and behavioural issues were likely to have poor parental involvement and reduced positive parenting (Jacob et al., 2021). Also, previous studies have suggested that dysfunctional parenting practices may contribute to the later emergence of behavioural issues in children with ADHD (Chronis-Tuscano et al., 2008).

Besides that, studies investigated the association between parenting styles and children's adjustment/maladjustment. The results of these studies indicate association of harsh and neglectful style with the problems of social adjustment and personal adjustment in children and adolescents with ADHD (Haskett & Willoughby, 2007; Ellis & Nigg, 2009; Fenesy & Lee, 2018; Park et al., 2017).

In addition, according to Pour and Kasaei (2013) significant lower level of healthy functioning in families of children with ADHD have been found, particularly in the area of problem-solving. Families communication with children with ADHD has been found to have higher level on emotional communication and emotional regulation problems (Pasalich et al., 2012; Moen et al.,2016; Arabi et al., 2020). A systematic review indicated

that youngsters with ADHD require supervision and monitoring by parents to fulfill their tasks and perform daily chores as compared to non-ADHD (Spaulding et al., 2020; Mendes et al., 2017). However, individuals with ADHD might have an impaired emotional reciprocation , especially in unhealthy families. As established by literature that children ADHD have greater problems related to emotional regulations, internalizing (depression) and externalizing problems (anger), and higher risk of family conflicts (Haydicky et al., 2013; Robin,2014; Sigfusdottir et al., 2017). Another aspect related to ADHD is behavioural control that may lead to risk taking behaviours. Evidence on risk factors in youth with ADHD demonstrated approximately 50% higher risks of injuries due to poor attention and lack of motor control (Ruiz-Goikoetxea et al., 2018).

Family functioning has been suggested to have a strong association with psychological distress among parents of children with ADHD that influence a child's well-being (Moen et al., 2016). For children and adolescents with ADHD, quality of life in the family, including communication, affective responsiveness, roles, and problem-solving, considerably changes, highlighting the significance of psychiatric and psychosocial features of ADHD (Kandemir et al., 2014). It is known that several changes take place during adolescence as findings of a study showed that developmental pathways differ when children enter adolescence. Additionally, the developmental trajectories of ADHD children have been linked to the moderating function of the family environment, including emotional expression and criticism (Musser et al., 2016). Numerous long-term researches on parenting and family functioning during the COVID-19 epidemic investigated the reciprocal relationship between parenting depression, stress, and family functioning in families with ADHD children. Additionally, these findings link ADHD adolescent externalising behaviours to the mother's heightened depressive symptoms and

overreacting. The bidirectional effect made the mother's symptoms worse in response to the child's symptoms getting worse over time (Breaux & Harvey, 2019; Robertson et al., 2021). A study found that a wealthier neighborhood contributes to decreasing inattention symptoms over time, while a less prosperous environment may result in the complexity of the ADHD symptoms. Other familial and environmental factors have also been linked to the reduction or increase in the symptoms of ADHD. The study also discovered that family conflicts and parents' low socioeconomic and educational status are another factor that contributes to the complexity of ADHD symptoms (Sharp et al.,2021; Mahmoudi & Mousavi, 2019).

Family functioning with ADHD children has also been influenced by the mental health and well-being of the parents (Moen et al., 2016). In addition, longitudinal and comparative studies investigated parents' family cohesion, adaptability, and reflective functioning in adoptive and non-adoptive families of children with ADHD. The findings of these studies revealed no differences among the stress scores of adaptive and non-adaptive families. Moreover, parental stress scores were reportedly significantly associated with hyperactivity in children with ADHD. The result also indicates an association between parental stress, family adaptability, cohesion and psychological adjustment in the children. However, hyperactivity of children strongly predicted stress in parents (Leon et al., 2015).

Compared to families with children who do not have ADHD, families with children with ADHD report more strained family relationships. According to a study, inherited factors play a significant role in the associations between child ADHD symptoms and family interactions. the effects of children's ADHD symptoms on the nature of the interactions in such families, temperamental characteristics, and maternal hostility, which in turn causes child ADHD symptoms in adopted children as early as 6 years old (Herold

et al., 2013). Since childhood, individuals with ADHD have experienced a variety of negative life outcomes and underachievement as a result of their enduring cognitive deficits, such as attentional problems, emotional instability, and disinhibition. Because of their impaired self-perceptions, they adopt unhealthy and schema-confirming coping strategies to deal with life situations, such as avoidance and procrastination (Newark & Stieglitz, 2010). Another systematic literature review of 10 original publications found that adult ADHD may be characterized by maladaptive schemata like failure, poor self-control, being different from others, and a sense of inadequacy. It was found that the usage of compensatory strategies and dysfunctional attitudes in individuals with ADHD were related to co-occurring mood issues (such as anticipatory avoidance). More negative automatic thoughts and cognitive distortions such as, overgeneralization, magical thinking, and comparative thinking were observed in adult ADHD patients (Máté et al., 2015).

ADHD is heritable, but it is also susceptible to environmental factors. According to research, family conditions and psychological stressors enhance the chance of developing and maintaining the severity of symptoms in adoptive children. To support a child's emotional and behavioural well-being, family communication and cohesion must be strengthened, as it mediates the effect of pre-adoptive risk factors (biological and environmental) in emerging symptoms of ADHD (Crea et al., 2014). The findings, based on a longitudinal cohort study, revealed that children with comorbid ADHD had increased symptoms of autism spectrum disorder, and problems in family functioning (an increased conflicts, parenting issues, and a lack of support). These factors were found to be associated with externalizing and internalizing behaviors, poor quality of life, and the severity of ADHD symptoms in children with autism spectrum disorder (Green et al., 2016).

Regardless of sociodemographic disparities, family functioning remains a powerful predictor of the impact on Parents of ADHD children and symptoms complication. According to an Australian community-based comparison study, parents have a low quality of life in areas such as emotional, family activities, decreases in parental warmth, increased stress and parental hostility in parenting practice, and increased sadness and anxiety. The study's findings indicated the importance of family context in improving monitoring of children with ADHD (Cussen et al., 2012).

Furthermore, while raising ADHD children, family chaos, parental stress, and poor parenting efficacy are unavoidable. A study based on secondary data on Latinx parent-child dyads revealed that the acculturation process and family functioning play an important influence in parenting anxiety and family turmoil when coping with children with ADHD (Malkoff et al., 2020). It is also well recognized that families with pre-existing psychiatric issues are more vulnerable to adversity in functional domains. A study based on patient medical records contrasted different family types to evaluate the causes of mood disorders, oppositional defiant disorder, and ADHD in children. The findings revealed that children with ADHD who had previously experienced stress, trauma, or maltreatment had a higher risk of hospitalization. When developing treatment techniques, it is critical to consider the psychosocial characteristics of a family, which may result in repeated hospitalization and a bad prognosis in children with ADHD (Behere et al., 2017).

However, there is still much to understand about how parent and family processes relate to the identification, care-seeking tactics, treatment decisions, and engagement with care systems and services for children with ADHD. As an integrated analysis examined how families and parents treat ADHD in children of various racial and ethnic backgrounds. Nine themes were discovered by the review from a sample of 32 articles. The results

recommended that health providers working with families from different backgrounds, including physicians, academics, and other professionals, must be aware of their unique perspectives to provide comprehensive treatment and care (Paidipati et al., 2017).

A different study in Tanzania recruited 16 parents of children with ADHD for a qualitative descriptive study. Data were acquired through in-depth semi-structured interviews, and the data were analyzed using qualitative content analysis. According to the findings, parents found it difficult to handle children whose level of functioning was damaged by abnormal and disruptive behaviour, such as failing to listen to directions. It is also clear that psychological issues, societal rejection, and stigma impede family functioning and social interactions. To meet the demands of these youngsters, a significant amount of family time and resources were invested, resulting in a disruption of economic activity that had a significant influence on daily life. Parents find it difficult to satisfy and manage the care demands posed by kids with ADHD. It is important to note that disruptive nature of ADHD symptoms presents a unique caring challenge different from those experienced with other childhood mental illnesses (Ching'oma et.al., 2022). Children with ADHD and conduct problems are difficult to raise because, so little is known about how the child's behavior affects the functioning of the family or how the parents of such children view their child.

A research explored whether families with children who have conduct issues and high vs. low levels of callous-unemotional traits encounter variations in family functioning and parental perceptions. The study included one hundred and one male parents or guardians and children under the age of seventeen. The McMaster Family Assessment Device was completed by children to measures various aspects of family functioning. A written statement describing the child from the parents or caregivers was used for

qualitative analysis. The affective involvement of families was lower than that of normal families. Such Families demonstrated much worse overall family functioning and less clearly defined family roles than families with typically developed children. Furthermore, children described parents as having a dichotomous personality and being outwardly charming. While parents report demonstrated playful, lovable, and a good interaction with their children. Overall, families reported distinct difficulty with affective participation, shallow affect and a lack of empathy in children with ADHD (Roberts et al., 2018).

The patient's personality disorder, which was linked to the maladaptive schemas of "Failure," "Social estrangement," and "Lack of self-control," was likely greatly influenced by ADHD (Lucke et al., 2017).). Additionally, it is well known that adolescents with ADHD experience social difficulties as a result of their inability to control their emotions and behaviour in social situations, which can result in clinical depression (Bunford et al., 2015).). According to a study both ADHD boys and girls were shown to be prone to in self-injury (Balázs et al., 2018). According to Meyer et al., (2022) overprotective parenting may be the cause of the sequential comorbidity of anxiety symptoms in young children with growing ADHD symptoms.

According to Fenesy et al. (2018) social issues in children with ADHD are predicted by high negative parenting. It has also been demonstrated that kids and teens who score much higher on schemas like social exclusion, failure, defectiveness or shame, and lack of self-control or self-discipline may be more prone to developing ADHD and fitting the criteria for its formal diagnosis (Lücke et al., 2017). Chronic impairment, rejection, and underperformance brought on by ADHD symptoms may drive individuals to adopt problematic fundamental beliefs that they are insufficient, incompetent, unreliable, and out of control (Newark & Stieglitz, 2010). It was also demonstrated by research that found

frequent prevalence of maladaptive schemas of self-mistrust, failure, incompetence, inadequacy, and instability ADHD-related disability in adults, which arise as a result of adverse childhood experiences (e.g., having poor relationships with their parents, frequently getting into trouble at school, and being rejected by peers). The motivation of people with ADHD to seek help may be hampered by maladaptive schemas (Ramsay & Rostain, 2005; Jansen, 2008).

The social environment and reactions of others also shape how an individual perceives himself. Beaton et al. (2020) used cross-sectional design to compare ADHD and non-ADHD adults in a study with 1203 participants. They investigated how others' criticism affects self-compassion in ADHD adults. The study's findings revealed that participants with ADHD had higher levels of perceived criticism and lower levels of self-concept than non-ADHD adults. Negative self-perception in ADHD children can have serious consequences, including lower self-esteem and emotional dysregulation (Barber et al., 2005; Paulus et al., 2021).

In addition, many types of psychopathology have been connected to the emergence of maladaptive schemas (Alloy et al., 2006; Eberhart et al., 2011). To this date, only two published research have looked at the connections between ADHD and maladaptive schemas. The association between ADHD symptoms and four theoretically relevant maladaptive schemas (Social Isolation, Defectiveness/Shame, Failure to Achieve, and Insufficient Self-Control) was examined by Miklósi et al. (2016). A convenience sample of 204 nonclinical adults aged 24 to 71 (mean 41, SD 7.8), with a gender distribution of 74.5%, performed self-report tests for maladaptive schemas and ADHD symptoms. Greater use of all four schemas was linked to more severe ADHD symptoms. Thus, even within a

nonclinical participant sample, ADHD symptoms were linked to higher scores on theoretically relevant maladaptive schemas.

Similarly, using a sample of 80 drug-naive patients and controls, Philipsen et al. (2016) expanded on this research and provided more evidence of the link between maladaptive schemas and ADHD symptoms. At a specialized outpatient clinic diagnoses were confirmed for adults with ADHD. On 16 maladaptive schemas, patients with ADHD diagnoses performed considerably worse than the control group, with a strong effect size reported for 10 schemas. This study adds to the growing body of research showing that adults with a diagnosis of ADHD are more susceptible to the development of dysfunctional schemas than healthy controls. However, in the ADHD sample of both investigations, comorbidity was not controlled for the presence of maladaptive schemas. Without taking age into account, both researches used older samples with a wide variety of ages.

Depending on the environmental circumstances, maladaptive schemas are likely to be triggered differently at different stages of life (Beck & Dozois, 2011; Young et al., 2003). For instance, the schema of insufficient self-control may be more applicable to emerging adults who are fully responsible for managing their own lives (such as going to bed and waking up on time). Additionally, these group differences were observed across a variety of seemingly unrelated schemas (such as Failure to Achieve and Subjugation). This unexpected outcome might be a result of how ADHD symptoms affect people over their lifespan in a wide range of domains, but it can also be because of the high comorbidity in the sample. According to Roelofs et al. (2011), the relationship between alienation from peers as a sign of attachment insecurity and emotional issues was mediated by the schema domain of disconnection/rejection in non-clinical adolescents. It was also shown that the schema of poor self-control/discipline and mistrust increases behavioural issues,

demonstrating that this schema contributes in problems in peer interaction, parent relationships, anger and aggressiveness (Calvete et al., 2005; Tremblay & Dozois 2009).

The maladaptive schema of social alienation/isolation had a key influence in a study based on a sample of Dutch teenagers with ADHD and ODD. However, in addition to the environment and unmet needs, other factors, such as the child's temperament and the presence of comorbid illness, play a significant role in the development of maladaptive schemas and a specific response to the environment (Thimm, 2010; Halvorsen et al., 2009; Dirzyte & Perminas, 2020). During the developmental phases, early maladaptive schemas (EMS) as well as core symptoms emerge in adults with ADHD that have a substantial impact on the environment. These adults might gain from treatments based on schema theories (Philipsen et al., 2016). With early maladaptive failure schemas, lack of self-discipline, social exclusion, and shame, ADHD adults and children are more susceptible to life stress that necessitates effective coping, which impairs emotional wellbeing (Miklosi et al., 2016). Early maladaptive schemas, such as "Failure," "Insufficient self-control," "Social isolation," and "Emotional Inhibition," have been proven to have a significant influence among people with ADHD. This outcome highlights the significance of corporation schema treatments for the efficient management of ADHD symptoms (Kiraz & Sertçelik, 2021).

2.8 Summary

ADHD is a most prevailing neurodevelopmental disorder. Adolescents go through a lot of physical and psychological changes during this developmental stage. These changes are far more difficult for adolescents with ADHD to manage because they face challenges in family and social life. Theories have been developed to explain the underlying causes of

this condition, which can further complicate this condition. Rohner’s theory explains how parental acceptance and rejection lead to psychological adjustment or maladjustment. The theories have also been directed toward parenting, where the role of the parent is emphasized for the individuals' psychological adjustment. Likewise, family structures, functions, and communication provide a foundation for an individual's mental health. Schema-based theories have provided valuable information on the development of maladaptive cognitive structures that contribute to an individual's maladaptive cognitions and behaviours in various life domains. This study provides a new perspective to study ADHD adolescents population in Pakistan using parenting practices (Darling & Steinberg, 1993), the McMaster family functioning model ((Epstein et al., 1983), Rohner's personality subtheory (Rohner, 1980), and early maladaptive schemas (Young et al, 2003) as its theoretical framework. Two dimensions of parenting practices (positive and negative) and two dimensions of family functioning (healthy and unhealthy family functioning) were included for this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The study was conducted in three phases: Phase-I, Translation Phase, Phase-II, Pilot Testing, and Phase-III, the main Study. After translating the study instrument in Urdu language, a pilot study was carried out on a sample of 56 non-ADHD participants to establish the validity of translated version of instruments. After that main study was carried out on a sample of 100 participants diagnosed with ADHD.

3.2Research Design

The present study adopted a questionnaire-based survey design using cross-sectional method.

3.3 Research instruments

3.3.1 Personality Assessment Questionnaire (PAQ)

The personality assessment questionnaire (PAQ), originally developed by Rohner (1978), is based on IPAR Theory. It is an evidence-based theory of socialization and lifespan development that aims to predict and explain significant consequences and other correlates of interpersonal (especially parental) acceptance-rejection worldwide (Rohner, 1986, 2004, 2016). This short form of PAQ questionnaire's child version measures child' self-reports about their psychological adjustment described in the acceptance-rejection syndrome. It is composed of seven scales: 1) Hostility/aggression ("I find myself pouting or sulking when I get angry"); 2) dependency ("I like my friends to make a fuss over me when I am hurt or sick"); 3) negative self-esteem ("I get disgusted with myself"); 4)

negative self-adequacy ("I am overcome by feelings of inadequacy"); 5) emotional unresponsiveness ("I feel distant and detached from most people"); 6) emotional instability ("I get upset easily when I meet difficult problems"); and, 7) negative view of the world ("I view the universe as a threatening, dangerous place"). Each scale is composed of 6 items for a total of 42 items. the questionnaire provides a four-point Likert-like scale for scoring on each item, ranging from 1 to 4, where (4) "almost always true of me" to (1) "almost never true of me."

A sum of the seven-scale score provides a profile of an individual's overall psychological adjustment. Possible scores spread from 42 through 168. The higher the score, the more psychologically maladjusted individuals report themselves to be. Research provides evidence of reliability and validity for the broader use of PAQ worldwide. Studies reveal mean-weighted effect size of coefficient alpha on the Adult PAQ was .86 (Khaleque & Rohner 2002). Test-retest reliability across periods ranging from 1 to 18 months for the Child PAQ was .61. Additional literature also provides reliability and validity evidence of the measure (Rohner & Chaki-Sircar, 1988; Rohner & Khaleque, 2005b). The Urdu version translated and adapted by Naz and Kausar (2012) with reported .82 alpha reliability for total scores on the scale.

3.3.2 Family Assessment Device (FAD)

Family Assessment Device (FAD) is originally developed by Epstein et al. (1983). There are 60 items in this self-report measure, further subdivided into seven subscales. McMaster's multi-dimensional family functioning model provides the foundation of this assessment to explore different aspects of a family's relationship and functioning (Epstein et al., 1978). The subscales are Problem-solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior control, and a unique General

Functioning scale to assess the overall family health. The FAD is scored on a Likert scale from 1 (strongly agree) to 4 (strongly disagree). Higher scores indicate more incredible difficulty, with General Functioning scale scores greater than 2.0 indicating clinical impairment. The FAD is well-validated and reliable with internal consistency for the subscales between .72 to .92 (Miller et al., 1985). Internal consistencies for all respondent subscale scores were high with 87 fathers, 90 for mothers, and 90 for adolescents. The FAD has been used in previous eating disorder studies and with adolescents, mother and father (Ciao et al., 2015; Emanuelli et al., 2004; North et al., 1995). The FAD was translated for the current study with an alpha reliability of .89.

3.3.3 Alabama Parenting Questionnaire (APQ)

Alabama Parenting Questionnaire (APQ) child form is originally developed by Frick (1991). It is a self-report questionnaire with 42-item and assesses different domains of parental behavior (Frick, 1991; Shelton, 1996). The measure consists of the five subscales, including Poor Monitoring/Supervision, Inconsistent Discipline, Corporal Punishment, Positive Parenting, and Involvement. Children use a 5- Point scale to report their parent's behavior on each item of the questionnaire. The options range from 1 (Never) to 5 (Always). Internal consistency and construct validity of the measure is adequately established. The questionnaire's internal consistency ranges from .54 to .83 for its subscales (Essau, et al., 2006). The Urdu version translated and adapted by Mushtaque (2015) was used with reported alpha reliabilities from .70 to .89 for subscales.

3.3.4 Swanson Nolan and Pelham (SNAP-IV)

The scale is originally developed by Swanson et al. (1992). SNAP- IV is a four-point scale scored as 3 (very much), 2 (quite a bit), 1 (just a little), 0 (not at all). The sub-domains included in the scale are inattention (items 1–9), hyperactivity/impulsivity (items

10–18). The SNAP-IV score defines, on each assessment, the average item-level score for all of the items. The sum of all item-level scores makes the total score on the scale. Subdomain scores within each domain of SNAP-IV, are indicated by summing up all item-level scores, and indicated by "items x-x." If the scores are higher on the scale, it indicates the worst symptoms of ADHD on SNAP-IV. The scale was translated in Urdu for the present study with an alpha reliability of .91 for the present sample.

3.3.5 Young Schema Questionnaire (YSQ-S3)

YSQ is the latest 6-point Likert scale originally developed by Young (2006), measuring 18 early maladaptive schemas (EMSs). The score ranges from 1 (Completely untrue of me) to 6. The YSQ-S3 was validated (Kriston et al., 2013) using clinical and community samples. Internal consistency of the EMSs was >.70 for 17, except for the EMS of Entitlement (.67). The reliability values for 17 EMSs were satisfactory, while only Entitlement has a Cronbach's alpha >.70. Another validation study (Bach et al., 2017) reported a Cronbach's alpha reliability value of >.70 for 18 EMSs of the YSQ-S3. The subscales of the YSQ-S3 are also meaningfully associated with personality disorders, with reported convergent validity with YPI-R2 (Father and Mother), ranging from .20 to .40. other studies also reported similar results (Thimm, 2010). The scale was translated in Urdu for the current study with an alpha reliability of .94 was found.

3.4 Verification of tool

After the translation of the study instruments a pilot study was carried out to find the reliability of the translated versions. The reliability analysis of the scales showed appropriateness of translated version for the present study. For the pilot study an alpha reliability value for FAD was .89, for SNAP was .91 and for YSQ short form it was .94.

3.5 Item total correlation

Item total correlation was performed to find the construct validity of the scales translated in Urdu language. According to the results of item total correlation few of the items in two scales were found to have negative correlation including; Family Assessment Device (item no. 36 *(r* =-.12), item no. 40 (*r* =-.06), item no.55 (*r*= -.07) Young's Schema Questionnaire version-3 item no. 18 (*r* =-.03). Since, these are significant items in original scale and the reporting population on these scales was clinical (adolescents with ADHD). Therefore, it was decided to keep these items for Urdu versions of the scales. However, it is suggested for future studies to test the scale with other population and if the trends are repeated then the researchers may drop these items from the scale. There is a need for future researches to confirm the retaining or rejection of the items based on normal and non-clinical population.

3.6 Population

The present study was conducted on the ADHD population. It included only Pre-diagnosed cases from Islamabad, Rawalpindi for the main study. The present study included a sample of 100 adolescents (50% boys, 50% girls). The age of the participants ranged from 12 to 20 years (M=14.73, SD=1.82). The data was gathered from different special education institutions, hospitals, schools, and Islamabad and Rawalpindi area colleges.

3.6.1 Inclusion criteria

Participants who were diagnosed with ADHD and met the criteria for ADHD Inattention, Hyperactivity/ Impulsivity, or Combined Type on SNAP-IV were included in the study.

3.6.2 Exclusion criteria

Participants who did not score or have borderline scores without a clear diagnosis were excluded from the sample. In addition, participants with any comorbid mental illness were also excluded.

1.7 Sampling technique

The sample for the present study was selected using purposive sampling technique.

1.8 Data Collection

The study was conducted in three phases. Firstly, in Phase-I scales in Urdu language were translated including FAD, YSQ-3, and SNAP-IV, as these scales were not available in Urdu language. The back-translation method was used. Afterwards, a booklet of all these translated scales and consent forms were organized in a sequence to collect data. The first section of the questionnaire booklet consists of informed consent and a demographic sheet, after that, all the questionnaires follow. Secondly, in Phase-II the translated scales were administered to a sample of 56 participants for the evaluation of psychometric properties and appropriateness of translated version for the main study. Thirdly in Phase-III for the main study , data collection was completed using Family Assessment Device (FAD) (Epstein et al., 1983), Alabama Parenting Questionnaire (PAQ) (Frick, P, J., 1991), Young Schema Questionnaire version 3 (YSQ-3) (Young, 2006) and Personality Assessment Questionnaire (PAQ) (Rohner, 1978). The sample of 100 adolescents diagnosed with ADHD was selected using purposive sampling technique based on cross-sectional method. The participants were also screened at the time of selection using Swanson, Nolan and Pelham (SNAP-IV) (Swanson et al., 1992) to find out the type of ADHD and a confirmation for the presented diagnoses.

However, in each phase, before approaching the participants, permission to visit institutions were formally requested, later granted by concerned authorities, including the Federal Directorate of Education, Director Special Education, and Outdoor Patients Departments of the hospitals. The researcher strictly followed all Standard Operating Procedures (SOPs) while visiting institutions or homes for data collection. Most of the data collection was possible using different sources due to the lockdowns and closure of institutions during Covid-19, throughout the country. In this context, the researcher also generated electronic forms on google forms for the convenience of participants where participants requested electronic access, ensuring their safety. Moreover, the parents also had their quarries and concerns where the child was just visiting psychiatric treatments without any counselling, so to address their issues, short online counselling sessions were also arranged. The participants received a briefing about the study's purpose and ensured confidentiality before filling the questionnaires.

As it was difficult for ADHD patients to concentrate and stay focused on task , therefore, to collect data from adolescents was based on distributed activities. The participants were given on average 2-3 sessions to complete the questionnaires (Parents/guardians were instructed to follow the same procedure). During the session the adolescents were given breaks to walk around or stretch

The participants were instructed on how to complete the questionnaire booklet. A few institutions participated with special interest and asked to share research reports and counselling for the parents and teachers as they reported having trouble dealing with issues of these children. Moreover, after participation, the adolescents received an incentive according to their age group with gratitude.

1.9 Data Analysis

The data was analyzed using SPSS Version 26. After performing the necessary data cleaning process and reverse coding, where required, a reliability test on the scales was performed to find the alpha reliability and descriptive further to establish the appropriateness of the translated versions of scales. To determine the construct validity item-total correlation was also performed for these scales. Furthermore, descriptive and frequency distribution was also calculated to determine the sample characteristics. After determining the normality and appropriateness of data for the study variables, further analysis was performed using Pearson Product Moment for Correlation, t-test for independent sample to find gender differences and One-Way ANOVA to find differences based on demographics variables. Lastly, in the present study, Hayes Process macro (2018) was used for mediation analysis. In addition, Cohen's d effect size and Tukey's HSD were also calculated where significant differences in the sample were found.

1.10 Research Ethics

Permission from the original authors of assessment tools was obtained to use and translate the assessment measures for the present research. For data collection, permission was gained from the respective heads including, Director Special Education Islamabad, Federal Directorate of Education General, Outdoor Patients Departments of the hospitals. Participants and their parents/guardians informed consent was also obtained to take part in the study. Participants were assured about the confidentiality of the information provided by them. Anonymity of the participants was ensured while collection of data, analysis and reporting to eliminate the danger of harm and labeling of the participants.

1.11 Delimitations of the Research Study

The researcher limited the study to 100 adolescents (50 boys and 50 girls) formally diagnosed with ADHD and selected from the area of Islamabad and Rawalpindi. For the present study only 12 to 20 years old participants were selected as only this age group comes under the defined criteria of adolescent. The participants were accessed through various sources including, personal visits, institutional visits, using google forms, and facilitation through WhatsApp to complete the questionnaires. The selected participants were from different institutions to prevent bias and gather objective responses.

1.12 Phase I

3.12.1 Translation of instrument

The three questionnaires, including Family functioning Device (FAD), Young Schema Questionnaire (YSQ- S3), and Swanson, Nolan, and Pelham (SNAP-IV), were translated from English to the Urdu language to measure the study variables. The study adopted a standard procedure to translate scales suggested by Vijver and Hambleton (1996). In the initial try-out the scales were administered on five adolescents aged 13 to 16 years, to evaluate the scales' language, difficulty level, and comprehension by the target sample. The translation comprised of five steps. Moreover, scales were translated by five expert and experienced translators with a vast background and experience of 15 to 20 years in the field, including language domain and were well versed in local and cultural context.

In first step the vocabulary of field related terms was provided by the researcher to facilitate the process. All the translators individually and independently did the translation. They communicated the difficulties and discrepancies in the statements during the process. They also handled carefully the cultural context while transformation of sentences. Scale

options were also translated. The process took three months to complete the first stage of forward translation.

In second step the translators synthesized their translations, compared and discussed all four versions. Where difference of opinion or cultural suitability was doubted, discrepancies were eliminated by decision on the most agreed one. Due to their choice of different words and writing style it was very amiable to agree on a simpler, easy to comprehend and clear statements. The conflicting statements were added after discussion and voting by the majority. The process was recorded in written form for each change in the version.

In third an expert bilingual translator, with no background of the field, did the back-translation (BT) for the first drafted version after consensus. BT was done in one and a half month. This step highlighted the differences in translation, wording and contextual limitations and was improved accordingly. Team of experts traced out those inaccuracies to refine the translation.

In fourth step Committee, translators who did forward and backward translation, participated along with a linguistic, supervisor and researchers. All of members were bilingual. The researchers were in close contact with the expert committee during this time. All versions were combined to produce a compatible pretest version of the scales. Each statement was repeatedly checked for errors or cultural differences. The version was refined to be used in the field. The details of process were documented. Committee experts focused to check if any part of the item(s) were left untranslated. Difficult or ambiguous terms/wordings were highlighted and changed. Any discrepancy with the cultural context was corrected.

In fifth step the translated version was implemented on a sample of 56 participants. The participants' responses were recorded on translated version of the scales. The queries from the participants were clarified, where they wanted an item to be explained or found difficult. In this case those items were recorded for future revision and improvement in the translation. Participants' responses on the irrelevance or disparity was also noted down. While the time of finalizing the version all responses and suggestions were incorporated. Few words and phrase which were reported as difficult to understand were replaced. All items were retained as no one reported any of the item as irrelevant or violating cultural context. During the translation process Zoom and Google meetings were arranged as per convenience of the translators.

3.13 Phase II: Objectives of pilot study

The main objectives of the pilot testing were to;

1. Determine the Psychometric properties of the scales
2. To determine the relationship among study variables
3. Evaluating the appropriateness of the translated scales for the target population

3.14 Results of pilot study

Table 1

Sociodemographic Characteristics of Participant of Pilot Study (N=56)

Sample Characteristics	*n*	%
Gender		
Boys	27	48.2%
Girls	29	51.8%
Age		
Below 15	34	60.7%
15-17 Years	17	30.4%
18-20 Years	5	8.9%
Grade		
Middle	16	28.6%
Higher	23	41.1%
Higher Secondary	17	30.4%
Family System		
Joint	13	23.2%
Nuclear	43	76.8%
Father's Education		
Educated	43	76.8%
Uneducated	13	23.2%
Mother's Education		
Educated	38	67.9%
Uneducated	18	32.1%
Father's Occupation		
Employed	51	91.1%
Unemployed	5	8.9%
Mother's Occupation		
Working	8	14.3%
Housewife	48	85.7%

Sample Characteristics	*n*	%
Family Monthly Income		
Below 25000	15	26.8%
25000 – 50000	25	44.6%
50000 - 100000	9	16.1%
Above 100000	7	12.5%

Note: N = 56 (*n* = number of participants in each category). Participants were on average 15.02 years old (*SD* = 1.57).

In Table 1, the sociodemographic information of the present study pilot phase sample. As depicted in the table, the sample consisted of 48.2% boys and 51.8% girls, suggesting the variability based on gender to below. Moreover, the age range of the pilot study sample fell between the ages of 12-20 with mean age of 15.02 years with a standard deviation of 1.52. In the current study, age was further subdivided into three subgroups that included below fifteen years of age (60.7%), fifteen to seventeen years old (30.4%), and eighteen to twenty years old (8.9%) participants. Similarly, the educational level of the current sample was divided into three groups, including middle(28.6%), secondary (41.1%) and higher secondary(30.4%). The percentage of secondary level adolescents in the pilot sample. The frequency distributions of the family system suggest the percentage of participants belonging to the joint family system (23.2%) and nuclear family system (76.8%). Additionally, the percentage of parents' education, including father (76.8%), mother(67.9 %), is shown in table 1. In addition, the employment status of mothers also depicted that more mothers of the pilot sample were housewives(85.7%). Similarly, the occupational status of parents, including father's employment (91.1%) and unemployment (8.9%) of the pilot sample, is described. Furthermore, the pilot sample included participants more from the second category of 25000 to 50000 (44.6%) in the pilot study.

Table 2

Descriptive Statistics and Alpha Reliability Coefficient for Study Instruments (N=56).

Scale	No of Items	M	SD	*a*	Range				*S*	*K*
					Actual		Potential			
					Min	Max	Min	Max		
SNAP	18	6.20	7.42	.91	0	30	0	54	2.06	3.75
INN	9	2.95	3.67	.82	0	15	0	27	1.84	3.39
HY/IM	9	3.25	4.13	.85	0	15	0	27	1.88	2.27
APQ	42	107.45	22.36	.91	80	168	42	210	.83	.24
PMON	10	21.19	7.74	.90	12	45	10	50	1.27	1.55
IDIS	6	13.86	5.14	.87	6	29	6	30	.67	.11
CPUN	3	6.68	2.70	.80	3	13	3	15	.72	-.12
PORI	6	24.89	4.15	.87	13	30	6	30	-1.19	.62
PINV	10	24.83	7.65	.79	14	43	10	50	.62	-.60
PDIM	25	81.12	15.22	.85	50	121	25	125	.07	.06
NDIM	19	43.94	8.75	.62	26	73	19	95	.26	.66
FAD	60	144.93	20.72	.89	99	189	60	240	-.21	-.29
HFF	25	54.04	6.82	.58	40	70	25	100	.10	-.30
UHFF	35	90.89	17.06	.90	58	127	35	230	-.14	-.53
YSQ	90	231.88	18.67	.94	196	276	90	540	.04	-.32
PAQ	42	95.50	17.31	.87	69	137	42	168	.51	-.47

Note: M= Mean, *SD*= Standard Deviation, *S*= skewness, *K*=Kurtosis, SNAP=Swanson Nolan and Pelham Scale, INN= Inattention, HY/IM=Hyperactivity/Impulsivity, APQ= Alabama parenting questionnaire, PMON= Poor monitoring, IDIS= Inconsistent discipline, CPUN= Corporal punishment, PORI= Positive reinforcement, PINV= Parental involvement, PDIM= Positive dimensions of parenting, NDIM= negative dimensions of parenting, FAD= Family Assessment Device, HFF= Healthy family functioning, UHFF= Unhealthy family functioning, YSQ= Young's schema questionnaire, PAQ= Personality assessment questionnaire.

In Table 2 the descriptive analysis of the pilot phase (N=56) represents the results of study instruments including mean, standard deviation, Cronbach alpha reliability, ranges, skewness and kurtosis. The overall main scales alpha reliability values range between .77 to .91, indicating all are in acceptable to good ranges. Likewise, the alpha reliabilities of the subscales also were between .62 to .90. Additionally, skewness and kurtosis values were also under the ranges of ±1 and ±3, respectively, for the main scales and the subscales. Hence, the overall results suggested the appropriateness of the instrument for the present study.

Table 3

Correlation between Study Variables and their Subdomains (N=56).

	Variables	1	2	3	4	5	6	7	8	9	10	11
1	HFF	—										
2	UHFF	-.39**	—									
3	PMON	-.30*	-.46**	—								
4	IDIS	-.31*	-.54**	.83**	—							
5	CPUN	-.25*	-.49**	.83**	.76**	—						
6	PORI	.37**	.14	-.65**	-.61**	-.57**	—					
7	PINV	-.26*	-.33**	.75**	.87**	.72**	-.52**	—				
8	PDIM[a]	-.07	-.30*	.46**	.84**	.49**	.07	.84**	—			
9	NDIM[b]	-.31*	-.53**	.97**	.93**	.89**	-.66**	.83	.56**	—		
10	PYAD	-.23*	-.46**	.70**	.72**	.62**	-.38**	.74**	.63**	.74**	—	
11	EMS	.25*	.33**	.29**	.18	.20	-.16	.40**	.38**	.25*	.56**	—

* *p<.05, ** p<.01*

Note: HFF= Healthy family functioning, UHFF= Unhealthy family functioning,, PMON= Poor monitoring, IDIS= Inconsistent discipline, CPUN= Corporal punishment, PORI= Positive reinforcement, PINV= Parental involvement, PDIM= Positive dimensions of parenting, NDIM= negative dimensions of parenting, YSQ= Young's schema questionnaire, PAQ= Personality assessment questionnaire. PDIM[a]=Positive dimensions (sum of Positive Reinforcement and Parental involvement), NDIM[b] =Negative dimensions (sum of Poor Monitoring, Inconsistent, Discipline, and Corporal Punishment).

As shown in Table 3, the correlation analysis of study variables and subdomains reflect an overall good correlation. The findings suggest a significant positive correlation of unhealthy family functioning with early maladaptive schemas (r=.33**) and psychological adjustment. Likewise, Healthy family functioning significantly positively

correlated with early maladaptive schemas and psychological adjustment . The correlation between early maladaptive schemas and psychological adjustment was also significant (r=.56**). Furthermore, the study found that the composite of positive domains has a significant positive relation with early maladaptive schemas and psychological adjustment (r=.63**). Moreover, the study observed the negative dimension of parenting practices to be significantly positively correlated with early maladaptive schemas and psychological adjustment (r=.74**). Additionally, apart from the main variables, correlation for other subscales was between -.25* to .87**. However, the subscales including positive reinforcement, inconsistent discipline and corporal punishment were nonsignificant.

Table 4

Item Total Correlations for Swanson Nolan And Pelham Scale (N=56)

Items	Item Total Correlations	Corrected Item-Total Correlation
1	.64**	0.60
2	.67**	0.62
3	.51**	0.44
4	.74**	0.69
5	.61**	0.56
6	.58**	0.52
7	.88**	0.86
8	.52**	0.42
9	.48**	0.44
10	.68**	0.62
11	.67**	0.63
12	.81**	0.78
13	.47**	0.41
14	.61**	0.55
15	.49**	0.41
16	.68**	0.63
17	.89**	0.86
18	.59**	0.53

***p<.01*

Table 4 indicates the item total correlation for Swanson Nolan And Pelham . The findings as revealed in the table points towards most items contributing positively towards the measure.

Table 5

Item Total Correlations for Family Assessment Device (N=56)

Items	Item Total Correlations	Corrected Item-Total Correlation
1	.47**	.43
2	.26	.22
3	.25	.21
4	.58**	.55
5	.53**	.49
6	.35**	.30
7	.36**	.32
8	.19	.14
9	.34*	.30
10	.13	.08
11	.20	.15
12	.18	.14
13	.72**	.70
14	.42**	.38
15	.03	-.02
16	.13	.09
17	.49**	.45
18	.06	.003
19	.34**	.30
20	.17	.13
21	.65**	.62
22	.34*	.29
23	.28*	.23
24	.20	.15
25	.43**	.39
26	.08	.03

Items	Item Total Correlations	Corrected Item-Total Correlation
27	.64**	.61
28	.41**	.37
29	.23	.19
30	.21	.17
31	.35**	.31
32	.39**	.35
33	.64**	.61
34	.36**	.32
35	.59**	.56
36	-.12	-.16
37	.61**	.58
38	.31**	.28
39	.67**	.65
40	-.06	-.10
41	.58**	.55
42	.58**	.55
43	.56**	.52
44	.66**	.63
45	.72**	.70
46	.18	.13
47	.62**	.59
48	.54*	.51
49	.24	.19
50	.02	-.03
51	.71**	.69
52	.53**	.49
53	.44**	.40
54	.66**	.64
55	-.07	-.11

Items	Item Total Correlations	Corrected Item-Total Correlation
56	.12	.08
57	.30*	.26
58	.62**	.59
59	.56**	.52
60	.18	.13

***p<.01, *p<.05*

Table 5 indicates the item total correlation for Family Assessment Device. The findings as revealed in the table points towards most items contributing positively towards the measure.

Table 6

Item Total Correlations for Young's Schemas Questionnaire (N=56)

Items	Item Total Correlations	Corrected Item-Total Correlation
1	.43**	.40
2	.48**	.45
3	.47**	.45
4	.20	.17
5	.51**	.49
6	.52**	.50
7	.60**	.58
8	.52**	.50
9	.32*	.29
10	.54**	.52
11	.24	.21
12	.41**	.39
13	.54**	.52
14	.14	.11
15	.37**	.34
16	.18	.15
17	.38**	.35
18	-.03	-.06
19	.40**	.37
20	.39**	.36
21	.56**	.54
22	.21	.18
23	.49**	.46
24	.61**	.59

Items	Item Total Correlations	Corrected Item-Total Correlation
25	.53**	.51
26	.32	.30
27	.33*	.30
28	.45**	.42
29	.20	.17
30	.44**	.41
31	.16	.13
32	.38**	.35
33	.40**	.37
34	.15	.12
35	.55**	.53
36	.36**	.33
37	.32*	.29
38	.43**	.41
39	.52**	.50
40	.57**	.54
41	.29*	.27
42	.35**	.32
43	.35**	.33
44	.52**	.50
45	.16	.13
46	.06	.03
47	.35**	.32
48	.38**	.35
49	.04	.01
50	.28*	.25
51	.31*	.29

Items	Item Total Correlations	Corrected Item-Total Correlation
52	.50**	.48
53	.46**	.44
54	.19	.16
55	.52**	.49
56	.36**	.33
57	.50**	.47
58	.54**	.53
59	.39**	.36
60	.40**	.38
61	.51**	.49
62	.42**	.40
63	.62**	.60
64	.64**	.62
65	.22	.20
66	.37**	.34
67	.53**	.51
68	.40**	.37
69	.38**	.36
70	.40**	.37
71	.55**	.53
72	.39**	.36
73	.36**	.34
74	.58**	.56
75	.45**	.43
76	.33*	.31
77	.37**	.35
78	.59**	.58

Items	Item Total Correlations	Corrected Item-Total Correlation
79	.61**	.60
80	.41**	.39
81	.53**	.51
82	.41**	.39
83	.54**	.52
84	.55**	.53
85	.56**	.53
86	.42**	.40
87	.44**	.42
88	.15	.13
89	.48**	.46
90	.52	.50

***p<.01, *p<.05*

Table 6 indicates the item total correlation for Yong's Schemas Questionnaire. The findings as revealed in the table points towards most items contributing positively towards the measure.

3.15 Discussion

The main objective of the pilot test was to determine the appropriateness of the scales to be used in the main study. The results indicate the normal distribution of scores within acceptable ranges. The subscales alpha (Table 2) coefficient also revealed acceptable to good ranges from α= .91 to α= .62 (Nunnally, 1978; Hinton et al., 2004; Taber, 2018). Moreover, Pearson Product-moment for negative dimensions of parenting practices were also found to be significantly correlated with early maladaptive schemas and psychological adjustment (Table 3). In line with the previous cross-sectional study, conducted by Pellerone et al. (2017) found a significant correlation between negative dimensions of parenting and early maladaptive schemas. Moreover, previous studies also revealed a positive correlation between parenting practices and development of early maladaptive schemas in adolescents (Esmali Kooraneh & Amirsardari, 2015; Pellerone et al., 2017; Langhinrichsen-Rohling et al., 2017). Furthermore, previously conducted systematic review highlighted significant correlation between negative parenting practices and early maladaptive schemas, that predicted personality dysfunction in children (Basso et al., 2019).

Additionally, results align with the previous research that shows the correlation of perceived healthy or maladaptive family functioning on the development of maladaptive coping mechanisms that predict psychological maladjustment in adolescents (Francisco et al., 2016). Another study revealed a significant positive correlation between early maladaptive schemas and family functioning that affected the communication pattern among married couples (Ghandpazi et al., 2020).

CHAPTER 4

ANALYSIS AND INTERPRETATION OF THE DATA

4.5 Phase III: Results of Main Study

Table 7

Sociodemographic Characteristics of Participant of Main Study (N=100)

Sample Characteristics	*N*	%
Gender		
Boys	50	50%
Girls	50	50%
Age		
Below 15	73	73%
15-17 Years	20	20%
18-20 Years	7	7%
Grade		
Middle	55	55%
Higher	37	37%
Higher Secondary	8	8%
Family System		
Joint	39	39%
Nuclear	61	61%
ADHD Type		
Inattention Type	23	23%
Hyperactive/Impulsive Type	26	26%
Combined Type	51	51%
Father's Education		
Educated	81	81%
Uneducated	18	19%
Mother's Education		
Educated	51	51%
Uneducated	49	49%
Father's Occupation		

Sample Characteristics	*N*	%
Employed	86	86%
Unemployed	14	14%
Mother's Occupation		
Working	18	18%
Housewife	82	82%
Family Monthly Income		
Below 25000	20	20%
25000 – 50000	41	41%
50000 – 100000	16	16%
Above 100000	17	17%

Note: N = 56 (*n* = number of participants in each category). Participants were on average 14.43 years old (*SD* = 1.81).

Table 7 shows the frequencies of the demographic information of the present study sample. As observed from the table, the sample consisted of 50% boys and 50% girls between the ages of 12-20 with mean age of 14.43 years and with a standard deviation of 1.81. Similarly, the education level of the current sample was divided into three groups, including middle, secondary and higher secondary, with most of the students subsiding in middle schools (55%). Furthermore, the frequency distributions of the current sample family system suggest that most of the sample lived in nuclear families (61%). Additionally, the sample frequency distribution concerning subcategories of ADHD was also elaborated that suggested 50% in the sample suffered from Combined type. Moreover, the table also depicts the percent of education of parents, occupational status and monthly income for the current sample.

Table 8

Descriptive Statistics and Alpha Reliability Coefficients for Study Instruments (N=100).

Scale	No of Items	M	SD	*a*	Range				*S*	*K*
					Actual		Potential			
					Min	Max	Min	Max		
SNAP	18	26.26	7.06	.73	13	46	0	54	.59	.10
INN	9	12.3	4.41	.71	2	23	0	27	-.08	-.15
HY/IM	9	13.97	4.85	.72	2	24	0	27	-.26	-.25
APQ	42	127.85	23.01	.77	67	177	42	210	-.54	.24
PMON	10	21.75	7.10	.70	10	31	10	50	.33	-.81
IDIS	6	16.98	3.58	.18	10	26	6	30	.38	-.13
CPUN	3	7.66	3.08	.63	3	15	3	15	.37	-.64
PORI	6	22.98	6.35	.89	7	30	6	30	-.84	-.24
FINV	9	26.97	8.15	.84	9	43	9	45	-.31	-.35
MINV	10	31.51	9.76	.87	10	47	10	50	-.25	-.86
FAD	60	142.24	15.15	.82	108	199	60	240	.70	1.86
HFF	25	53.14	10.46	.84	34	86	25	100	.08	.03
UHFF	35	89.10	12.09	.80	70	126	35	230	.59	-.05
YSQ	90	275.04	59.95	.95	137	434	90	540	.16	-.23
PAQ	42	96	16.20	.85	62	139	42	168	.17	-.49

Note: M= Mean, *SD*= Standard Deviation, *S*= skewness, *K*=Kurtosis, SNAP=Swanson Nolan and Pelham Scale, INN= Inattention, HY/IM=Hyperactivity/Impulsivity, APQ= Alabama parenting questionnaire, PMON= Poor monitoring, IDIS= Inconsistent discipline, CPUN= Corporal punishment, PORI= Positive reinforcement, FINV= Father involvement, MINV= Mother involvement PDOM= Positive dimensions of parenting, NDOM= negative dimensions of parenting, FAD= Family Assessment Device, HFF= Healthy family functioning, UHFF= Unhealthy family functioning, YSQ= Young's schema questionnaire, PAQ= Personality assessment questionnaire.

Table 8 reported the descriptive analysis results of the present study and includes the mean, standard deviation, Cronbach alpha reliability, ranges, skewness and kurtosis of N = 100 participants (Boys = 50, Girls = 50) with age range between 12-20. The overall main scales alpha reliability values ranged between .73 to .95, indicating all are in good, acceptable ranges. Likewise, the alpha reliabilities of the subscales also were between .89 to 63, with lower reliability of one subscale that was inconsistent discipline. However, the variability of responses on this subscale can be suggested as applicable reliabilities' as well. Similarly, skewness and kurtosis values were also under the ranges of ±1 and ±3, respectively, for the main scales and the subscales. Thus, suggesting that the overall results depict that the instruments used to measure the variables of the present study are all appropriate.

Table 9

Correlations between Study Variables and their subdomains (N=100).

	Variables	1	2	3	4	5	6	7	8	9	10	11	12
1	HFF	—											
2	UHFF	-.10	—										
3	PMON	.29**	-.12	—									
4	IDIS	.04	-.21*	-.02	—								
5	CPUN	.29**	.02	.10	.21*	—							
6	PORI	-.17*	-.24**	-.38**	.13	.03	—						
7	FINV	-.33**	-.19*	-.18*	.25**	.01	.68**	—					
8	MINV	-.37**	-.22*	-.11	.13	.03	.63**	.85**	—				
9	PDIM[a]	-.33**	-.24**	-.23*	.19	.03	.82**	.94**	.94**	—			
10	NDIM[b]	.35**	-.17*	.82**	.45**	.51**	-.24**	-.04	-.02	-.10	—		
11	PYAD	.35**	.09	.25**	.05	.41**	-.25**	-.41**	-.41**	-.40**	.36**	—	
12	EMS	.42**	.02	.21**	-.09	.54**	-.17*	-.35**	-.33**	-.33**	.31**	.61**	—

* *p<.05, ** p<.01*

Note: HFF= Healthy family functioning, UHFF= Unhealthy family functioning, PMON= Poor monitoring, IDIS= Inconsistent discipline, CPUN= Corporal punishment, PORI=Positive reinforcement, FINV= Father involvement, MINV= Mother involvement, PDIM= Positive dimensions of parenting, NDIM= negative dimensions of parenting, YSQ= Young's schema questionnaire, PAQ= Personality assessment questionnaire. PDIM[a]=Positive dimensions(sum of Positive Reinforcement and Parental involvement) NDIM[b]=Negative dimensions(sum of Poor Monitoring, Inconsistent, Discipline, and Corporal Punishment).

Table 9 depicts the correlational analysis of the study variables and the instruments' subscales. The results suggest that the main study variables subdomain was all highly

correlated to each other the correlation for main variables range from -.17* to .94**. Likewise, the subdomains of parenting practices were also found to be significantly correlated with psychological adjustment with correlation range from .25** to .41**. Then significant negative correlation was also observed for Positive dimensions of parenting with Psychological adjustment (-.40**) and early maladaptive schemas (.33**), that suggested improved psychological adjustment due to positive parenting practices. Moreover, negative dimensions of positive parenting were also found to be significantly positively correlated with the early maladaptive schemas (.31*) and psychological adjustment (.36**) suggesting that the more negative parenting practices, the increased maladjustment among adolescents with ADHD. However, unhealthy family functioning was nonsignificant positive correlation, as the sample size was not large enough to achieve the significance.

Table 10

Mediating Role of Early Maladaptive Schemas in Relationship between Healthy Family Functioning and Psychological Adjustment Among Adolescents with ADHD (N=100)

	Psychological Adjustment			
		Model 2		
			95%CI	
Predictors	Model 1	*B*	*UL*	*LL*
1 Constant	147.48**	44.76**	90.99	203.98
HFF	2.40**	.19	1.36	3.44
EMS		.15**	29.73	59.78
R^2	.18	.38		
F	20.85**	29.68**		
ΔR^2		.20		
ΔF		8.83		

** *p<.01, * p<.05,*

Note. HFF=Healthy family functioning, EMS=Early maladaptive schemas. R^2 = Explained variance.

Figure 2

Mediating Role of Early maladaptive schemas in relation between Healthy family functioning and Psychological adjustment among adolescent with ADHD.

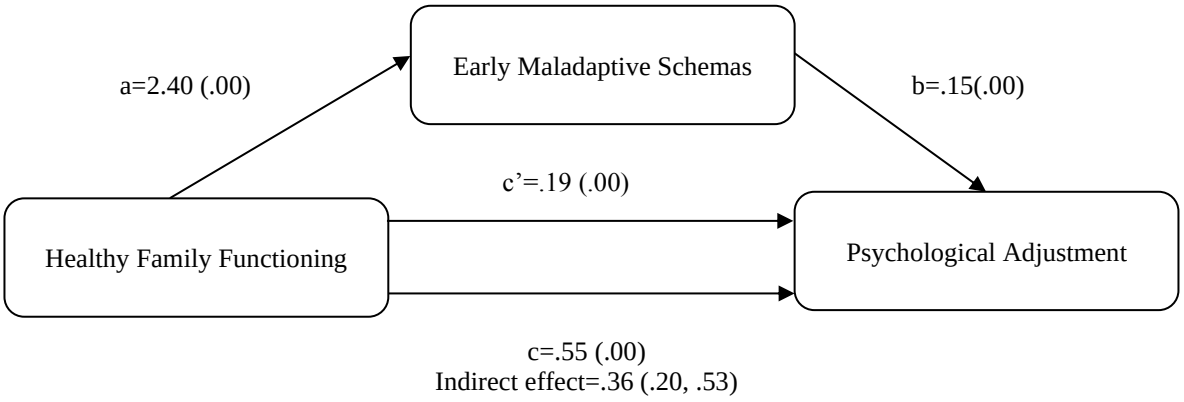


Table 10 shows that early maladaptive schemas mediate the relationship between healthy family Functioning and psychological adjustment among adolescents with ADHD. In model 1of the mediation analysis, healthy family functioning accounts for 18% variance in predicting psychological adjustment . the variance is increased to38% in Model 2 when early maladaptive schemas is introduced, indicating that early maladaptive schemas explained an additional 20% of variance in predicting psychological adjustment among adolescents with ADHD. Hence, confirming the partial mediation effect of early maladaptive Schemas. The mediation analysis results imply that a healthy family provides a framework to reduce the emergence of early maladaptive schemas and improve psychological adjustment among ADHD adolescents.

Table 11

Mediating Role of Early Maladaptive Schemas in Relationship between Unhealthy Family Functioning, and Psychological Adjustment Among Adolescents with ADHD (N=100)

	Psychological Adjustment			
		Model 2		
			95% CI	
Predictors	Model 1	*B*	*LL*	*UL*
Constant	267.14**	42.02**	*177.86*	*356.42*
UHFF	.09	.10	-.90	1.08
EMS		.16 **	-.11	.32
R^2	.00	.37		
F	0.31	28.89**		
ΔR^2		.37		
ΔF		.29		

** *p<.01*, * *p<.05*,

Note. R^2 = Explained variance, UHFF=Unhealthy family functioning, EMS=Early maladaptive schemas.

Figure 3

Mediating Role of Early maladaptive schemas in relation between Unhealthy family functioning and Psychological adjustment among adolescent with ADHD.

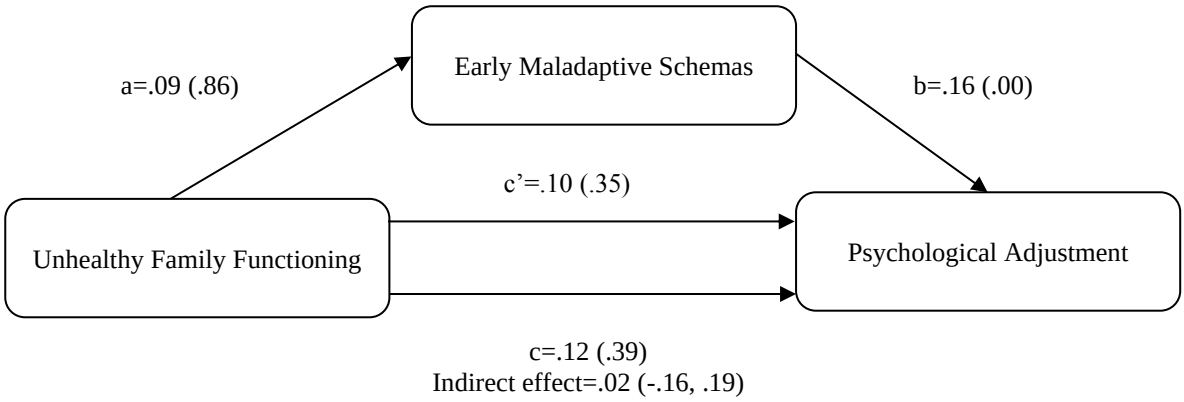


Table 11 shows mediating role of early maladaptive schemas on Unhealthy Family Functioning and Psychological Adjustment among adolescents with ADHD. In model 1of the mediation analysis is indicted that there is a nonsignificant positive association between unhealthy family functioning and early maladaptive schemas, explaining only 0.03% variance in predicting psychological adjustment . It was observed that there was a significant positive relationship between early maladaptive schemas and psychological adjustment. After adding unhealthy family functioning and early maladaptive schemas to predict psychological adjustment the relationship became nonsignificant .However, the explained variance increased to 37% in Model 2 when early maladaptive schemas is introduced, indicating that early maladaptive schemas explained an additional 37% of variance in predicting psychological adjustment among adolescents with ADHD.

Table 12

Mediating Role of Early Maladaptive Schemas in Relation Between Positive dimensions of Parenting Practices and Psychological Adjustment Among Adolescents with ADHD (N=100).

	Psychological Adjustment			
		Model 2		
			95% CI	
Predictors	Model 1	*B*	*LL*	*UL*
Constant	347.59 **	69.98 **	*51.90*	*88.06*
PDIM	-.89 **	-.17 *	-.29	-.05
EMS		.14 **	.10	.19
R^2	.11	.41		
F	11.78**	34.18**		
ΔR^2		.2		
ΔF		22.4		

** *p<.01, * p<.05,*

Note. R^2*= Explained variance, PDIM= Positive dimensions of Parenting Practices, EMS= Early maladaptive schemas.*

Figure 4

Mediating Role of Early maladaptive schemas in relation between Positive dimensions of Parenting Practices and Psychological adjustment among adolescent with ADHD

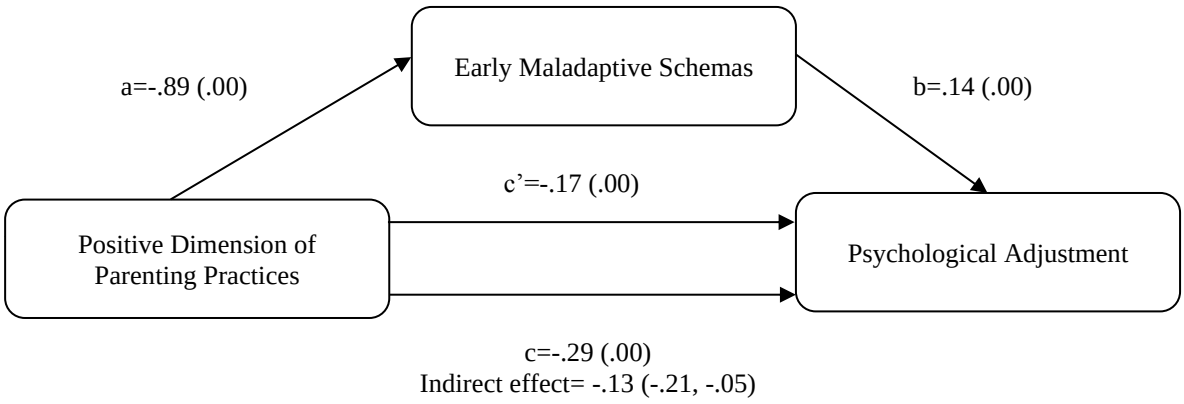


Table 12 shows the mediating role of early maladaptive schemas between the relationship of Positive dimensions of parenting practices and Psychological adjustment among adolescents with ADHD. In model 1of the mediation analysis, Positive dimensions of parenting practices accounts for 11% variance in predicting psychological adjustment . the variance is increased to 41% in Model 2 when early maladaptive schemas is introduced, indicating that early maladaptive schemas explained an additional 30% of variance in predicting psychological adjustment among adolescents with ADHD. Hence, confirming the partial mediation effect of early maladaptive Schemas. The results imply that a Positive dimensions of parenting practices provides a framework to reduce the emergence of early maladaptive schemas and improve psychological adjustment among ADHD adolescents.

Table 13

Mediating Role of Early Maladaptive Schemas in Relation Between Negative Dimensions of Parenting Practices and Psychological Adjustment Among Adolescents with ADHD (N=100)

	Psychological Adjustment			
		Model 2		
			95% CI	
Predictors	Model 1	*B*	*LL*	*UL*
Constant	178.36**	39.41 **	23.94	54.87
NDIM	2.08 **	.34 *	.047	.64
EMS		.15 **	.103	.19
R^2	.09	.40		
F	10.61**	32.40**		
ΔR^2		.31		
ΔF		21.8		

** *p<.01, * p<.05,*

Note. R^2 = Explained variance, NDIM= Negative Dimensions of Parenting Practices, EMS=Early maladaptive schemas.

Figure 5

Mediating Role of Early maladaptive schemas in relation between Negative dimensions of parenting practices and Psychological adjustment among adolescent with ADHD

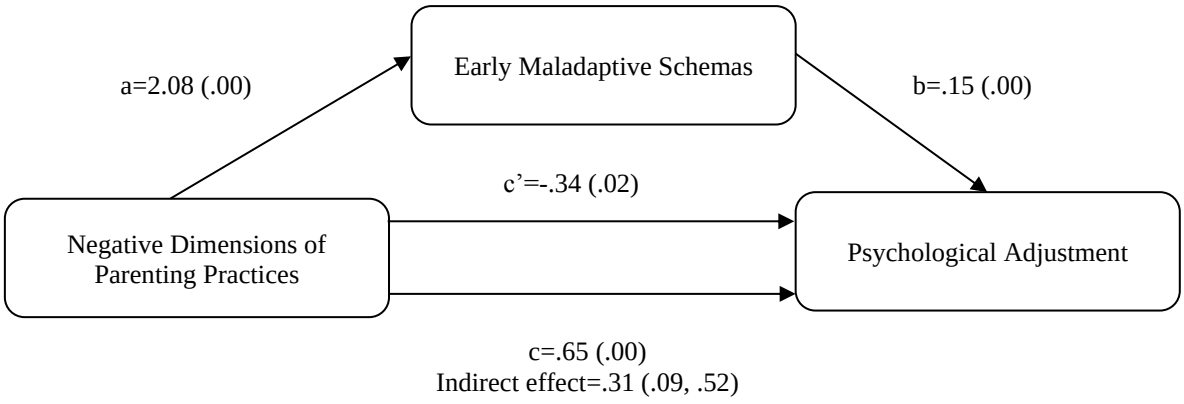


Table 13 shows the mediating role of early maladaptive schemas between the relationship of negative dimensions of parenting practices and Psychological adjustment among adolescents with ADHD. In model 1of the mediation analysis, negative dimensions of parenting practices accounts for 9% variance in predicting psychological adjustment . the variance is increased to 40% in Model 2 when early maladaptive schemas is introduced, indicating that early maladaptive schemas explained an additional 31% of variance in predicting psychological adjustment among adolescents with ADHD. Hence, confirming the partial mediation effect of early maladaptive Schemas. The results imply that negative dimensions of parenting practices provide a framework to increase the emergence of early maladaptive schemas and contribute to psychological maladjustment among ADHD adolescents.

Table 14

Gender wise differences on study variables (N=100)

Variables	Boys (n=50)		Girls (n=50)		*t*(98)	*p*	*Cohen's d*
	M	*SD*	*M*	*SD*			
IDIS	17.66	4.20	16.30	2.69	1.93	.00	0.39
PSOL	21.40	2.742	21.80	3.272	3.74	.03	0.13
EMD	14.14	5.08	13.90	6.52	.205	.05	0.04
EIN	17.20	3.91	16.46	6.27	.708	.00	0.14
DFS	14.36	5.21	10.50	3.92	4.12	.00	0.84
VLH	13.22	3.70	11.54	6.07	1.67	.01	0.01
ETI	16.76	3.33	15.24	4.38	1.95	.04	0.39
SES	15.88	4.61	17.50	6.07	-1.50	.02	0.30
EIN	15.00	3.99	16.04	3.07	-1.46	.03	0.29

p<.05*, p<.005**

Note: IDIS= Inconsistent discipline, PSOL=Problem solving, EMD=Emotional deprivation, EIN=Emotional inhibition, DFS=Defectiveness/Shame, VLH= Vulnerability to harm, ETI=Entitlement, SES=Self-sacrifice, EIN=Emotional instability

Table 14 shows the differences between boys' (n=50) and girls' sample (n=50) on the present study variables and their subscales. The results of the analysis suggest that no significant difference exist between ADHD adolescents based on gender other than on few subscales such as on Problem solving, (*t*=3.74, *p*=.027, *d*=0.13), Self-sacrifice (*t*=1.50, *p*= .015, *d*= 0.30), and Emotional Instability (*t*=1.46, *p*= .03, *d*=0.29), where girls scored higher.

Moreover, the result indicates the effect size for both the variables were of small to medium effect size (d=.13—.30). Additionally, on early maladaptive schemas which had some significant subscales in relation to gender where boys score significantly higher such as Inconsistent discipline (t=1.93, p=.001), Emotional deprivation (t=.21, p=.047), Emotional Inhibition (t=.708, p=.004), Defectiveness (t=4.12, p=004), Vulnerability to harm (t=1.67, p=.014), Entitlement (t=1.95, p=.036). The effect size on these subdomains indicate a very small to large effect size (d= 0.006—0.84).

Table 15

One-Way Analysis of Variance Between Study Variables and Age Groups of the ADHD Sample (N=100)

Variables	12-14 Years (n=59)		15-17 Years (n=34)		18-20 Years (n=7)		*F*(2, 97)	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*		
IDIS	17.75	3.68	15.59	3.06	17.29	3.40	4.21	0.08
FINV	28.46	6.90	24.26	9.51	27.57	8.73	2.99	0.06
MINV	33.47	9.48	27.88	9.81	32.57	7.76	3.79	0.07
EMS	252.47	54.12	306.71	57.98	311.43	16.10	12.61	0.21
PYAD	91.25	16.68	103.47	12.44	99.71	15.36	7.11	0.13

Note. p<.05*, p<.005**, *p*= significance, IDIS=Inconsistent discipline, FINV=Father involvement, MINV=Mother involvement, EMS= Early maladaptive schemas, PYAD= Psychological adjustment.

The findings of One-way ANOVA in Table 15 demonstrated a statistically significant difference between the three levels of age groups on two of the positive subdomains of the main variable of parenting practices . The results indicate Adolescents with ADHD in at least one of the age groups significantly differ on Father Involvement, $F(2,97)= 2.99$, $p =.04$, $\eta2=0.06$ and Mother involvement, $F(2,97)= 5.59$, $p =.02$, $\eta2=0.07$. Similarly, the table also highlights a significant difference between age groups on negative domains of parenting practice, including Inconsistent discipline, $F(2, 97) = 2.16$, $p = .01$, $\eta2= 0.08$. The table also depicts a significant difference in scores on early maladaptive schemas between the level of age, $F(2,97)=12.61$, $p =.00$, $\eta2=0.21$). Similarly, the ANOVA table shows a significant difference between age groups and scores on Psychological adjustment, $F(2,97= 7.11$, $p =.00$, $\eta2=0.13$). However, the Post hoc comparisons using the Tukey's HSD test indicated that the mean score on early maladaptive schemas for the second level age group ($M = 306.71$, $SD = 57.98$) and third-level age group ($M=311.43$, $SD=16.10$) was significantly different from the first level age group ($M = 252.47$, $SD= 54.12$).

CHAPTER 5

SUMMARY, FINDINGS, DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This study's primary purpose was to measure the impact of early maladaptive schemas in parenting practices, family functioning, and psychological adjustment of adolescents with ADHD. The study also measured the indirect and direct relationship between parenting practices and family functioning. The study also explored gender differences on study variables and differences based on age group. For this purpose, using a cross-sectional research design, a sample of 100 (Boys=50, Girls=50) adolescents was selected from different special education institutions, schools and colleges of government and private sector in Islamabad and Rawalpindi. The age range varied from 12 to 20 years (M=14.73, SD=1.82). The data was collected using Urdu version of Alabama Parenting Questionnaire, Family Assessment Device, Young's Schema Questionnaire, and Personality Assessment Questionnaire. A simple mediation analysis confirmed the significant partial mediation. The direct effect of healthy family functioning was nonsignificant, while the indirect effect was significant. The direct effect of positive dimensions of parenting practices was significant, while the indirect effect was also significant. The negative dimensions of parenting practices also found to have significant direct and indirect effect on psychological adjustment. The results also confirm significant gender-based differences among adolescents with ADHD on subdomains of study variables. The results suggest broader treatment strategies, considering the parents and family for the adolescents with ADHD in context of Pakistan.

5.2 Findings

In the Pilot phase was carried out on 56 adolescents. Overall results of pilot study suggested the appropriateness of the translated Urdu versions of instruments for the present study. The alpha reliability for main scales was between .77 to .91. while for subscales . The alpha reliabilities of the subscales were between .62 to .90.

The correlation analysis of study variables and subdomains reflect an overall good correlation. Item total correlation showed most items contributing positively towards the measure. A few of the items in two scales were found to have negative correlation including; Family Assessment Device (item no. 36, item no. 40, item no.55). In Young's Schema Questionnaire (item no. 18). These are significant items in original scale and the reporting population on these scales was clinical (adolescents with ADHD). There is a need for future researches to confirm the retaining or rejection of the items based on normal and non-clinical population, if the trends are repeated.

In the main study the sample was consisted of 100 participants, 50% boys and 50% girls between the ages of 12-20 with mean age of 14.43 years and a standard deviation of 1.81. 50% of the sample was diagnosed with combined type of ADHD. The overall main scale's alpha reliability was found to be in good ranges. However, low reliability was found one subscale that was inconsistent discipline for the ADHD sample that could have been caused due to the variability of responses on this subscale by this population and need to be explored in future researches with larger samples.

The results suggest that the subdomains of main study variables were all highly correlated to each other. Unhealthy family functioning was found to have positive nonsignificant correlation, as the sample size was not large enough to achieve the significance. It was found that early maladaptive schemas mediated between healthy

family functioning and psychological adjustment among adolescents with ADHD. It was found that early maladaptive schemas mediated the relationship between healthy family functioning and psychological adjustment by adding 20% variance in predicting psychological adjustment. However, early maladaptive schemas explained an additional 37% variance in predicting psychological adjustment while mediating between unhealthy family functioning. The direct and indirect relationship was not found to be significant, but it showed a positive trend. In addition, early maladaptive schemas mediate between positive dimensions of parenting practices and psychological adjustment. Where early maladaptive schemas explained an additional 30% variance in predicting psychological adjustment. Similarly, early maladaptive schemas mediated between negative dimensions of parenting practices and psychological adjustment by explaining an additional 39.9% variance in predicting psychological adjustment. The difference based on gender on main study variables were not found significant between ADHD adolescents however, on few subscales where girls scored higher including problem solving, self-sacrifice and emotional Instability. Whereas, boys scored higher on 6 of subscales of early maladaptive schemas (Inconsistent discipline, Emotional deprivation, Emotional Inhibition, Defectiveness, Vulnerability to harm, Entitlement). The effect size on these subdomains indicate a very small to large effect size. Tukey's HSD test confirmed significant difference for three age groups on early maladaptive schemas only where adolescents in peak transition stage scored higher than the other age groups.

5.3 Discussion

The purpose of the current study was to investigate the direct and indirect relationship of family functioning, parenting practices, and psychological adjustment, and mediating role of early maladaptive among adolescents with ADHD. The findings suggested significant indirect relationship between healthy family functioning and

psychological adjustment, while the direct relationship was nonsignificant. The direct relationship of positive dimension of parenting (direct and indirect) was significantly inversely related to psychological adjustment. While negative dimensions of parenting (direct and indirect) was significantly positively related to psychological adjustment. The simple mediation analysis confirmed significant partial mediating role of early maladaptive schemas.

In the first hypothesis it was assumed that “healthy family functioning will have a positive correlation with psychological adjustment among adolescents with ADHD”. The findings of the present study confirmed and in line with previous conducted researches that show significant positive effect of healthy family functioning in terms of communication, cohesion and problem solving and support (Dai and Wang, 2015; Procentese et al., 2019) on cognitive wellbeing, social and psychosocial adjustment of children and adolescents with special needs and chronic illnesses (Qiu et al., 2021; Lang, 2018). These findings provide an insight into the importance of family functioning with reference to adolescents with ADHD. It also provides a future direction for the researches in this area with larger samples. The finding may help not only resolve problems of an individual patients but also the whole family can benefit from the planned family-based interventions to improve healthy Family functioning, problem solving and better psychological adjustment (Power et al., 2012; Wiegand-Grefe et al., 2019; Paclikova et al., 2019).

However, the third hypothesis of the current study assumed that "the unhealthy family functioning will be negatively correlated with psychological adjustment among adolescents with ADHD", was not supported by the data. The response trend in a positive direction is informative to show increased scores on unhealthy family functioning domain and psychological adjustment that explains high scores as maladjustment in ADHD

sample. Inconsistent findings on this domain can be explained by the unique characteristics of the ADHD sample, the number of items to respond on the relevant domain, sample size, and most importantly, the recent impact of confinements and related problems might have shadowed the results. As studies on pandemic suggested, the challenges of isolation had a more significant effect, especially in families with children with special needs (Sheen et al., 2021). Furthermore, many participants completed the questionnaire an average of four days, which might have caused response variations. Family system are unique yet divergent contributor in the development of a child. It is important to note that malfunctioning and low connectedness in family members and parents effects the psychological health of children and adolescents (Montejo et al., 2019).

The fourth hypothesis of the study assumed that" corporal punishment will be negatively correlated with psychological adjustment among adolescents with ADHD. The results revealed a significant positive relationship between corporal punishment and psychological adjustment for the ADHD sample. In other words, the participants experiencing a harsh form of punishment have poor psychological adjustment in terms of high scores on the PAQ scale indicating maladjustment. This finding in line with the previously conducted researches that indicated a significant increase in children's externalizing behaviours in response to corporal punishment (Hecker et al., 2014). Corporal punishment also increases the complexity of symptoms and lead to poor social and psychological adjustment in young children with ADHD (Li et al., 2018b). In this context it can be implied that adolescents with ADHD are more prone to poor psychological adjustment if exposed to corporal punishment. This finding points out the core need for a healthy environment (reassurance and support by parents and teachers) both at home and academic for the adolescents with ADHD. As frequent exposure to harsh punishment may increase behavioural difficulties including oppositional defiance and

aggression in children with ADHD (Tung, 2012). Further researches also need to be directed towards exploring this area to improve monitoring of adolescents with ADHD with effective ways and tailoring preventive measures via skill training programs for parents and teachers.

The fifth hypothesis of the study assumed that " inconsistent discipline will be negatively correlated with psychological adjustment among adolescents with ADHD". The findings did not show a negative relationship for ADHD sample rather the findings were nonsignificant positive correlation. This trend of relationship is indicative of maladjustment among ADHD sample. As suggested by previous researches, the importance of supervision and discipline during the course of development of children are very crucial elements in acquiring good social and academic skills in general (i.e. accomplishing daily tasks and homework's) (Zhu et al., 2021; Loe et al., 2007; Aduen et al., 2018). It is also evident that lack of discipline may further complicate the behavioral and social difficulties of children and adolescents with ADHD (Teixeiva et al., 2015; Tung, 2012). The researches regarding ADHD population in Pakistan lack information in this area and availability of family and school-based insertions. There is a need to explore this area using larger samples from rural and urban areas to develop a clearer picture regarding this issue and guide policy making.

Moreover, in the sixth hypotheses it was assumed that "poor monitoring will be negatively correlated with psychological adjustment among adolescents with ADHD". The findings of the current study did not support this hypothesis. However , in this sample poor monitoring was found to have a significant positive correlation with psychological adjustment for the adolescent with ADHD. According to previous researches, conducted elsewhere, indicated increased maladjustment in children and adolescents due to lower control (Jaureguizar et al., 2018). Similarly thwarting parental control also lead to unmet

needs and poor psychological adjustment in children (Costa et al., 2019). Parental monitoring is in developing children a crucial factor. It leads the child towards developing life skills to develop life skills and monitor their own daily routines effectively to accomplish academic goals and maintain social relationships (Aghebati et al., 2014).

The quality of time parents spends with their children (i.e., supervising in daily chores, homework, and play activities) influence the social and psychological adjustment of children (Kousha and Abbasi, 2019). Due to the insufficient evidence on inconsistent discipline , poor monitoring in Pakistan with reference to ADHD adolescent population, finding of this research highlight the importance of future researches to explore this neglected area to help understand the underlying complex factors associated with parent-child relationship. The findings also provide an opportunity to explore interventions and implementation of programs for this population that is rarely addressed in our lower and middle school set ups. Parents and teachers need to be trained in best possible ways to supervise and monitor their children and adolescents with ADHD and improve their psychological adjustment (Bikic et al., 2021; Syed and Hussein, 2010; Malik et al., 2014) It may also provide an opportunity/ for the child to learn skills to function independently later in life and monitors their ADHD related difficulties (van der Oord and Tripp, 2020).

In the seventh hypothesis of the study it was assumed that " Parental involvement will have a positive correlation with the Psychological adjustment among adults with ADHD" . The findings of the study showed a significant inverse relationship parental involvement and psychological adjustment scale. This finding is indicative of psychological adjustment in current ADHD sample. These findings are in line with the results of previously conducted researches that suggested parental involvement as a significantly stronger contributor in increased motivation and academic adjustment in children (Yan & Ansari, 2016). In addition, the social adjustment problem, internalizing

and externalizing behaviours are also predicted by parental involvement elsewhere (Bhide et al., 2019). It is important to note that the unique relationship of parent-child provides a key to unlock the underlying mechanisms in child's social and psychological development. Researches need to carefully explore and find comprehensive answers to social, emotional and academic difficulties related to ADHD population. This finding bridges the gap and provide an additional information for effective the parenting regarding psychological adjustment of adolescents with ADHD.

The finding of presents study did not supported the eighth hypothesis that " positive reinforcement will have a positive correlation with the psychological adjustment of adolescents with ADHD". The results showed a significant inverse relationship for the study sample, in line with the previous researches that indicated lack of positive reinforcement and increase in corporal punishment are associated with increase in behavioural dysregulation in children with ADHD (Friedrich et al., 2017; Joseph et al., 2019). These findings high light the importance of positive reinforcement for future researches and for planning in family-based interventions. As use of positive reinforcement in behavioural monitoring of adolescents with ADHD is evident (Li, 2018b; Alsop et al., 2018). Researches could also explore the sociocultural factors in positive reinforcement used in domestic and academic set ups, for designing individual need-based and evidence-based interventions for ADHD adolescent's population (Ryan et al., 2017). There is a need for training programs in effective parenting to improve parental skills and perception to deal with behavioural and learning difficulties in adolescents with ADHD (Cappe et al., 2017).

The current study also explored the role of early maladaptive schemas by assuming that "early maladaptive schemas will mediate the relationship of parenting practices, family functioning and psychological adjustment. The results indicated significant partial

mediation that parenting practices (Positive and Negative dimensions) and family functioning (Healthy family functioning) are indirectly related to psychological adjustment in adolescents through its relationship with early maladaptive schemas. The results of the study are in line with the findings of previous researches that indicated the mediating role of maladaptive schemas in parenting practices and depressive symptoms, psychological distress, and emotional disorders in early to young adolescents (Tutal & Yalcin, 2021). Furthermore, studies reveal the partial mediating role of early maladaptive schemas concerning family functioning and subjective well-being (Haugh et al., 2017; Gong & Chan, 2018; Farazmand et al., 2015; Rafi et al., 2017; Stanescu & Romer, 2011; Demby et al., 2017).

In addition, the presence of maladaptive schemas complicates the ADHD symptoms and increase social, educational, performance and learning difficulties (Philipsen et al., 2016). Adolescents with ADHD may face greater difficulties while coping with their cognitive and emotional functioning and may adopt unhealthy modes to cope with difficulties and external challenges (Schilder et al., 2021). For example, one of the unhealthy coping mechanisms is the schema of disconnection and rejection (Van Wijk-Herbrink et al., 2018). The findings of present study also show a significant positive relationship between the early maladaptive schemas and psychological adjustment for the adolescents with ADHD. To develop a better understanding in underlying cognitive and emotional difficulties due to unmet needs, malparenting and family dysfunction that might hinder the psychological adjustment in adolescents with ADHD. In Pakistan very few researches have been directed to explore this area. There is a need to do extensive researches using larger samples and comparison groups to explore early maladaptive schemas in ADHD population. Schema therapy can be adapted for interventional plans for

adolescentes with ADHD to treat maladaptive schemas and improve their psychological adjustment (Cecero & Young, 2001).

The current study also explored gender differences and ADHD adolescents on study variables and assumed that "there will be a difference in gender on all study variables. According to the results of present study the significant difference was found in only one subdomain of parenting practices that is inconsistent discipline where boys scored higher than their girls' counterparts. The findings point out the presence of inconsistent discipline practice in adolescents with ADHD as reported by previous researches (Alperin et al., 2019; Mokrova et al., 2010; Ellis & Nigg, 2009). However, parenting practices may vary depending on child's gender, age, and type of ADHD (Muñoz-Suazo et al., 2020). Another explanation of this finding can be related with sociocultural factors that prevails in our society to deal with children based on their gender. In Pakistan there is a cultural influence on parenting practices to raise and train children (Zaman, 2014) therefore, gender differences regarding ADHD population may require more careful exploration. Women mostly undergo strict disciplinary boundaries , whereas men can be waived off from such boundaries in certain situations (Bibi, 2021). Interpreting these finding need more careful and in-depth investigation that can be achieved in future researches with ADHD population.

However, on early maladaptive schemas, boys scored higher than girls on five of the eighteen schemas including, Emotional deprivation, Emotional Inhibition, Defectiveness/Shame, Social Inhibition, and Vulnerability to Harm. In contrast, girls observed to score higher on subscale of self-sacrifice in line with the previous findings (Shorey et al., 2012; El-Gilany et al., 2013, Janson et al., 2019; Alimoradi et al. 2022;). The results are counterintuitive to researches that report almost all maladaptive schemas

mostly in girls except for schema of vulnerability to harm (Wijk-Herbrink et al., 2020; Shorey et al., 2012).

In fact, previous studies demonstrated varied results for the presentation of maladaptive schemas regarding gender and sociodemographic characteristics. However, the findings of the current study are informative regarding Pakistani context concerning presence of ADHD and sociocultural context of the current sample and effects of restrictions during lockdowns. Early maladaptive schemas need to be studied in sociocultural perspective as the findings of present study showed counterintuitive results regarding gender differences. Previous researches on different samples reported variant results regarding gender based on sociodemographic characteristics (Dattilio, 2002; Ricardo-Ruy & Valle-Mena, 2016). Further research in this area can provide information regarding other factors including resilience , and personality traits in ADHD population. Perhaps these factors also effect the maladaptive schemas in adolescents. The findings of the present study contribute in the literature for early maladaptive schemas among adolescents with ADHD in Pakistan. This information can be implied for future researches.

In addition, on psychological adjustment, the difference between gender was observed on only one subscale, Emotional instability, where girls scored higher than their boys' counterparts. Since emotional stability refers to one's composure of emotions in response to external difficulties and challenges, however findings of this research suggested higher emotional instability in girls with ADHD. It can also be inferred that girls have greater difficulties in coping with emotions while dealing with challenges in environment.

The difference across age groups on study variables was also explored for the present study using One Way ANOVA. The finding reveals that children at different age

groups have differentiated scores on study variables. The adolescence in peak transition have more maladaptive schemas then the younger group. It is possible that adolescents in this age group step towards gaining more autonomy may express more maladaptive schemas to stress, conflicts and hurdles. Previous studies confirm the role of parental disciplining practices across the age of children and their low, medium to higher social and physical aggression. The decline through middle to late age groups are predicted by parenting practices and family monitoring (Ehrenreich et al., 2014). Girard et al. (2019) suggested timely interventions to prevent long-term effects on children with mental illness to control the child's risk of developing aggressive behavior. Other studies also point out the importance of parenting in the developmental trajectories of children maladaptive behaviors (Luyckx et al., 2011).

The results of the current study in this part are in line with previous studies that different age groups and parenting practices, including father and mother involvement and coercive discipline, are associated with child increased symptoms at varied age phases. Similarly, Pauwels et al. (2018) refer to maladaptive schemas regarding age related changing intrapersonal to interpersonal values as a response to external demands, changing social responsibilities with increasing life. However, the interplay of culture with such factors may need to be explored further.

5.4 Conclusion

According to the results, we conclude that Parenting practices and family functioning significantly influence the psychological adjustment of adolescents with ADHD. In addition, the early maladaptive schemas play a significant role in the psychological adjustment of adolescents with ADHD. Early maladaptive schemas significantly partially mediated the relationship between Parenting practices, family functioning and psychological adjustment. Healthy family functioning was found to have

a significant positive relationship with psychological adjustment. While, unhealthy family functioning was found to have nonsignificant positive relationship with psychological adjustment. The subdomains of negative parenting practices including corporal punishment and poor monitoring was found to have a significant positive relationship with psychological adjustment. While inconsistent discipline was found to have nonsignificant positive relationship with psychological adjustment. However, the positive dimensions of parenting practices including parental involvement and positive reinforcement had a significant inverse relationship with psychological adjustment. Gender difference were also found only on few subdomains of main variables where boys scored higher including inconsistent discipline and on five schemas including, Emotional deprivation, Emotional Inhibition, Defectiveness/Shame, Social Inhibition, and Vulnerability to Harm. Girls were found to scored higher on schema of self-sacrifice and emotional Instability . The difference across age groups on study variables showed the adolescence in peak transition have more maladaptive schemas then the younger group.

5.5 Recommendations

The finds of the present study suggest the suitability of McMaster family function, parenting practices, Young's schema theory and interpersonal acceptance rejection theory to understand the complicated interplay of manifold factors underlying ADHD population. In Future, researches can provide an in-depth insight into this area, considering cultural context, to develop understanding of these factors in relevance to ADHD.

Since Parenting practices (positive/ negative) and family functioning (healthy/ unhealthy) are important factor to understand psychological adjustment in adolescents with ADHD. It is also important to consider the early maladaptive schemas to understand the underlying cognitions of adolescents with ADHD.

Patient-focused treatments ignore the importance of the patient's family environment and the nature of interaction with the caregiver, which significantly affects the elevation of symptoms and adjustment problems. The findings of this study can be used to evaluate and design the treatment plans for adolescents with ADHD by clinicians. It may help the practitioners to pinpoint the complexity of the illness, accurate diagnosis, evaluate poor response to medication, finding suitable interventions for treatment by considering all stakeholder including parents, caregivers, children and family members, and designing group therapy sessions.

In educational set up these finding may help in training workshops for the teachers to improve the understanding of the needs of adolescents with ADHD, classroom monitoring and facilitate learning process.

The finding can also be incorporated with interactive session for children, parents and family members to develop understanding of the nature of problem , related complexities within families and sorting strategies for the monitoring and betterment of growing children. The finding may also be disseminated through handouts, awareness seminars for parents and teachers, or using social media forums.

5.6 Suggestions

It is suggested for future studies to use larger sample size for deeper understanding of ADHD population. The application of translated scales on a larger sample is also suggested to determine validity and reliability for local population. Development of short forms for research purpose with clinical population. Finally, researches including comparison groups, children and adults with ADHD can be more insightful regarding ADHD in Pakistan.

5.7 Limitation

Firstly, due to restrictions during COVID-19 Pandemic it was really challenging to access to the sample for data collection and very limited data was possibly gathered.

Secondly, the questionnaires used for data collection were lengthy, and administration with ADHD adolescents took more time to complete the task that might have influenced the response pattern of the participants.

Thirdly, the study was conducted during the Covid-19 pandemic. Therefore, the changed routine and increased difficulties during the confinement period might influence the study variables. Consequently, it is suggested to consider these limitations in future studies. The study has limitation of generalizability to non-ADHD population.

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APPENDIX-A

اجازت نامہ

میں ادارۂ نفسیات، نمل یونیورسٹی، اسلام آباد میں ایم فل کی طالبہ ہوں۔ میں چند عوامل کے کردار سے متعلق تحقیق کر رہی ہوں، جو بیش فعالی اور توجہ کی کمی کے شکار نوعمر افراد کی شخصیت میں اہم کردار ادا کرتے ہیں۔ آپ سے گزارش ہے کہ ان سوالناموں کو اپنی رائے کے مطابق مکمل کریں۔ اس تحقیق میں آپ کی شرکت کا فیصلہ آپ کی مرضی پر منحصر ہے۔ آپ کی طرف سے فراہم کردہ تمام تر معلومات کو خفیہ رکھا جائے گا اور صرف تحقیقی مقاصد کے لیئے استعمال کیا جائے گا۔ اگر آپ اس تحقیق میں تعاون کرنا چاہتے/ چاہتی ہیں تو اس فارم پر دستخط کر دیں۔

شکریہ !

دستخط_____

تاریخ_____

رومانہ اقبال
ادارہ نفسیات، نیشنل یونیورسٹی آف ماڈرن لینگویجز (NUML)، اسلام آباد
ای میل: romanaiq@gmail.com

APPENDIX-B

ہدایات

یہ سوالنامہ چار حصوں پر مشتمل ہے۔ ہر حصہ کے ساتھ اس حصہ کو مکمل کرنے کے لیے ہدایات دی گئی ہیں۔
برائے مہربانی ہر حصہ کو دی گئی ہدایات کے مطابق مکمل کریں۔اس سوالنامہ میں دیئے گئے سوالات کا کوئی صحیح یا غلط جواب نہیں ہے۔

کوائف نامہ

1	جنس: لڑکا / لڑکی
2	عمر: _____
3	تعلیم: _____
4	والد کی تعلیم: _____ ، والد کا پیشہ: _____
5	والدہ کی تعلیم: _____ ، والدہ کا پیشہ: _____
6	گھریلو ماہانہ آمدنی: _____
7	مشترکہ خاندانی نظام: _____ ، انفرادی خاندانی نظام _____
8	بہن/بھائیوں کی تعداد: _____ ،آپکی ترتیبِ پیدائش: _____

APPENDIX-C

Alabama Parenting Questionnaire

(Child Form)

نام_____عمر_____کلاس_____

ہدایات: درج ذیل بیانات آپکے خاندان کے متعلق ہیں۔ برائے مہربانی جو باتیں آپکے خاندان میں خاص طور پر پائی جاتی ہیں اُن کی نشاندہی کیجیے۔ اگر آپکے والد یا والدہ آپکے ساتھ نہیں رہ رہے تو ان کے متعلق سوالات کو آپ حل نہ کریں۔

ممکنہ جوابات ہیں 1) کبھی نہیں 2) بہت ہی کم 3) کبھی کبھار 4) اکثر اوقات 5) ہمیشہ

نمبر شمار	سوالات	کبھی نہیں	بہت ہی کم	کبھی کبھار	اکثر اوقات	ہمیشہ
.1	آپ اپنی والدہ سے دوستانہ گفتگو کرتے ہیں۔	1	2	3	4	5
	a) کیا والد سے کبھی کرتے ہیں؟	1	2	3	4	5
.2	جب آپ اچھا کام کرتے ہیں تو کیا آپکے والدین آپکو سراہتے ہیں۔	1	2	3	4	5
.3	آپکے والدین آپکو سزا کی دھمکی دیتے ہیں مگر سزا نہیں دیتے۔	1	2	3	4	5
.4	آپکی والدہ آپکے خاص کاموں میں مدد کرتی ہیں۔ مثلاً کھیل، اسکاؤٹ، مذہبی سرگرمیاں وغیرہ۔	1	2	3	4	5
	a) کیا والد آپکی مدد کرتے ہیں؟	1	2	3	4	5
.5	آپکے والدین آپکے اچھے برتاؤ کے بدلے میں آپکو انعام دیتے ہیں یا کچھ اور خاص کرتے ہیں۔	1	2	3	4	5
.6	آپ کوئی نوٹ نہیں چھوڑتے یا اپنے والدین کو یہ نہیں بتاتے کہ آپ کہاں جا رہے ہیں۔	1	2	3	4	5
.7	آپ اپنی والدہ کے ساتھ گیمز کھیلتے ہیں یا کوئی اور تفریحی کام میں حصہ لیتے ہیں۔	1	2	3	4	5
	a) کیا اپنے والد کے ساتھ کرتے ہیں؟	1	2	3	4	5
.8	غلطی کرنے کے بعد آپ اپنے والدین کو سزا ہو جانے کے ڈر کے باوجود بتا دیتے ہیں۔	1	2	3	4	5
.9	آپ کی والدہ آپ سے پوچھتی ہیں کہ اسکول میں آپکا دن کیسا گزرا۔	1	2	3	4	5
	a) کیا آپکے والد آپ سے پوچھتے ہیں؟	1	2	3	4	5
.10	شام کو آپ دیر تک باہر رہتے ہیں یعنی اُس وقت تک جب آپ کو گھر میں ہونا چاہیئے۔	1	2	3	4	5
.11	آپکی والدہ آپکے ہوم ورک میں مدد کرتی ہیں۔	1	2	3	4	5
	a) کیا آپکے والد آپکی مدد کرتے ہیں؟	1	2	3	4	5
.12	آپکو فرمانبردار بنانے کے معاملے کو لے کر آپکے والدین ہار مان چکے ہیں کیونکہ یہ بہت مشکل کام ہے۔	1	2	3	4	5
.13	جب آپ کوئی اچھا کام کرتے ہیں تو آپکے والدین آپکی تعریف کرتے ہیں۔	1	2	3	4	5

.14	آپکی والدہ آپکے آئندہ آنے والے دن کے معاملات کے بارے میں آپ سے پوچھتی ہیں۔	1	2	3	4	5
	a) کیا آپکے والد پوچھتے ہیں؟	1	2	3	4	5
.15	آپکی والدہ آپ کو خاص (special) سرگرمی کے لئے لے کر جاتی ہیں۔	1	2	3	4	5
	a) کیا آپ کے والد لے کر جاتے ہیں؟	1	2	3	4	5
.16	آپ کے والدین آپ کے اچھے رویئے پر آپ کی تعریف کرتے ہیں۔	1	2	3	4	5
.17	آپ جن دوستوں کے ساتھ وقت گزارتے ہیں آپکے والدین اُن سے واقف نہیں۔	1	2	3	4	5
.18	جب آپ کچھ اچھا کرتے ہیں تو آپ کے والدین آپ کو گلے لگاتے یا پیار کرتے ہیں۔	1	2	3	4	5
.19	آپ گھر سے باہر جاتے وقت واپسی کے وقت کا تعین نہیں کرتے۔	1	2	3	4	5
.20	آپ کی والدہ آپ سے آپ کے دوستوں کے متعلق بات کرتی ہیں۔	1	2	3	4	5
	a) کیا آپ کے والد کرتے ہیں؟	1	2	3	4	5
.21	آپ رات کے وقت کسی بڑے کو ہمراہ لئے بغیر باہر جاتے ہیں۔	1	2	3	4	5
.22	آپ کے والدین آپ کو مقررہ وقت سے پہلے سزا سے چھوٹ دے دیتے ہیں (یعنی اپنے مقرر کردہ وقت سے پہلے پابندیاں اٹھا لیتے ہیں)۔	1	2	3	4	5
.23	آپ فیملی کی سرگرمیوں کو plan کرنے میں مدد دیتے ہیں۔	1	2	3	4	5
.24	آپ کے والدین اتنا مصروف ہو جاتے ہیں کہ یہ بھی بھول جاتے ہیں کہ آپ کہاں ہیں اور کیا کر رہے ہیں۔	1	2	3	4	5
.25	جب آپ کچھ غلط کر دیتے ہیں تو آپ کے والدین آپ کو سزا نہیں دیتے۔	1	2	3	4	5
.26	آپ کی امی آپ کے سکول کی میٹنگ (meeting) میں جاتی ہیں مثلاً Parent Teacher Meeting وغیرہ۔	1	2	3	4	5
	a) کیا آپ کے والد جاتے ہیں؟	1	2	3	4	5
.27	جب آپ گھر کے کاموں میں مدد کرتے ہیں تو آپ کے والدین اپنی پسند کا اظہار کرتے ہیں۔	1	2	3	4	5
.28	آپ گھر سے دیر تک باہر رہتے ہیں جس کا علم آپ کے والدین کو نہیں ہوتا۔	1	2	3	4	5
.29	آپ کے والدین گھر سے جاتے ہوئے آپ کو یہ بتا کر نہیں جاتے کہ وہ کہاں جا رہے ہیں۔	1	2	3	4	5
.30	اپنے والدین کی امید کے برعکس آپ سکول سے تقریباً ایک گھنٹہ دیر سے گھر آتے ہیں۔	1	2	3	4	5
.31	آپ کے والدین اپنے موڈ کے مطابق آپ کو سزا دیتے ہیں۔	1	2	3	4	5
.32	آپ گھر پر اکیلے بغیر کسی بڑے کے ہوتے ہیں۔	1	2	3	4	5
.33	جب آپ کچھ غلط کر دیتے ہیں تو آپ کے والدین آپ کی ہاتھ سے پٹائی کرتے ہیں۔	1	2	3	4	5
.34	بدتمیزی کرنے پر آپ کے والدین آپ کو نظر انداز کرتے ہیں۔	1	2	3	4	5
.35	جب آپ کچھ غلط کرتے ہیں تو آپ کے والدین آپ کو تھپڑ مارتے ہیں۔	1	2	3	4	5

.36	سزا کے طور پر آپ کے والدین پیسے یا اور کوئی مراعات آپ سے واپس لیتے ہیں۔	1	2	3	4	5
.37	آپ کے والدین سزا کے طور پر آپ کو کمرے میں بھیج دیتے ہیں۔	1	2	3	4	5
.38	جب آپ کچھ غلط کر دیتے ہیں تو آپ کے والدین آپ کو بیلٹ یا کسی اور چیز سے مارتے ہیں۔	1	2	3	4	5
.39	جب آپ کچھ غلط کر دیتے ہیں تو آپ کے والدین آپ پر چیختے اور چلاتے ہیں۔	1	2	3	4	5
.40	جب آپ بدتمیزی کرتے ہیں تو آپ کے والدین تحمل سے آپ کو سمجھاتے ہیں کہ جو رویہ آپکا تھا اُس میں کیا غلطی ہے۔	1	2	3	4	5
.41	آپ کے والدین سزا کے طور پر آپ کو ایک کونے میں کھڑا ہونے کو یا بیٹھنے کو کہہ دیتے ہیں۔	1	2	3	4	5
.42	سزا کے طور پر آپ کے والدین آپ سے زیادہ کام کرواتے ہیں۔	1	2	3	4	5

Developed by Frick, P. J.(1991)

Translated in Urdu by

Mushtaque, A. 2015)

APPENDIX-D

Family Assessment Device (FAD)

خاندانی تشخیص کا آلہ

ہدایات: یہ سوالنامہ خاندان کے بارے میں مختلف بیانات پر مشتمل ہے۔ ہر ایک بیان کو غور سے پڑھیں اور فیصلہ کریں کہ یہ آپ کے کنبہ کو کس طرح بیان کرتا ہے۔ آپ اپنے کنبے کو کس طرح دیکھتے ہیں، اسکے مطابق جواب کا انتخاب کریں۔ ہر بیان کے چار ممکنہ جوابات ہیں۔

Strongly Agree (SA) پر نشان لگائیں اگر آپکو لگتا ہے کہ بیان آپکے کنبے کو بہت درست بیان کرتا ہے.

Agree کو(A) پر نشان لگائیں اگر آپکو لگتا ہے کہ بیان آپکے کنبے کو تھوڑا بہت بیان کرتا ہے۔

Disagree کو(D) پر نشان لگائیں اگر آپکو لگتا ہے کہ بیان آپکے کنبے کو تھوڑا سا بھی بیان نہیں کرتا ہے۔

Strongly Disagree کو(SD) پر نشان لگائیں اگر آپکو لگتا ہے کہ بیان آپکے کنبے کو ہرگز بیان نہیں کرتا ہے۔

براہِ کرم ہر بیان کا جواب ضرور دیں اور بیانات کے نیچے فراہم کردہ جگہ پر نشان لگائیں۔

نمبر شمار	بیانات	مکمل طور پر متفق (SA)	متفق (A)	غیر متفق (D)	مکمل طور پر غیر متفق (SD)
1	خاندانی سرگرمیوں کے بارے میں منصوبہ بندی کرنے میں مشکل ہوتی ہے کیونکہ ہم ایک دوسرے کے بارے میں غلط فہمی رکھتے ہیں۔	1	2	3	4
2	ہم زیادہ تر روزمرہ کے مسائل گھر کی چار دیواری میں حل کر لیتے ہیں۔	1	2	3	4
3	جب کوئی پریشان ہوتا ہے تو دوسروں کو وجہ معلوم ہوتی ہے۔	1	2	3	4
4	جب آپ کسی کو کوئی کام کرنے کا کہتے ہیں تو آپ کو دیکھنا پڑتا ہے کہ کیا انہوں نے وہ کیا ہے یا نہیں۔	1	2	3	4
5	اگر کوئی پریشان/مشکل میں ہوتا ہے تو دوسرے بھی (اس پریشانی میں) شریک ہوجاتے ہیں۔	1	2	3	4
6	مشکل وقت میں ہم سہارا لینے کے لیئے ایک دوسرے سے رجوع کرسکتے ہیں۔	1	2	3	4
7	ہمیں معلوم نہیں ہوتا کہ ہنگامی صورتحال کے وقت کیا کرنا ہے۔	1	2	3	4
8	کبھی کبھار ہمیں جن چیزوں کی ضرورت ہوتی ہے وہ ختم ہوجاتی ہیں۔	1	2	3	4
9	ہم ایک دوسرے کے لیئے پیار کا اظہار کرنے میں ہچکچاتے ہیں۔	1	2	3	4
10	ہم یہ یقینی بناتے ہیں کہ سبھی افراد اپنی خاندانی ذمہ داریوں کو پورا کریں۔	1	2	3	4
11	ہم جو اداسی محسوس کرتے ہیں اس کے بارے میں ایک دوسرے سے بات نہیں کرسکتے ہیں۔	1	2	3	4
12	ہم عام طور پر مسائل کے بارے میں لیئے گئے اپنے فیصلوں پر عمل درآمد کرتے ہیں۔	1	2	3	4
13	آپ صرف اسی وقت دوسروں کی توجہ/دلچسپی حاصل کرپاتے ہیں جب کوئی چیز ان کے لیئے اہم ہو۔	1	2	3	4
14	کسی شخص کے کچھ کہنے سے آپ یہ نہیں بتاسکتے کہ وہ کیسا محسوس کررہا ہے۔	1	2	3	4
15	گھر کے کام سارے افراد میں مساوی طور پہ بانٹے نہیں جاتے ہیں۔	1	2	3	4
16	(گھر کے) افراد جیسے ہیں انہیں ویسے ہی قبول/تسلیم کیا جاتا ہے۔	1	2	3	4
17	آپ اصولوں/قواعد کو توڑنے کے بعد باآسانی بچ سکتے ہیں۔	1	2	3	4

18	لوگ اشاروں میں (گھما پھرا کر) بات کرنے کے بجائے اپنی بات واضح طور پر بیان کر دیتے ہیں ۔	1	2	3	4
19	ہم میں سے کچھ لوگ اپنے جذبات کا اظہار نہیں کرتے ہیں۔	1	2	3	4
20	ہمیں معلوم ہے کہ ہنگامی صورتحال (ایمرجنسی) کے وقت ہمیں کیا کرنا ہے۔	1	2	3	4
21	ہم اپنے خوف اور پریشانیوں/ تحفظات کے بارے میں بات کرنے سے گریز کرتے ہیں۔	1	2	3	4
22	ایک دوسرے سے حساس جذبات کے بارے میں بات کرنا مشکل ہوتا ہے	1	2	3	4
23	ہمارے لیئے اپنے بلوں کی ادائیگی مشکل ہوتی ہے۔	1	2	3	4
24	جب ہمارا خاندان کسی مسئلہ کو حل کرنے کی کوشش کرتا ہے تو اسکے بعد ہم عام طور پر اس بارے میں تبادلہ خیال کرتے ہیں کہ اس سے فائدہ ہوا یا نہیں۔	1	2	3	4
25	ہم اپنے آپ میں مگن رہتے ہیں۔	1	2	3	4
26	ہم ایک دوسرے سے احساسات کا اظہار کر سکتے ہیں۔	1	2	3	4
27	ہماری بیت الخلاء کی عادات کے بارے میں کوئی واضح توقعات نہیں ہیں۔	1	2	3	4
28	ہم ایک دوسرے کے لیئے اپنی محبت کا اظہار نہیں کرتے ہیں۔	1	2	3	4
29	ہم لوگوں سے براہ راست بات کرتے ہیں نا کہ کسی تیسرے کے ذریعے۔	1	2	3	4
30	ہم میں سے ہر ایک کے مخصوص فرائض اور ذمہ داریاں ہیں۔	1	2	3	4
31	خاندان میں کافی تلخیاں ہیں۔	1	2	3	4
32	ہمارے پاس لوگوں کو مارنے پیٹنے سے متعلق قواعد وضوابط ہیں۔	1	2	3	4
33	ہم ایک دوسرے کے ساتھ صرف اس وقت شامل ہوتے ہیں جب کوئی چیز ہمارے مطلب/فائدے کی ہو، ہمارے مفاد میں ہو۔	1	2	3	4
34	(ہمارے پاس) ذاتی مفادات کو جانچنے کے لیئے بہت کم وقت ہوتا ہے۔	1	2	3	4
35	ہم اکثر وہ نہیں کہتے جو کہنا چاہتے ہیں۔	1	2	3	4
36	ہمیں محسوس ہوتا ہے کے ہم جیسے ہیں ویسے ہی قبول کیئے جاتے ہیں۔	1	2	3	4
37	ہم ایک دوسرے میں اس وقت دلچسپی ظاہر کرتے ہیں جب ہم اس سے اپنا کوئی ذاتی مفاد حاصل کر سکیں۔	1	2	3	4
38	ہم سامنے آنے والے زیادہ تر جذباتی مسائل/ پریشانیوں کو حل کر لیتے ہیں۔	1	2	3	4
39	ہمارے خاندان میں دوسری چیزوں کی نسبت نرمی وشفقت کو دوسرے نمبر/درجے پر رکھا جاتا ہے۔	1	2	3	4
40	ہم اس بارے میں بات چیت /تبادلہ خیال کرتے ہیں کہ گھر کے کام کس نے کرنے ہیں۔	1	2	3	4
41	فیصلے کرنا ہمارے خاندان کے لیئے ایک مسئلہ ہے۔	1	2	3	4
42	ہمارے گھر والے ایک دوسرے میں صرف اس وقت دلچسپی ظاہر کرتے ہیں جب وہ اس سے کچھ (فائدہ) حاصل کر سکیں۔	1	2	3	4
43	ہم ایک دوسرے کے ساتھ بے تکلف ہیں۔	1	2	3	4
44	ہم کسی بھی قواعد وضوابط کی پاسداری نہیں کرتے ہیں۔	1	2	3	4
45	اگر لوگوں کو کچھ کرنے کو کہا جائے تو انہیں یاددہانی کرانی پڑتی ہے۔	1	2	3	4

46	ہم مسائل کو حل کرنے کے بارے میں فیصلے لینے کی صلاحیت رکھتے ہیں۔	1	2	3	4
47	اگر قوانین ٹوٹ جاتے ہیں تو ہم نہیں جانتے کہ کیا توقع رکھی جائے۔	1	2	3	4
48	ہمارے خاندان میں سب کچھ چلتا ہے۔	1	2	3	4
49	ہم شفقت و نرمی کا اظہار کرتے ہیں۔	1	2	3	4
50	ہمیں جذبات کے اظہار میں مسائل کا سامنا کرنا پڑتا ہے۔	1	2	3	4
51	ہمارے ایک دوسرے کے ساتھ اچھے تعلقات نہیں ہیں۔	1	2	3	4
52	جب ہم غصے میں ہوتے ہیں تو ایک دوسرے سے بات نہیں کرتے ہیں۔	1	2	3	4
53	ہم عام طور پر ان خاندانی ذمہ داریوں سے مطمئن نہیں ہوتے جو ہمیں سونپی جاتی ہیں۔	1	2	3	4
54	اگرچہ ہمارا مقصد اچھا ہوتا ہے لیکن ہم ایک دوسرے کی زندگیوں میں بہت زیادہ دخل اندازی کرتے ہیں۔	1	2	3	4
55	خطرناک حالات کے بارے میں قواعد/اصول موجود ہیں۔	1	2	3	4
56	ہم ایک دوسرے پر اعتماد/ بھروسہ کرتے ہیں۔	1	2	3	4
57	ہم کھل کر (سب کے سامنے) روتے ہیں۔	1	2	3	4
58	ہمارے پاس مناسب/ معقول ٹرانسپورٹ/سواری نہیں ہے۔	1	2	3	4
59	جب کوئی کچھ کرے اور ہمیں اچھا نہ لگے تو ہم اسے بتا دیتے ہیں۔	1	2	3	4
60	ہم مسائل کو حل کرنے کے لیئے مختلف طریقے سوچنے کی کوشش کرتے ہیں۔	1	2	3	4

Developed 1983 by Epstein, Baldwin, and Bishop

Urdu translation in 2021 by

Romana Iqbal

National University of Modern Languages, Islamabad

Pakistan

APPENDIX-E

Youngs Schema Questionnaire (YSQ-S3)

ینگو کا سکیما کا سوالنامہ

ذیل میں دیئے گئے بیانات لوگ اپنی وضاحت کے لیے استعمال کر سکتے ہیں۔ براہِ مہربانی ہر بیان کو غور سے پڑھیں اور اپنے گزشتہ سال کے مطابق اسکی درجہ بندی کریں کہ یہ آپکو کتنا بہتر بیان کرتے ہیں۔

اگر آپکو یقین نہیں ہے تو اپنے جواب کا انتخاب اپنے جذباتی احساس کے مطابق کریں، اس بات پر نہیں کہ جو آپکو سچ لگتا ہے۔

ذیل میں سے کچھ بیانات آپکے والدین اور شریکِ حیات کے ساتھ تعلقات کے بارے میں ہیں، اگر ان میں سے کوئی حیات نہیں ہے تو ان تعلقات کے بارے میں سوالات کا جواب اسکے مطابق دیں جب وہ حیات تھے۔ اگر آپکا ابھی کوئی شریکِ حیات نہیں ہے، اور گزشتہ ماضی میں تھا، تو ان سوالات کا جواب حالیہ پارٹنر کو ذہن میں رکھ کر دیں۔

درجہ بندی کا پیمانہ

1: میرے بارے میں مکمل طور پر غلط
2: میرے بارے میں کافی حد تک صحیح
3: میرے بارے میں زیادہ تر غلط
4: میرے بارے میں زیادہ تر صحیح
5: میرے بارے میں تھوڑا بہت صحیح
6: میرے بارے میں مکمل طور پر صحیح

نمبر شمار	بیانات	میرے بارے میں مکمل طور پر غلط	میرے بارے میں زیادہ تر غلط	میرے بارے میں تھوڑا بہت صحیح	میرے بارے میں کافی حد تک صحیح	میرے بارے میں زیادہ تر صحیح	میرے بارے میں مکمل طور پر صحیح
1	میرے پاس ایسا کوئی نہیں تھا جو میرا خیال رکھے، میرے دکھ درد میں شریک ہو یا میرے ساتھ ہونے والی ہر چیز کی بہت زیادہ پروا کرے۔	1	2	3	4	5	6
2	میں خود کو ان لوگوں سے لپٹا ہوا پاتا/پاتی ہوں جن کے میں قریب ہوں کیونکہ مجھے یہ ڈر/خوف رہتا ہے کہ وہ مجھے چھوڑ نہ دیں۔	1	2	3	4	5	6
3	مجھے محسوس ہوتا ہے کی لوگ مجھ سے فائدہ اٹھائیں گے۔	1	2	3	4	5	6
4	میں (معاشرے سے) مطابقت نہیں رکھتا/رکھتی ہوں۔	1	2	3	4	5	6
5	کوئی مرد / عورت جس کی میں خواہش کرتا/ کرتی ہوں میرے عیب اور خامیوں کو دیکھنے کے بعد مجھ سے محبت نہیں کر سکتا / سکتی۔	1	2	3	4	5	6
6	کام پر (یا سکول) تقریبا کچھ بھی میں اتنا اچھے سے نہیں کر پاتا/ پاتی ہوں جیسا کہ دوسرے لوگ کر سکتے ہیں۔	1	2	3	4	5	6
7	میں خود کو اس قابل محسوس نہیں کرتا/ کرتی ہوں کہ روزمرہ کی زندگی میں اپنے بل بوتے پر کچھ حاصل کر سکوں۔	1	2	3	4	5	6
8	میں اس احساس سے پیچھا نہیں چھڑا سکتا/سکتی ہوں کہ کچھ برا ہونے والا ہے۔	1	2	3	4	5	6

9	میں خود کو اپنے والدین سے اس طرح الگ نہیں کر پایا/پائی ہوں، جس طرح میری عمر کے دوسرے لوگ کر لیتے ہیں۔	1	2	3	4	5	6
10	میرے خیال میں اگر میں جو چاہتا/چاہتی ہوں وہ کروں تو یہ محض پریشانی مول لینے کے مترادف ہے۔	1	2	3	4	5	6
11	عام طور پر آخر کار مجھے ہی ان لوگوں کا خیال رکھنا پڑتا ہے جن سے میں قریب ہوتی/ ہوتا ہوں۔	1	2	3	4	5	6
12	میں دوسروں سے مثبت جذبات کا اظہار کرنے میں بہت محتاط ہوں (جیسا کہ پیار اور پرواہ کرنے کا اظہار)	1	2	3	4	5	6
13	میں جو بھی کرتا/ کرتی ہوں اس میں زیادہ تر مجھے بہترین ہونا چاہیئے، میں دوسرے نمبر پر آنا قبول نہیں کر سکتا/ سکتی۔	1	2	3	4	5	6
14	جب مجھے دوسرے لوگوں سے کچھ چاہیئے ہوتا ہے تو جواب میں مجھے انکار سننے میں بہت پریشانی ہوتی ہے۔	1	2	3	4	5	6
15	بہت سے معمول کے یا بے لطف کاموں کو مکمل کرنے کے لیئے میں نظم وضبط کا مظاہرہ نہیں کر پاتا/پاتی۔	1	2	3	4	5	6
16	پیسے کے ہونے اور اہم شخصیات کو جاننے سے میں قابل قدر محسوس کرتا/ کرتی ہوں۔	1	2	3	4	5	6
17	یہاں تک کے جب معاملات ٹھیک چل رہے ہوں تو مجھے ایسا محسوس ہوتا ہے کہ یہ سب عارضی ہے۔	1	2	3	4	5	6
18	اگر میں کوئی غلطی کرتا/ کرتی ہوں تو میں سزا کا/ کی مستحق ہوں۔	1	2	3	4	5	6
19	میرے پاس ایسے لوگ نہیں ہیں جو میرے ساتھ شفقت برتیں، مجھے گلے لگائیں اور پیار کریں۔	1	2	3	4	5	6
20	مجھے دوسرے لوگوں کی اتنی ضرورت ہوتی ہے کہ میں انہیں کھو دینے سے پریشان ہو جاتا/جاتی ہوں۔	1	2	3	4	5	6
21	مجھے یہ محسوس ہوتا ہے کہ میں دوسروں کی موجودگی میں غیر محتاط نہیں ہو سکتا/ سکتی، نہیں تو وہ مجھے جان بوجھ کر نقصان پہنچائیں گے۔	1	2	3	4	5	6
22	میں بنیادی طور پر دوسرے لوگوں سے مختلف ہوں۔	1	2	3	4	5	6
23	کوئی بھی ایسا شخص جسے میں چاہتا/چاہتی ہوں میری اصلیت جاننے کے بعد میرے قریب رہنا پسند نہیں کرے گا۔	1	2	3	4	5	6
24	جب بھی کامیابی کی بات ہوتی ہے میں اپنے آپ کو نااہل سمجھتا / سمجھتی ہوں۔	1	2	3	4	5	6
25	روزمرہ کے معمولات میں، میں خود کو دوسروں کا محتاج سمجھتا/ سمجھتی ہوں۔	1	2	3	4	5	6

26	مجھے محسوس ہوتا ہے کہ کسی بھی وقت کوئی آفت (قدرتی، مجرمانہ، مالی یا طبی) آسکتی ہے۔	1	2	3	4	5	6
27	میرے والدین اور میں ایک دوسرے کی زندگیوں اور پریشانیوں میں ضرورت سے زیادہ دخل اندازی کرتے ہیں۔	1	2	3	4	5	6
28	مجھے محسوس ہوتا ہے کہ میرے پاس دوسرے لوگوں کی خواہشات کے آگے جھک جانے کے سوا کوئی چارہ نہیں ورنہ وہ لوگ جوابی کاروائی کریں گے، ناراض/غصہ ہونگے یا مجھے کسی بھی طرح مسترد کردیں گے۔	1	2	3	4	5	6
29	میں ایک اچھا انسان ہوں کیونکہ میں اپنے سے زیادہ دوسروں کے بارے میں سوچتا/ سوچتی ہوں۔	1	2	3	4	5	6
30	میں دوسروں کے سامنے اپنے احساسات کا اظہار کرنے میں شرمندگی محسوس کرتا/ کرتی ہوں۔	1	2	3	4	5	6
31	میری کوشش ہوتی ہے (کہ میں ہر کام) بہترین کروں کیونکہ میں صرف اچھے (بہترین سے کم) پر رضامند نہیں ہوسکتا/سکتی۔	1	2	3	4	5	6
32	میں خاص ہوں اس لیئے مجھے دوسرے لوگوں پر عائد حدود یا پابندیوں کو قبول نہیں کرنا چاہیئے۔	1	2	3	4	5	6
33	اگر میں کسی مقصد تک نہیں پہنچ سکتا/سکتی تو میں آسانی سے مایوس ہوکر ہار مان لیتا/لیتی ہوں۔	1	2	3	4	5	6
34	کامیابیاں میرے لیئے بہت زیادہ اہمیت کی حامل ہیں اگر دوسرے لوگ ان پر متوجہ ہوں/ یا ان کو سراہیں۔	1	2	3	4	5	6
35	اگر کچھ اچھا ہوتا ہے تو مجھے یہ پریشانی رہتی ہے کہ اسکے بعد کچھ برا ہونے والا ہے۔	1	2	3	4	5	6
36	اگر میں اپنی پوری کوشش نہیں کرتا/ کرتی ہوں تو مجھے ہارنے کی توقع کرنی چاہیئے۔	1	2	3	4	5	6
37	میں نے کبھی یہ محسوس نہیں کیا ہے کہ میں کسی کے لیئے خاص ہوں۔	1	2	3	4	5	6
38	مجھے یہ پریشانی ہوتی ہے کہ میں جن لوگوں سے قریب محسوس کرتا/ کرتی ہوں وہ مجھے چھوڑ دیں گے یا نظر انداز کردیں گے۔	1	2	3	4	5	6
39	یہ بس وقت کی بات ہے، جب کوئی مجھے دھوکا دے دے۔	1	2	3	4	5	6
40	میرا کسی سے تعلق نہیں ہے، میں تنہا ہوں۔	1	2	3	4	5	6
41	میں دوسروں کے پیار، توجہ اور عزت/احترام کے قابل نہیں ہوں۔	1	2	3	4	5	6
42	کام کے میدان اور کامیابیوں کے حصول میں بہت سے دوسرے لوگ مجھ سے زیادہ قابل ہیں۔	1	2	3	4	5	6
43	میرے اندر عام سمجھ بوجھ/عام فہمی کی کمی ہے.	1	2	3	4	5	6
44	مجھے لوگوں کے جسمانی طور پر حملہ آور ہونے کی فکر/پریشانی رہتی ہے۔	1	2	3	4	5	6
45	میرے والدین اور میرے لیئے ایک دوسرے سے اندرونی رمعاملات چھپانا مشکل ہو جاتا ہے۔ کیونکہ اس سے ہمیں پچھتاوے اور دھوکہ دہی کا احساس ہونے لگتا ہے۔	1	2	3	4	5	6
46	تعلقات میں، میں عام طور پر دوسرے شخص کو برتری قائم کرنے دیتا/دیتی ہوں۔	1	2	3	4	5	6

47	جن لوگوں کی میں پرواہ کرتا/ کرتی ہوں ان کے کاموں میں میں اس قدر مصروف ہوتا/ ہوتی ہوں کہ میرے پاس اپنے لیئے بہت کم وقت بچتا ہے۔	1	2	3	4	5	6
48	میرے لیئے دوسرے لوگوں کے آس پاس آزاد اور بے ساختہ ہونا مشکل ہوتا ہے۔	1	2	3	4	5	6
49	مجھے اپنی تمام ذمہ داریوں کو پورا کرنا چاہیئے ۔	1	2	3	4	5	6
50	مجھے نفرت ہوتی ہے جب مجھے پابند کیا جائے یا جو میں کرنا چاہتا/ چاہتی ہوں وہ کرنے سے روکا جائے۔	1	2	3	4	5	6
51	طویل فاصلی مقصد کے حصول کے لیئے مجھے اپنے فوری سکون/ اطمینان یا خوشی کو قربان کرنے میں بہت مشکل درپیش ہوتی ہے۔	1	2	3	4	5	6
52	میں غیر اہم محسوس کرتا / کرتی ہوں، جب تک میں دوسروں سے بہت سی توجہ نہیں حاصل کر لیتا۔	1	2	3	4	5	6
53	آپ بہت محتاط نہیں رہ سکتے (کیونکہ) تقریباً ہمیشہ ہی کچھ نا کچھ غلط رہے گا۔	1	2	3	4	5	6
54	اگر میں اپنا کام صحیح طور پر نہیں کرتا/ کرتی ہوں تو مجھے اس کے نتائج بھگتنے چاہیئں ۔	1	2	3	4	5	6
55	مجھے ایسا کوئی شخص نہیں ملا جو واقعی میری بات سنتا ہو مجھے سمجھے یا میری حقیقی ضروریات اور احساسات کا خیال رکھے۔	1	2	3	4	5	6
56	میں مایوس ہو جاتا/ جاتی ہوں جب کوئی ایسا شخص مجھ سے دور ہو رہا ہو یا پیچھے ہٹنے لگے جس کی میں پرواہ کرتا/ کرتی ہوں۔	1	2	3	4	5	6
57	مجھے دوسرے لوگوں کے مقاصد پر کافی شک ہے۔	1	2	3	4	5	6
58	مجھے دوسرے لوگوں سے اجنبیت یا قطع تعلقی کا احساس ہوتا ہے۔	1	2	3	4	5	6
59	مجھے محسوس ہوتا ہے کہ میں پیار کے قابل نہیں ہوں۔	1	2	3	4	5	6
60	میں اتنا باصلاحیت نہیں ہوں جتنا زیادہ تر لوگ اپنے کام میں (قابل) ہیں۔	1	2	3	4	5	6
61	روزمرہ کے معاملات میں میرے فیصلے پر اعتماد/ انحصار نہیں کیا جا سکتا ہے۔	1	2	3	4	5	6
62	مجھے یہ خوف/ پریشانی رہتی ہے کہ میں اپنا سارا مال کھو دوں گا اور بے سہارا یا بہت غریب ہو جاؤں گا۔	1	2	3	4	5	6
63	مجھے اکثر یہ محسوس ہوتا ہے کہ میرے والدین مجھ میں جی رہے ہیں اور میری اپنی کوئی زندگی نہیں ہے۔	1	2	3	4	5	6
64	میں نے ہمیشہ دوسروں کو اپنے لیے انتخاب کرنے دیا ہے، اسلیئے مجھے اندازہ نہیں ہے کہ مجھے اصل میں کیا چاہیئے ۔	1	2	3	4	5	6
65	میں ہمیشہ سے وہ شخص رہا/ رہی ہوں جو سب کے مسائل سنتا/ سنتی ہوں۔	1	2	3	4	5	6
66	میں خود پر اتنا قابو رکھتا/ رکھتی ہوں کہ بہت سے لوگ یہ سمجھتے ہیں کہ میرے کوئی جذبات یا احساسات نہیں ہیں۔	1	2	3	4	5	6
67	مجھے یہ محسوس ہوتا ہے کہ مجھ پر کچھ حاصل کرنے اور چیزوں کو مکمل کرنے کا ایک مستقل دباؤ رہتا ہے۔	1	2	3	4	5	6

68	مجھے یہ محسوس ہوتا ہے کہ مجھے عام اصولوں یا روایات کی پیروی نہیں کرنی چاہیئے جو دوسرے لوگ کرتے ہیں۔	1	2	3	4	5	6
69	میں خود کو وہ کام کرنے کے لیئے مجبور نہیں کرسکتا/سکتی ہوں جو مجھے نہیں پسند حالانکہ میں یہ جانتا/جانتی ہوں کہ یہ میرے ہی فائدے / بھلائی کے لیئے ہے۔	1	2	3	4	5	6
70	اگر میں کسی میٹنگ میں رائے (ریمارکس) دیتا/دیتی ہوں یا کسی سماجی اجتماع میں میرا تعارف کرایا جاتا ہے تو میرے لیئے یہ ضروری ہے کہ لوگ مجھے پہچانیں اور میری تعریف کریں۔	1	2	3	4	5	6
71	چاہے میں جتنی بھی محنت کرلوں مجھے یہ پریشانی رہتی ہے کہ میں مالی طور پر کنگال ہو جاؤنگا اور تقریباً سب کچھ کھودونگا۔	1	2	3	4	5	6
72	اس سے کوئی فرق نہیں پڑتا کہ میں کیوں غلطی کرتا/ کرتی ہوں۔ جب میں کچھ غلط کرتا/ کرتی ہوں تو مجھے نتائج/ خمیازہ بھی بھگتنا چاہیئے۔	1	2	3	4	5	6
73	میرے پاس کوئی مضبوط یا دانش مند شخص نہیں ہے جو مجھے کوئی صحیح مشورہ دے یا راہ دکھائے جب مجھے سمجھ نہیں آتی کہ مجھے کیا کرنا چاہیئے	1	2	3	4	5	6
74	کبھی کبھار میں لوگوں کے چھوڑ جانے سے اتنا پریشان ہوجاتا/جاتی ہوں کہ میں خود ہی انہیں اپنے سے دور کردیتا/دیتی ہوں۔	1	2	3	4	5	6
75	میں عام طور پر لوگوں کے درپردہ یا پوشیدہ مقاصد کی تلاش میں رہتا/رہتی ہوں ۔	1	2	3	4	5	6
76	مجھے ہمیشہ یہ محسوس ہوتا ہے کہ میں (سماجی) گروہوں کا حصہ نہیں ہوں۔	1	2	3	4	5	6
77	بنیادی طور پر میرے لیئے یہ ناقابل قبول ہے کہ میں دوسرے لوگوں کے سامنے اپنے آپ کو ظاہر کروں یا ان کو خود کو اچھے سے جاننے کا موقع دوں۔	1	2	3	4	5	6
78	کام (یا سکول) کے معاملے میں میں زیادہ تر لوگوں کی طرح ذہین نہیں ہوں۔	1	2	3	4	5	6
79	میں روزمرہ کی آنے والی مشکلات کو حل کرنے کے لیئے اپنی قابلیت کے بارے میں پر اعتماد محسوس نہیں کرتا/ کرتی ہوں۔	1	2	3	4	5	6
80	میں پریشان رہتا/رہتی ہوں کہ مجھے کوئی خطرناک بیماری لاحق ہورہی ہے اگرچہ ڈاکٹر نے کسی سنگین بیماری کی تشخیص نہیں کی۔	1	2	3	4	5	6
81	مجھے اکثر محسوس ہوتا ہے کہ میری میرے والدین/ساتھی یا شریک حیات سے الگ کوئی پہچان نہیں ہے۔	1	2	3	4	5	6
82	مجھے یہ مطالبہ کرنے میں بہت مشکل پیش آتی ہے کہ میرے حقوق کا احترام کیا جائے اور میرے احساسات کی بھی قدر کی جائے۔	1	2	3	4	5	6
83	دوسرے لوگوں کی نظر میں، میں اپنے لیئے کچھ نہیں کرتا/ کرتی اور دوسروں کے لیئے بہت کچھ کرتا/ کرتی ہوں۔	1	2	3	4	5	6
84	لوگ مجھے جذبات کے اعتبار سے ذہنی تناؤ میں دیکھتے ہیں۔	1	2	3	4	5	6
85	میں اپنی غلطیوں پر بہانے بنانے یا پھر باآسانی اپنی ذمہ داریوں سے پیچھے ہٹنے کا نہیں سوچ سکتا/سکتی ہوں۔	1	2	3	4	5	6

86	مجھے محسوس ہوتا ہے کہ دوسروں کی شراکت کی نسبت میری طرف سے پیش کیا جانے والا تعاون زیادہ اہمیت کا حامل ہے۔	1	2	3	4	5	6
87	میں بہت کم ہی اپنے ارادوں/عزائم پر قائم رہ سکا / سکی ہوں۔	1	2	3	4	5	6
88	بہت سی تعریفیں اور مثبت آراء مجھے ایک قابل قدر شخص ہونے کا احساس دلاتی ہیں۔	1	2	3	4	5	6
89	میں پریشان رہتا/رہتی ہوں کہ یہ میرا ایک غلط فیصلہ مجھے تباہی کی طرف لے جا سکتا ہے۔	1	2	3	4	5	6
90	میں ایک برا شخص ہوں جو سزا کا مستحق ہے۔	1	2	3	4	5	6

APPENDIX-F

Adult PAQ: Personality Asssessment Questionnaire (Sort Form)

شخصیت کی جانچ کا سوالنامہ

مندرجہ ذیل صفحات چند بیانات پر مشتمل ہیں جو کہ بیان کرتے ہیں کہ مختلف لوگ اپنے بارے میں کس طرح محسوس کرتے ہیں۔ ہر بیان کو غور سے پڑھیں اور یہ بتائیں کہ یہ آپ پر کس حد تک لاگو ہوتا ہے۔ ہر بیان کے لیے وہ جواب دیں جو فوراً آپ کے ذہن میں آئے پھر اگلے بیان پر جائیں۔ کسی بھی بیان پر زیادہ دُت نہ لگائیں۔ ہر بیان کے بعد چار خانے دیئے گئے ہیں۔ اگر کوئی بیان آپ کے بارے میں واقعی درست ہے تو پھر اپنے آپ سے سوال کریں، " کیا یہ تقریباً ہمیشہ صحیح ہے "یا" کیا یہ صرف بعض اوقات صحیح ہے "اگر آپ کو لگے کہ یہ تقریباً ہمیشہ صحیح ہے تو " تقریباً ہمیشہ صحیح ہے "والے خانے پر x کا نشان لگائیں اگر آپکو یہ لگے کہ یہ بیان صرف "بعض اوقات صحیح ہے "ہے تو "بعض اوقات صحیح ہے "پر نشان لگائیں۔ اگر آپ کو لگے یہ بیان درحقیقت آپ کے لیئے صحیح نہیں ہے تو پھر اپنے آپ سے یہ سوال کریں کیا یہ "بہت کم صحیح ہے "یا" کیا یہ تقریباً کبھی صحیح نہیں ہے "۔ اگر یہ "بہت کم صحیح ہے "ہے تو "بہت کم صحیح ہے "والے خانے پر x کا نشان لگائیں اگر آپ کو یہ لگے یہ بیان " تقریباً کبھی صحیح نہیں "ہے تو " تقریباً کبھی نہیں "پر نشان لگائیں۔

یاد رکھیں کہ کسی بھی بیان کے لیئے کوئی صحیح یا غلط جواب نہیں ہے اس لیئے جتنی دیانتداری سے آپ جواب دے سکتے ہیں دیں۔ ہر بیان کے لیئے اس طرح جواب دیں جس طرح آپ سمجھتے ہیں کہ آپ ہیں نہ کہ ایسا جیسا آپ بننا پسند کرتے ہیں۔

نمبر شمار	بیانات	تقریباً ہمیشہ صحیح	بعض اوقات صحیح	بہت کم صحیح	تقریباً کبھی نہیں
1	میرا لڑنے کو جی چاہتا ہے۔	1	2	3	4
2	میں چاہتا/چاہتی ہوں کہ جب بیمار ہوں تو میرے والدین میرے لیے پریشان ہوں۔	1	2	3	4
3	میں اپنے آپ کو پسند کرتا/کرتی ہوں۔	1	2	3	4
4	میں محسوس کرتا/کرتی ہوں کہ میں وہ کچھ کر سکتا/سکتی ہوں جو دوسرے لوگ کر سکتے ہیں۔	1	2	3	4
5	مجھے لوگوں کو یہ بتانے میں مشکل ہوتی ہے کہ میں کیا محسوس کرتا/کرتی ہوں۔	1	2	3	4
6	جب میں کوئی کام کرنے کی کوشش کرتا/کرتی ہوں اور نہیں کر سکتا/سکتی، تو مجھے بُرا محسوس ہوتا ہے یا مجھے غصہ آجاتا ہے۔	1	2	3	4
7	مجھے یقین ہے کہ زندگی ایک نعمت ہے۔	1	2	3	4
8	میرا دل کسی چیز یا شخص کو ٹھوکر مارنے کو چاہتا ہے۔	1	2	3	4
9	میں چاہتا/چاہتی ہوں کہ میرے والدین مجھے بہت پیار کریں۔	1	2	3	4
10	میں محسوس کرتا/کرتی ہوں کہ میں اچھا/اچھی نہیں ہوں اور کبھی بھی اچھا/اچھی نہیں بن سکوں گا/گی۔	1	2	3	4
11	میں محسوس کرتا/کرتی ہوں کہ میں کسی کام کو اچھے طریقے سے نہیں کر سکتا/سکتی۔	1	2	3	4
12	اپنے والدین سے محبت کا اظہار میرے لیے کافی آسان ہے۔	1	2	3	4
13	بغیر کسی مناسب وجہ کے میرا موڈ خراب ہو جاتا ہے۔	1	2	3	4
14	میں زندگی کو خطرات سے بھرپور دیکھتا/دیکھتی ہوں۔	1	2	3	4

15	غصے میں بے قابو ہو کر میں توڑ پھوڑ شروع کر دیتا/دیتی ہوں۔	1	2	3	4
16	جب میں پریشان ہوتا/ہوتی ہوں، تو اپنی مشکلات خود حل کرنا چاہتا/چاہتی ہوں۔	1	2	3	4
17	جب بھی میں کسی اجنبی سے ملتا/ملتی ہوں، میرا پہلا تاثر ہوتا ہے کہ وہ مجھ سے بہتر ہے۔	1	2	3	4
18	میں جن چیزوں کو حاصل کرنا چاہتا/چاہتی ہوں ان کے لیے جدوجہد کر کے کامیابی حاصل کر سکتا/سکتی ہوں۔	1	2	3	4
19	مجھے اچھے دوست بنانے اور دوستی قائم رکھنے میں مشکل پیش آتی ہے۔	1	2	3	4
20	جب مجھ سے کام خراب ہو جائے تو میں پریشان ہو جاتا/جاتی ہوں۔	1	2	3	4
21	میں سوچتا/سوچتی ہوں کہ دنیا ایک اچھی اور خوشگوار جگہ ہے۔	1	2	3	4
22	مجھے لوگوں کی احمقانہ حرکات پر ہنسی آتی ہے۔	1	2	3	4
23	میں چاہتی/چاہتا ہوں کہ میرے والدین مجھے پوری توجہ دیں۔	1	2	3	4
24	میرا خیال ہے کہ میں ایک اچھا شخص ہوں اور میں چاہتا/چاہتی ہوں کہ دوسرے بھی میرے متعلق یہی خیال رکھیں۔	1	2	3	4
25	میں سوچتا/سوچتی ہوں کہ میں ایک ناکام شخص ہوں۔	1	2	3	4
26	یہ میرے لئے آسان ہے کہ میں اپنے گھر والوں کو بتا سکوں کہ میں ان سے محبت کرتا/کرتی ہوں۔	1	2	3	4
27	میں ایک منٹ میں خوش ہوتا/ہوتی ہوں اور دوسرے ہی منٹ اداس اور پریشان ہو جاتا/جاتی ہوں۔	1	2	3	4
28	دنیا میرے لیے ایک ناخوشگوار جگہ ہے۔	1	2	3	4
29	شدید غصے میں میری حالت جذباتی ہو جاتی ہے۔	1	2	3	4
30	میں چاہتا/چاہتی ہوں کہ جب میں کسی معاملہ میں پریشان ہوں تو میری ہمت افزائی کی جائے۔	1	2	3	4
31	میں اپنے متعلق اچھا محسوس کرتا/کرتی ہوں۔	1	2	3	4
32	میں محسوس کرتا/کرتی ہوں کہ میں وہ بہت ساری چیزیں نہیں کر سکتا/سکتی جو میں کرنا چاہتا/چاہتی ہوں۔	1	2	3	4
33	مجھے کسی سے یہ کہنے میں دشواری پیش آتی ہے کہ میں اسے پسند کرتا/کرتی ہوں۔	1	2	3	4
34	میں بہت کم غصہ کرتی/کرتا یا ناراض ہوتی/ہوتا ہوں۔	1	2	3	4
35	میں دنیا کو ایک خطرناک جگہ تصور کرتا/کرتی ہوں۔	1	2	3	4
36	مجھے اپنے مزاج پر کنٹرول نہیں رہتا۔	1	2	3	4
37	جب میں پریشان یا بیمار ہوتا/ہوتی ہوں تو میں چاہتا/چاہتی ہوں کہ میرے والدین میرے لیے پریشان ہوں۔	1	2	3	4
38	میں اپنے آپ سے ناخوشگوار ہو جاتا/جاتی ہوں۔	1	2	3	4

39	میں محسوس کرتا/کرتی ہوں کہ میں جو کام کرتا/کرتی ہوں اس میں کامیاب ہوں۔	1	2	3	4
40	یہ میرے لیے آسان ہے کہ میں اپنے دوستوں کو بتا سکوں کہ میں حقیقت میں ان کو پسند کرتا/کرتی ہوں۔	1	2	3	4
41	جب مجھے مشکل مسائل کا سامنا کرنا پڑتا ہے تو میں جلد ہی پریشان ہو جاتا/جاتی ہوں۔	1	2	3	4
42	زندگی میرے لیے ایک اچھی چیز ہے۔	1	2	3	4

APPENDIX-G

Swanson Nolan and Pelham (SNAP-IV)

سوالنامہ

ہر بیان کے سامنے وہاں نشان لگائیں جو بچے کو بہترین طور پر بیان کرے۔

نمبر شمار	بیانات	بلکل نہیں	تھوڑا سا	قدرے زیادہ	بہت زیادہ
1	اکثر تفصیلات پر توجہ دینے میں ناکام رہتا/رہتی ہے یا اسکول اور دیگر کاموں میں لاپرواہی کے باعث غلطیاں کرتا/کرتی ہے۔	0	1	2	3
2	اکثر کاموں یا کھیل کی سرگرمیوں پر توجہ برقرار رکھنے میں مشکل پیش آتی ہے۔	0	1	2	3
3	اکثر براہِ راست بات کیے جانے پر نہیں سنتا/سنتی ہے۔	0	1	2	3
4	اکثر ہدایات پر عمل نہیں کرتا/کرتی اور اسکول یا دیگر کام مکمل کرنے میں ناکام ہو جاتا/ جاتی ہے۔	0	1	2	3
5	اکثر کاموں اور سرگرمیوں کو منظم انداز سے کرنے میں مشکل پیش آتی ہے۔	0	1	2	3
6	اکثر ایسے کاموں کو ناپسند/ یا ہچکچاہٹ سے کرتا/کرتی ہے جن کے لیے مستقل ذہنی توجہ کی ضرورت ہوتی ہے۔	0	1	2	3
7	اکثر ان چیزوں کو کھو دیتا/ دیتی ہے جو مختلف سرگرمیوں (کو سرانجام دینے کے لیے) ضروری ہیں۔	0	1	2	3
8	اکثر بیرونی محرکات کی وجہ سے توجہ پھیر دیتا/ دیتی ہے۔	0	1	2	3
9	اکثر روزمرہ کی سرگرمیوں کو بھول جاتا/ جاتی ہے۔	0	1	2	3
10	اکثر ہاتھوں اور پیروں سے بے چینی ظاہر کرتا ہے یا سیٹ پہ بے قرار رہتا/ رہتی ہے۔	0	1	2	3
11	اکثر کلاس روم یا دیگر مواقعوں پر (جہاں نشست پر بیٹھے رہنے کی توقع کی جاتی ہے) اپنی نشست چھوڑ دیتا/ دیتی ہے۔	0	1	2	3
12	اکثر ان مواقعوں پر حد سے زیادہ بھاگتا/ بھاگتی یا پھلانگتا/ پھلانگتی ہے، جہاں غیر مناسب ہوتا ہے۔	0	1	2	3
13	اکثر کھیل اور فراغت کی سرگرمیوں کو خاموشی سے کرنے میں مشکل پیش آتی ہے۔	0	1	2	3
14	اکثر مستقل متحرک رہتا/ رہتی ہے، (یا ایسے متحرک رہتا ہے جیسے موٹر سے چل رہا/ رہی ہو۔	0	1	2	3
15	اکثر مسلسل بولتا رہتا/ بولتی رہتی ہے۔	0	1	2	3
16	اکثر سوالات کے مکمل ہونے سے پہلے بغیر سوچے سمجھے جوابات دیتا/ دیتی ہے۔	0	1	2	3
17	اکثر اپنی باری کا انتظار کرنے میں مشکل پیش آتی ہے۔	0	1	2	3
18	اکثر اجازت کے بغیر دوسروں کے کھیل اور باتوں میں مداخلت کرتا/کرتی ہے۔	0	1	2	3

Developed by Swanson, Nolan & Pelham (1992)
Translated 2021 by Romana Iqbal
National University of Modern Languages,
Islamabad, Pakistan.

Pakistan.

Pakistan