Adaptation of child focused cognitive behavior therapy as an intervention program

A dissertation submitted to the Department of Educational and Counselling Psychology, University of Dhaka in partial fulfillment of the requirements for the degree of Masters of Philosophy (M.Phil.) in Educational Psychology.

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List of Abbreviations

ADHD	Attention Deficit Hyperactive Disorder
APA	American Psychiatric Association
ASD	Autism Spectrum Disorder
BAI-Y	Beck Anxiety Inventory for Youth
BANI-Y	Beck Anger Inventory for Youth
BSMMU	Bangabandhu Sheikh Mujib Medical University
BT	Behavior Therapy
BYI	Beck Youth Inventory
CBT	Cognitive Behavior Therapy
CF-CBT	Child Focused Cognitive Behavior Therapy

CP	Cerebral Palsy
CT	Cognitive Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
GAD	Genaralized Anxiety Disorder
ICDDR,B	International Center for Diarrhoeal Disease Research, Bangladesh
IPNA	Institute of Paediatric Neurodisorder and Autism
NDDs	Neurodevelopmental Disorders
NIMH	National Institute of Mental Health
OCD	Obsessive-Compulsive Disorder
PTSD	Post-traumatic Stress Disorder
RCT	Randomized Clinical/Control Trial
SES	Socio Economic Status
SPSS 21	Statistical Package for the Social Sciences Version 21
WL	Wait List Control

Declaration

I, Sadia Afrin, M. Phil degree researcher of Educational Psychology, Department of Educational and Counselling Psychology, University of Dhaka, states that the research tittle on **"Adaptation of child focused cognitive behavior therapy as an intervention program"** has been my own exertion. It has been consummated by me, from origination to implementation under the guidance of Professor Dr. Mahjabeen Haque and Professor Dr. Mehtab Khanam, Department of Educational and Counselling Psychology, University of Dhaka. All the resources that have applied and cited/enumerated have been acknowledged by cited complete references. I also announce that any section of this dissertation has not been submitted in assistance of any degree by any university or educational/research institute.

……..

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Certificate of Supervisor

This is to accredit that I have perused the research paper entitled **"Adaptation of child focused cognitive behavior therapy as an intervention program"** put forward by **Sadia Afrin** in partial attainment for the degree of Masters of Philosophy (M. Phil.) in Educational Psychology. I also certify that I have scrutinized this research which had been completed by Sadia Afrin. This is a charter and authentic research accomplished by Sadia Afrin concealed by my guidance, headship and supervision.

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Dedication

To my Parents Md. Shah Alam and Piary Begum, my brothers Md. Shah Jamal and Md. Shah Kamal and my loving, cute nephew Zarif-Ibna-Jamal. Their inspiration guided me throughout my entire journey.

Abstract

Child-focused cognitive behavioral therapy (CF-CBT) is a treatment approach which is based on evidence. The purpose of this therapy is to help children, adolescents, and their parents (or other caregivers) overcome child-related difficulties. These difficulties include anxiety, anger, maladaptive behavior, negative irrational thinking process etc. As far as Bangladesh is concerned, more often than not, western values influence cognitive behavioral therapy (CBT) since it was primarily developed and practiced in the West. Cultural understanding and contextualizing have always led to a better therapy outcome. Many a researcher have suggested that CBT need modification and adaptation to non-western clients' cultural and social backgrounds. In Bangladesh, there is a scarcity of organized and systematic intervention programs in Bangla. In that case, applying and developing interventions for Bangladeshi culture to serve the affected children is of vital importance. It is the necessity of the time to adapt the intervention culturally. The main objectives of the present study were to adapt the Child Focused Cognitive Behavior Therapy as an intervention for children and assess the effectiveness of adapted Child Focused Cognitive Behavior Therapy as an intervention. To attain these two objectives, the research has been divided in two sections (section 1 & 2).

Section 1 was constructed for general objective 1 and five specific objectives were administered to fulfill the general objective 1. General objective 2 was administered in section 2 with 3 specific objectives. Again, the researcher has divided section-1 in two phases (Phase 1 & 2). To accomplish the phase 1, a number of child focused activities were selected, translated and reviewed. 20 regular random children were taught some

techniques. These children also practiced the activities in several sessions. With their feedback and psychologists' constructive opinion by credibility questionnaires, bangla activities were reviewed and re-constructed which was the researcher's draf-2. In phase 2, purposively selected 10 children were skilled with draft-2. After their comments and review, draft-3 was developed.

In the section 2, draft-3 was applied on 49 children, who the researcher has termed as Case Group, with extremely elevated or moderately elevated anxiety and anger. There were 3 control groups. Control Group-1 did not receive any intervention; they also did not come to the hospital for their own treatment purpose. Control group-2 and 3 were already assessed by other psychologists. There were extremely elevated or moderately elevated anxiety and anger in these children and they received intervention by general instruction and creative therapy respectively. 49 children from Case group, 28 children from control group 2 and 30 children from control group 3, all attended 14 sessions in 14 weeks. The time duration was 1 hour 30 minutes for each of the sessions. So, the total number of the sessions were 1498 (107 participants multiplied by 14 sessions).

By comparing the mean score by t value, the researcher saw that among all the groups, the mean score of anxiety and anger level in the Case Group is the lowest than 3 control groups. Also, the credibility questionnaire percentage among the children, parents and psychologists proved that the child focused CBT Bangla activities, which were developed by the researcher, were more effective in reducing anger and anxiety among the children. So, the researcher finally deduced that these CBT Bangla activities could be used in a larger scale throughout the nation.

Chapter 1

Introduction

Introduction

Cognitive Behavior Therapy (CBT) is evidence based psychotherapeutic treatment that aids people become acquainted to define their negative thinking pattern and learn how to modify the destructive disturbing cognition that makes a negative impression on their emotions and behaviors; overall their social, economic life. The efficacy of CBT in children and adolescents with anxiety disorders has been established in numerous evidence based studies and are considered as the first-line treatment of choice for anxiety disorders (Silverman, Pina, & Viswesvaran, 2008; Walkup, Albano, Piacentini, & Et al., 2008; see meta-analysis Ishikawa, Okajima, Matsuoka, & Sakano, 2007; Ollendick & King, 2004). There is a great need for cross-culturally validated research instruments because of the variety of the population worldwide. Researchers and clinicians need access to reliable and valid measures of concepts of interest in their own cultures and languages. The process of adapting an existing well validated instrument, rather than developing a new one has considerable advantages. Developing a new instrument/scale is time-consuming and costly, so by adaptation professional can get a valid instrument for the betterment of the client in their own cultural basis.

Cognitive Behavior Therapy (CBT)

CBT is also defined as psycho- social intervention techniques that intents to abate prefix of manifold mental health ambiance. The focal point of CBT is switching the automatic negative notion that can contribute to and pollute individual's emotional difficulties. These negative notions have a deleterious influence on human mind. Through

CBT, psychologist along with the client identifies the negative trap or thoughts, conduct the thought challenge process, recapture client's positive thinking pattern and replace the negative notions with more structured, tangible, realistic cognition. (Shortt, Barrett, & Fox, 200).

CBT is more about than discovering thought patterns; it is focused on applying varies of techniques to assist client to overcome these negative thoughts. CBT does not incline to concentrate on underlying unconscious resistances to switch as much as another approach such as psychoanalytic psychotherapy. Clients who are more comfortable with a structured and focused approach it is often best-suited for them. CBT will be more effective when the client must be ready and willing to expand time and effort to analyze their unhealthy thoughts and feelings. The activities for intervention by CBT are difficult to do in home but client knows how a person's internal states, thinking affects his or her external observable behavior or action (McLoone, Hudson, & Rapee, 2006; Nehmy, 2010).

Most of the time, CBT is a continual process which assist a client to take successive steps toward to change her or his behavior. For example, person with severe anger might start with the triggering situation. The client can analyze the situation, make some small part then practice to calm down in small group like family members, friends then apply the small changes to colleagues. Nest, he or she might start to practice in larger group. Start with a small goal to larger goal is the progressive working process of CBT. The process seems less appall and the destination easier to achieve.

CBT is a contemporary form of short-tenure psychotherapy grounded on the idea that the manner a person thinks and feels affects the way she or he behaves with others in a specific situation. One of the problem engrossed approach is CBT that concentrate to help others to identify and make alteration to the dysfunctional-negative beliefs, opinions and patterns of actions that contribute to person's problems. Cognitive behavioral therapy is an experiential and confirmation-centered psychotherapy that assimilates cognitive discipline and behavioral models. CBT's fundamental ethos is that belief affects feelings, which then dominate actions or behaviors. CBT consolidates two identical operative kinds of psychotherapy, one is cognitive therapy (CT) and another is behavioral therapy (BT).

Cognitive Therapy (CT)

Cognitive therapy (CT) is a way to gain control over inappropriate repetitive thoughts that often feed or triggers various presenting problems (Beck 2010). Cognitive therapy focuses on human's higher mental process such as thinking process, beliefs, point of view to make assumption for any topic and contemplations. By means of cognitive therapy, person has been imbued to identify own dysfunctional thoughts, beliefs and to modify that irrational, illogical, maladaptive thought process. Primarily cognitive therapy emphases on human's thought configuration which is accountable for deleterious sloppy emotion and maladaptive behavior pattern. Commencing point of CT is our undesirable emotional conditions are triggered and flowed by unproductive and exaggerated preconceptions in our thinking process.

The vital intermediation in cognitive therapy is detecting erroneous or self-conquering patterns, and learning to retort to them with more sensible, fact-based logical thinking. At that point, emotional instability is decreasing and more effective behavior is increasing. This practice is acknowledged as cognitive restructuring (Veek, Derkx, Benninga, Boer, & Hann, 2013)

Behavior Therapy (BT)

Behavior therapy (BT) concentrates on specific actions and environments that either change or maintain behaviors (Skinner 1974; Bandura 1977; Walkup et al., 2008). Exchanging undesirable actions or behaviors with desirable behavior is a recognized technique to modify the behavior, mostly by reinforcing the new behavior. Behavioral therapy concentrates more on the activities as the more dominant factor of challenging psychological patterns. In behavioral therapy, complications are evaluated with anticipants, situation, consequences, after all analysis challenging behaviors are identified. The foremost mechanism which expediting the modification in behavioral therapy are facilitating the learning process and execution of definite behaviors to swap unproductive or challenging behaviors. This process is known as the form of modeling/training of different actions, snowballing exposure to previously-avoided stimuli, and accumulative worthwhile performance. Some managements depend on more profoundly on cognitive mediations, while others predominantly on behavioral. On the other hand, treatments or intervention for most psychological worries or issues depend on a conjunction of both cognitive and behavioral interventions to accomplish enduring change.

As human being, through different senses, we acquire lots of information in every moment. These are known as stimuli. A stimulus does not have any particular characteristics. We give them a term like negative or positive stimuli by perceiving the stimulus with our experiences. Experiences are the series of our learning; learning is a process of gathering the information. In our everyday life we experience lots of events but every single event does not trigger us. A particular stimulus triggers us when we recognize it by our template or cognition. Cognition roots from the Latin word *cognoscere* that means "to know". It is a process of information accumulation which is already stored in our memory and we acquired them through the scheme of learning or experiences.

When we perceive a stimulus, we are alluding it to our store. We compare it and acknowledge it by an event. Afterwards, we accumulate emotion with it and we do some actions. Cognition is the knack to channel information through our perception and knowledge gained through experience. We then integrate all of these to evaluate and expound the world. Cognition is the legerity to assimilate and process the gathered information and metamorphose to knowledge. All the elements of our intellectual development and experiences as learning attention, perception, reasoning, decision making, and language are known as a term of cognition. Thus, cognition refers to a range of mental processes relating to the acquisition, storage, manipulation, and retrieval of information. So, we can define Cognition as 'the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses.'

With the collaboration of CT and BT, Cognitive-behavioral therapy is a form of conversation concentrated on explaining, analyzing and rationalizing client's destructive,

irrational or illogical beliefs, thinking process and activities. This goal is accomplished by thought-provoking and challenge cognitive dysfunction and reframing irrational thoughts to more rational thoughts.

A widespread practice of psychotherapy for children is Child-focused cognitive behavior therapy (CBT). At the present child focused CBT is extensively applied with a range of mental health problems obtainable by children and adolescents. The experiential foundation of child-focused CBT has been evidenced through a number of randomized controlled trials that have resulted in a growing condemnation amongst Psychologists that CBT is the treatment of choice for many disorders with children (Schneider et al. 2006).

CBT established a set of activities, skills that empowers the clients to be mindful of situation, own thoughts and emotions with consequences. For adult client, CBT helps to analyze the situation, antecedents, thought process and how behavior influenced by emotions or feelings. It is also very helpful for the child client. It also have to be mentioned, if children learn to be mindful in situation, restructure the thought, share their feelings in healthy way it would be very helpful for them to be confident, high self-esteemed person. The process of child focused CBT is more or less similar to CBT process.

Child Focused Cognitive Behavior Therapy (CF-CBT)

To work with child, professional have to be more cautious for the process. Children and adolescence are the most sophisticated group of client. They are dealing their most vulnerable period of life. To conduct a successful therapy process, psychologists have to be aware about child's engagement in the sessions and readiness to

change steps. At the inauguration of the healing process the psychologists introduce with the child and the child's parent's (caretaker) in order to evaluate the level and nature of the current concerns and the outcomes they would like to attain through the sessions. The concerns of the child usually have been recognized by their parents or caregivers. Therefore, child may not have any awareness to convey the modification. So convince the child to engage in the session is one of most difficult steps for child focused CBT. Usually children do not refer themselves and may not be interested to share their difficulties. An important first task is to evaluate the child's readiness to change and to identify whether they have any problems they would like to address or destination they would like to achieve. The first step is concerned with building-up a rapport or partnership between the psychologist and child. Through a good partnership an open and collaborative way of working is endorsed and the significant and active involvement of the child to the therapeutic process is emphasized, exhilarated and encouraged.

The intervention then has to be leaning with the exact level of development so that the child can entirely engross with the process of CBT. This entails the models, approaches and strategies of CBT to be converted with the intention of make them more enjoyable. The activities which are applied in the session it would be compatible with the child's linguistic, cognitive and social development. Empathy is a significant fragment of the process in which the psychologist expresses concern and aims to understand as abundantly as possible how the child recognizes their own world and the actions. This also delivers a meaning to the child that their interpretations are

significant and the psychologist wishes to listen to them. Creativity is the method by which the psychologist involves and continues the child's attention. The models, activities, techniques and strategies of CBT are carefully constructed according to the child's individual comforts. The idea of conducted detection is encouraged through the idea of investigation. The child is encouraged to pinpoint their beliefs, thoughts, and assumptions to conduct behavioral experiments objectively. Efficiency encourages the clue of enablement and inspires the child to build upon their own concepts and to find out their own explanations. This encompasses to help the child to identify and acknowledge previous successful experiences, their strengths or skills and to consider whether they can be used to help with the current situation. Finally, CBT with children needs to be enjoyable so that the process is fun, entertaining and engaging to the children (Kendall, Safford, Flannery-Schroeder, & Webb, 2004).

To apply CBT for children, more non-verbal activities have to be inputted. Games, puppets, using play accessories, pictures, role play, crafting, art would be the helpful method for child focused CBT.

During initial sessions of child focused cognitive behavioral therapy, issue, difficulties or problems are discussed, and therapy or intervention goals are established. Centered on the treatment objectives and formulation of the issues or problem, every single session is dedicated to solve the existing difficulties. To facilitate the client, like other procedures of psychotherapy, between-session home exercise, tasks, assignments are allocated as a technique of implementation of the solution in clients' daily life issues (Ishikawa, 2015).

In point of fact, child focused CBT becomes child enthusiastically involved in the intervention so that they recognize that the approach to develop their survival is to regulate their thinking process and their approach to ordinary conditions.

The complete aim of the treatment is to reduce the symptom, improve the daily functioning and decrease of the level of issues or problem or disorder. The preliminary sessions of child-focused CBT are interpreted the close association among cognition and emotions. Each one distinctive treatment session initiates launching an outline of existing difficulties, monitored by cognitive reformation of maladaptive behavior and irrational cognitions. At the conclusion of the session, the therapist allocates exercise to benefit the client or children to apply precise efficiency in own actual events (Beidel, Turner, Young, & Paulson, 2005). Every single phase of child-focused CBT is rational, specific, and transparent also. If the client or child agonizes from stress, depression, trauma, anger, aggressive behavior child focused CBT applied behavioral strategies with cognitive interventions. The psychologist or therapist can also practice a chain of queries to help the children or client to evaluate the efficacy and rationality of their cognitions.

Child-focused CBT is grounded on an ever-evolving construction of patients' difficulties. In cognitive terms, it is an individual conceptualization of every single client or child. The existing thinking configurations of the child or client and challenging behaviors are identified and acknowledged. A number of features must be well-thought-out with the clients' or child's life experiences. To construct a whole accurate view of the child's present situation or behavior, based on the information gathered by parents, caregiver and child Conceptualization of the case is formulated.

As more and more information becomes available in every single session, the conceptualization is more polished. Child-focused CBT entails a thorough therapeutic association between psychologist or therapist and client or children. It is important to have a strong trusting relationship between the therapist and patient. The therapist should be able to provide care, warmth, empathy, and competence. Child-focused CBT puts emphasis on association and active participation of the client (Hirshfeld-Becker et al., 2010).

Collaboration is exhilarated during the sessions and conclusions of what to work on and how often are definite collaboratively. Energetic input from the client is vital for construction a permanent influence in the intervention or treatment. The client or children with family/parents/caregiver had better to establish a precise objectives throughout the early sessions. Objectives are essential to estimate with response to point of view of the client. This helps the child or client to identify and interrupt those thoughts easily. Child-focused CBT initially highlights the present situation, problems and behaviors. The therapy or intervention must be concentrated on existing maladaptive behavior, irrational thinking, problems and specific conditions that are stressful to the client or child. Child-focused CBT demonstrates children or clients to detect, estimate, and react to their maladaptive behavior or challenging behavior, dysfunctional or irrational thought process and core negative beliefs. Psychologist or therapist plays a role like assistance to the child or clients to detect the key cognitions and embrace additional accurate, balanced, rational thoughts and perspectives. This is reached from side to side the progression of guided detection by systematic questioning client or child's opinions to estimate their

thinking (Eley et al., 2003; Spence et al., 2001).

Child-focused CBT practices a diversity of techniques or strategies to modify irrational thinking, destructive mood, and maladaptive behavior.

Child-focused CBT is a form of treatment that involves active involvement from the children. The central focus of child-focused CBT is to modify irrational, illogical, negative thought process and maladaptive challenging behaviors to be more rational, logical, realistic and helpful for dealing social life. Throughout child-focused CBT sessions child supposed to acquire to:

- Point out the difficulties and figure out consciousness of irrational, negative thoughts and challenging behavior
- Identify thinking process is the own point of view and be competent to discriminate between evidences and unreasonable, irrational, illogical thinking process
- Intentionally test and reframe or reconstruct irrational, maladaptive dysfunctional assumptions
- Establish attainable, achievable, practicable and feasible aims
- Improve a more affirmative viewpoint of circumstances

Elements of CBT based intervention

CBT is a psychosocial treatment or intervention that usually comprises psycho-education, stabilization or grounding or relaxation techniques, anxiety- stress-depression-anger management or controlling strategies, exposure healing, role play or participant modeling, reinforcement and reward system, cognitive restructuring or thought process

reconstruction, amalgamation of practice for societal skills and problem-solving exercises, and self-help trainings and therapeutic home exercise as well as other deterioration and maintenance approaches (e.g., Waters, Ford, Wharton, & Cobham, 2009). In CBT, young children are trained and educated to identify their emotional state associated to anxiety, anger (i.e., feelings, emotions, behavior and physical senses), to pinpoint or find-out and encounter their anxious or aggressive negative self-talk, to cultivate managing abilities, and to assess and reward expertise practice. In addition, a key element of child-focused CBT is to systematically desensitize the situation, expose to hostile or threatening conditions and trained to practice relaxation or grounding techniques to take challenge of these pressures, (Kendall & Hedtke, 2006).

Intervention has been given to the client by different types of therapy, at first look at the contents of the therapy.

Definition of the Therapy

Therapy is acknowledged as a procedure of management which purposes at opening up emotive instabilities, rational thinking, and psychological well-being concerns as long as by proficient, skilled specialists such as psychiatrist, psychologist, and social workers. Frequently persons obstructed by lots of complications in rapport build-up with others, relationships such as couple, family, friends, peer, siblings etc. In such conditions, therapy encompasses analytical and emergent point of view to understand the life choices and complications tackled by persons. In order to, to progress some of the features of client's life, therapy sessions deliver well-structured arrangements of consultation between mental health professional and client. Therapy constitutes

multiple types of treatments which are practiced by a range of clinicians using variety of strategies (Roder V, Müller DR, Mueser KT, Brenner HD, 2006).

The core feature of therapy is that the client deals with the therapist combinedly and can identify enhancement and constructive change over time. The profits of effective therapies are life shifting. Too boost up the contentment in people's lives, therapy can be constructive tool.It engraves varied array of mental health issues, which are continued from end to end long period of phase namely depression, anxiety, anger, grief, and trauma though it can also be used for immediate mental health concerns (Charlotte Paterson, et. al.2018).

Definition of the Intervention

Intervention initiated from the Latin term "*intervenire"*, meaning "to come between, interrupt." An intervention is proposed to make things better. The meanings of intervention are "The act of intervening, interfering or interceding with the intent of modifying the outcome". In applied psychology, interventions are engagements which are executed to carry out the modification. At the present time a wide-ranging of intervention approaches is present and professionals applied these techniques to unravel several forms of complications. Psychological interventions are organized methods or techniques applied to simplify the modification in an individual.

Interventions may be executed in diverse situations counting groups, workplace, educational institution, health care institutes, and faith-based administrations or even in the home environment. Interventions executed by expending several approaches to reach a aim for benefit of the client.

Substantiation has publicized that interventions generate alteration by:

- Prompting individuals' acquaintance, approaches, principles and expertise;
- Cumulative community backing; and;
- Generating reassuring atmospheres, strategies and assets;

In applied psychology, interventions are activities attained to convey the change in individuals.

The definitive goal behind these interventions is not only to lighten symptoms but also to target the core cause of mental disorders(Feldman, D. B. & Dreher, D. E. 2012).

Therapy and Intervention

Typically, therapy and intervention words are used interchangeably. But both have different impact on the professional field. To a mental health professional, intervention is a vast area where different types of therapy has been applied for client's betterment based on client's opinion, choices.

However, these two terms should have distinct and different meanings. Understanding the difference between *therapy* and *intervention* is crucial for everyone involved in the process of intervention, including parents, caregivers and therapists.

Therapy is the time the child spends in direct contact with the therapist each week. Services are provided by the therapist. Intervention is what occurs the rest of the time between therapy sessions. The family and caregivers provide the intervention.

When a young child receives CBT through the counseling program, the goal of therapy should NOT be to teach the child how to talk, follow directions, point to body parts, etc. The goal of therapy should be to provide the family with the competence and the confidence to help their child learn how to talk, follow directions, point to body parts, etc. The focus of therapy in counseling session should be on child and caregiver education. While therapists do need to spend some therapy time in direct contact with the child, they also need to spend thoughtful time consulting with and educating families and caregivers about what kind of intervention they can be focusing on until the next therapy session. Therapists should avoid leaving homework per se, but rather provide specific, relevant suggestions that allow the family to incorporate strategies into their existing daily activities and routines (during bath time, during breakfast, when going for a walk, riding in the car etc.

In intervention, we do not use a medical model of service delivery (let me "fix" your child) but rather we use a developmental model that focuses on the entire family, not just the child with needs. When a child is learning a new skill, he or she will have to practice that skill often in order for it to become established. One hour per week of therapy is NOT often enough! That is why the intervention piece (provided by the family) is so crucial. Young children who receive intervention services will make the most progress when the family is actively involved in the intervention process.

Effectiveness of intervention is depends on client's acceptance. When client feels that the activities are appropriate for him or herself and he or she can do the activities more flexible way, the words can be easily understand, the steps can be easily followed then the activities of the intervention is doing better. Most of the CBT activities

are developed in western culture. The materials are also used according to western society. As far as Bangladesh is concerned, more often than not, western values influence cognitive behavioral therapy (CBT) since it was primarily developed and practiced in the West. Cultural understanding and contextualizing have always led to a better therapy outcome. Many a researcher have suggested that CBT need modification and adaptation to non-western clients' cultural and social backgrounds. So, the following discussion focuses on the basics of adaptation.

Adaptation

Adaptation to an intervention contains brush up and altering the organization of a program or exercise to further suitably appropriates the requirements and inclinations of a certain cultural cluster of people or public. The fundamental indication is that interventions are not always one-size-fits-all. When the situation, culture, nation, beliefs, language is different, they may necessity to be modified. Conceivably the most significant motive strength the want to adapt intervention to diverse cultures is because intervention has been functioned already effectively and would correspond it to work yet again. A well-adapted intervention can increase the relevance of actions, decrease the possibility of unwanted surprises, and increase the chances for success of intervention (and its community impact) (Card JJ, Solomon J, Cunningham SD,2011).

There is a great need for cross culturally validated research instruments because of the variety of the population worldwide. Researchers and clinicians need access to reliable and valid measures of concepts of interest in their own cultures and languages. The process of adapting an existing well validated instrument, rather than developing a

new one has considerable advantages. Developing a new instrument/scale is time-consuming and costly. This supports the adaptation of an existing psychometrically sound measure. Adaptation also allows a researcher to compare data from different samples and from different backgrounds, which enables greater fairness in the evaluation because the same instrument assesses the construct based on the same theoretical and methodological perspectives. The use of adapted instruments obviously enables a greater capability to generalize and also permits one to explore differences within an increasingly diverse population (Hambleton, Merenda, & Spielberger, 2004).

In recent years, a growing interest in cross-cultural studies in psychology has been observed, which have demanded greater concern about the quality and suitability of adapted and validated instruments for use in different contexts (ITC, 2016). Translation, adaptation and validation of an instrument or scale for cross- cultural research is time-consuming and requires careful planning and adoption of rigorous methodological approaches to derive a reliable and valid measure of the concept of interest in the target population. There are a number of guidelines describing the steps of adapting a scale. Except some minor variations, they advocate similar procedures that one can follow to ensure sound psychometric properties, and cultural and conceptual equivalence of adapted scales (Beaton, Bombardier, Guillemin, & Ferraz, 2000; Sousa & Rojjanasrirat, 2011; ITC, 2016).

Adaptation to an intervention involves reviewing and changing the structure of a program or practice to more appropriately fit the needs and preferences of a particular cultural group or community. The elementary idea is that interventions are not always one-size-fits-all. When the setting, culture, language is different, they may need to be

adapted.Possibly the most important reason might want to adapt intervention to different cultures is because intervention has worked already and would like it to work again. A well-adapted intervention can increase the relevance of actions, decrease the possibility of unwanted surprises, and increase the chances for success of intervention (and its community impact) (Card JJ, Solomon J, Cunningham SD,2011).

It is necessary to find a sense of balance to adapt an intervention program. This is needed to be sure that program components are designed and ensuring the appropriateness of the intervention tool. When an existing model need to be adapted then this is also necessary to ensure that the program relevancy is appropriate for the community. Conversely, it is necessary to avoid eliminating the components of the program which are related to positive outcomes.

To minimize huge mismatching between the original program and adapted intervention tools investigators have recommended few types of anticipated program changes and adaptations like as cultural adaptation, cognitive adaptation, affective-motivational adaptation, environmental adaptation, adaptation of program content, adaptation of program form.

Program implementers should careful consideration about adapting a program so that effective practices from the unique program endure integral. Acceptable changes will not modify the theory and inner sense of the intervention and confirm critical steps subsidizing to the intervention usefulness are retained. Acceptable changes include

translating language or modifying vocabulary, modifying some aspects of activities. To make the program more appealing researcher are adding relevant evidence-based content.

Less acceptable changes may make a considerable change to a program's possible effectiveness:

- Reducing number or length of program sessions
- Reducing participant engagement
- Eliminating key messages or skills learned
- Using inadequately trained staff

Adapting intervention is a systematic process which is applied to modify an individual or group's behavior, emotional state, or feelings, anxiety, depression and anger. Most of the time, we feel anxious for our past or future which is disturbing our present. Anxiety is such a feeling which is the source of other feelings.

As we know that, all feelings are interconnected. In a situation, when we feel anxious for a future event a fear feeling is generated inside us. If we have enough confidence that we can face the situation then we can manage but if we have lack of confidence or irrational thinking then we react in the way of flight. We show aggressive behavior or depressed behavior. In this study, the researcher focuses on two more crucial feelings.

Here, the researcher focuses on anxiety and anger. Nowadays, lot of study conducted on anxiety and anger. Now the discussion focuses on anxiety, anger and the interconnection between anxiety and anger.

Anxiety

Anxiety is our natural responses to stress. More specifically anxiety is the mind and body reaction to stressful situation, event, person or object. It is a feeling of fear about future and past that creates internal irritation and nervousness that hampered our present situation. Every person have a feeling of little bit anxiety in their daily life situation. This is normal and needed to finish our daily activities. But when the anxiety is the cause of extreme fear, continuous uneasiness, excessive worry and distressed feeling then this is need to be concerned. During final exam or facing viva little bit anxiety is needed to perform and also helpful to be active to face the situation. Every individual in their life time Anxiety is a common feeling that every person in their lives has to go through. Initial from early youthful to old stage, people happenstance anxiety in their daily life, for example, new toys, new peers, first time at the school, seeming for an interview, waiting for test grades, facing the teacher, making a presentation, being alone in dark etc. In case of children and adolescents, all children experience anxiety more or less when separated from attached figures (mostly around nine months), pre-school children usually have the fear of ghosts, dark and animals, primary school going children go through the phases of more realistic fears related to illness and death, and most adolescents experience some form of worry related to their appearance and evaluation by others (Nauta, 2005).

Anxiety in childhood is a fragment of archetypal development and children often grow out of this anxiety as they mature. Some anxieties are mild and manageable, and some are severe and it interferes with daily functioning and mental well- being. In real sense, anxiety is not all bad and to some extent it has beneficial consequences. Anxiety

helps to avoid dangerous situations, the fear of failing in exams motivates student to study hard and perform well in exams. Little amount of anxiety helps one to perform well in every sector of live. If people did not have anxieties, one would cross the road without looking and end up in hospital. Therefore, it is considered as a valuable and functional emotion. But sometimes children and teenager find it difficult to control their anxiety. Their continuous feeling of anxiety constantly affects their daily lives. If anybody's feeling of anxiety are extreme and last longer than six months than it can be included anxiety disorder that hampered someone's functioning life and to be concerned (Davison GC, 2008).

Anxiety is an emotional state that is often measured equivalent to fear (Sweeney & Pine, 2004; (Campbell, 2005). Fear is the emotional rejoinder to real or perceived impending threat, whereas anxiety is the anticipation of future danger. There is close knot between these two states and they overlap but still they differ.

Fear is more often associated with rush of autonomic arousal necessary for fight or flight, thoughts of abrupt danger, and escape behaviors, whereas anxiety is more often connected with muscle strain and caution in preparation for future danger and avoidant behaviors (American Psychiatric Association, 2013). As a basic human emotion, anxiety consists of fright and doubt that typically appears when an individual identifies an event as being a threat to oneself.

Anxiety may be triggered in response to specific situations, people or events, as well as in anticipation of an event and is generally conceptualized as consisting of physiological, cognitive, and behavioral responses (Craske & Waters, 2005; Campbell,

2009. Others held the view that anxiety is comprised of cognitions, behaviors, physiological responses, and relational aspects (Ollendick & March, 2004; Morris & March, 2004; Silverman & Treffers, 2001). Physiologically, anxiety is defined by heightened autonomic arousal (e.g., increased hear and respiration rate, perspiration, sweating, desire to urinate, and generalized muscle tension) and somatic complaints (e.g., headaches, stomachaches).

Behaviorally, anxiety is characterized by avoidance and escape, deficits in attention, performance and control, restlessness and agitated behaviors. Cognitive features of anxiety include hyper vigilance for threat, danger-loaded thoughts, worry, maladaptive thoughts, cognitive distortions, misinterpretation, catatrophising and persistent intrusive thoughts.

The term anxiety is used to describe uncomfortable and unpleasant feelings that an individual goes through when in stressful or scared situations. It can best be understood on a continuum ranging from a normal, adaptive response, to the demands of a chaotic life full of stress, strain and, deadlines to a more severe form that interrupts a person's daily functioning. Worry, fear, and anxiety are met commonly in therapeutic settings but anxiety requires professional intervention when it is severe, persistent and developmentally irrational (i.e. which continues beyond reasonable age norms). Although it is considered a part of normal human development and is adaptive in some circumstances, fear and anxiety can become so intense that they can affect a child's functioning and psychosocial development. In these cases, anxiety may be considered

"clinically significant" or/and "pathological" and warrants a diagnosis (Waters, Farrell, & Schilpzand, 2013). The segregation between normal and clinical anxiety, however, can be meticulously difficult in children because children exhibits many fears and anxieties as part of their normal development (Murris, Merckelbach et al., 1998).

Normal anxiety can come and goes that not bother us mostly but in case of anxiety disorder intense anxiety interfere everyday life. Increased heart rate, rapid breathing, restlessness, trouble concentrating, difficulty falling asleep are few symptom of general anxiety disorder. Every child and teenagers goes through anxiety that is a normal part of life. Children and adolescence, who suffer anxiety disorder experience excessive shyness, fear and nervousness and they avoid their social surroundings and irritated feeling about other. Later they can perform poorly on their school life and anxiety hampered their personal life too. This is look like wave that can destroy internal external locus of control and achievements. Teens, their parents and teachers are recognizing that the impact of excessive anger is serious.

Anxiety disorder is work as a gateway that permits other disorder to entry within ourselves and it develop further mental health problems. Mental health workers concern about it because this is the origin of other disorder. Children and teens have more faced more types of anxiety disorder such as separation anxiety disorder, generalized anxiety disorder, social phobia, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder and selective mutism (*Barlow DH, 2000).*

As a parent, we get to see our children go through many phases in their lives. The happiness of getting a new toy, the tears from falling off the bike, and sometimes anger too. Each child has a unique way of expressing their anger. Some sit and pout in

silence, while others express their concern in words. However, there are times when their behavior begins to push limits. Shouting, biting, kicking and fighting are very common behavior issues.

For parents, especially new parents, it can be difficult to control and understand their behaviors and the reason why they are behaving in a particular way. Usually, when children express anger more than often they are labeled as ‘aggressive’ or ‘angry children’. But aggression isn’t the only reason why your child could be behaving this way. Anxiety can often mask itself as aggression. Even as adults it can be difficult to recognize the symptoms and control our anxiety, so when children experience these emotions, they often don’t understand what to do.

When we think of anxiety, we always think about freezing up, withdrawing from social situations and not speaking up. But that is not always the case. Anxiety occurs when our brain's amygdala senses trouble-causing hormones like adrenaline to rise in the body, hence triggering our fight or flight response. This fight or flight response is essential for keeping humans alive and healthy. Anxious brains are also just as strong and healthy as any other, but it’s just a little protective of itself. At times when the fight or flight response is activated, instead of ‘flight’ from the situation of anxiety the brain ‘fights’ against it. There isn’t a lot of time for your consciousness to judge whether the behavior is correct or not. It just wants protect itself.

Children experience many new things in day to day life, meeting new people, trying new things – they go through several emotions. Experiencing these emotions allows them to grow into healthy adults able to form good relationships and perform

better at tasks. For anxious children, every new step, new emotion can trigger the amygdala to believe it's dangerous and activate the fight or flight response. Their response in the fight towards protecting themselves can be taken as aggression from parents and onlookers. It is never too late for you to recognize these signs in your child's behavior and be able to give them the help they need.

Understanding that the reason for your child's behavior could be anxiety is important. Your child isn't trying to annoy you on purpose, they could be facing stronger emotions themselves and are unable to talk about it. Children need their parents to be their friends and guide them through life. To be able to help them, you have to be willing to understand them.

The most powerful way to help them overcome anxiety is to explain, talk to your child about anxiety. Children are very accepting of new topics; they are quick learners and their potential for understanding is boundless. When they can relate to the teaching, they gain an even better understanding. Be upfront about it, make them comfortable and they will understand.

Equip them with the right skills. As your child slowly starts to understand anxiety, it is also important for them to know what to do if they are anxious. Breathing exercises can always calm an anxious brain. Teach them to count up to 10 and take a breath when they feel these emotions. You can also teach them the 5 tricks – five things they can see, 4 things they can feel, 3 things they can touch, 2 things they smell and 1 deep breath. This exercise can help bring their focus off the topic of anxiousness to the present where everything is calm and okay. If you feel that your child isn't too

comfortable talking to you, get help from others. Allow a close family member they are comfortable with or even a therapist to speak with them.

At times many parents can feel offended that they are the reason why their child is experiencing anxiety and get angry themselves, but you have to remind yourself that if you become angry as well and try to push their boundaries you will only end up shutting them off even more. Children's emotions are delicate and we can't always expect them to know what to do. They are still humans and they are learning and will make mistakes. As parents, all we can do is allow them to experience these emotions independently and guide them to express their feelings healthily.

At times it can be overwhelming to deal with young children, but if you are patient and notice the underlying reasons for their behavior, you will be able to help them. Anxiety can be a masterful imposter. In children, it can sway away from the more typical avoidant, clingy behavior and show itself as tantrums, meltdowns and aggression. When children are under the influence of an anxious brain, their behavior has nothing to do with wanting to push against the limits. They are often great kids who don't want to do the wrong thing, but they are being driven by a brain in high alert. If we could see what was happening in their heads when anxiety takes hold like this, their behavior would make sense. We would want to scoop them up and take them away from the chaos of it all. Of course, that doesn't mean that they should be getting a free pass on their unruly behavior. Their angry behavior makes sense, and it's important to let them know this, but there will always be better choices they are capable of making.

Once kids have a more solid understanding of why they do what they do, they will be well on their way to finding a better response. Here's where the adults in their lives will make a critical difference. Parents, grandparents, teachers – anyone who is able to understand and respond to their behavior as something driven by anxiety, rather than 'naughty' behavior, will be helping them to find healthier, stronger, more effective ways to respond to the world. All kids have it in them to do this, but anxiety can have a sly way of stealing the attention from their strengths.

Anxiety happens when a part of the brain, the amygdala, senses trouble. When it senses threat, real or imagined, it surges the body with hormones (including cortisol, the stress hormone) and adrenaline to make the body strong, fast and powerful. This is the fight or flight response and it has been keeping us alive for thousands of years. It's what strong, healthy brains are meant to do. An anxious brain is a strong, healthy brain that is a little overprotective. It is more likely to sense threat and hit the panic button 'just in case'. When this happens often, it can create 'anxiety about the anxiety'. One of the awful things about anxiety is the way it launches without warning, and often without need, sending an unsuspecting body unnecessarily into fight or flight.

For kids with anxiety, any situation that is new, unfamiliar, difficult or stressful counts as a potential threat. The fight or flight response happens automatically and instantaneously, sending neurochemicals surging through their bodies, priming them for fight or flight. Every physical symptom that comes with anxiety – racy heart, sick tummy, clammy skin, vomiting, shaky arms or legs – is because of the surging of these neurochemicals. The natural end to the fight or flight response is intense physical activity. If the threat was real, they'd be fighting for their lives or running for it. When

there is no need to fight or flee, there is nothing to burn up the neurochemicals and they build up, causing the physical symptoms of anxiety. (For a detailed child-friendly explanation of what causes each of the physical symptoms of anxiety, see here.)

If anxiety is having a hand in the angry behavior, the signs of anxiety will still be there in some way. Look for any type of avoidant behavior, sick tummies, headaches, sensitivity to new or unfamiliar situations. Any of these might be a clue that anxiety is hard at work. Take note of when the meltdowns or tantrums happen. Is there a pattern? Do they seem to happen more in unfamiliar situations or situations that might overspend your child's emotional resources? Anxiety is often associated with avoidance or clinginess but it doesn't necessarily present itself in this way. The physiological driver is the same – a brain under threat – but instead of flight, it initiates fight. It doesn't matter that there's nothing at all there to worry about. When the brain thinks there's trouble, it acts as though it's true.

Think of this like a smoke alarm. A smoke alarm can't tell the difference between a real fire and burnt toast, and it doesn't care. All it wants to do is keep you safe. It does this by making enough noise to get a response. Better safe than sorry. The brain works the same way. An anxious brain is a very protective brain, and it will be quicker to hit the alarm, even when there is no need. This could happen in response to unfamiliar situations or people, playground scuffles, criticism, disappointment, threat of embarrassment or failure – anything that could potentially trigger the feeling that something bad may be about to happen.

The fight response is the brain's adaptive way of giving a young body the physical resources it needs to deal with a situation that feels potentially harmful. Remember, this reaction happens automatically and instantly. It's so quick that there's no time for any conscious consideration as to whether or not the threat is real. Anxiety is tightly linked to worry and fear that is out of the ordinary for everyday triggers. Many individuals with an anxiety disorder will often be quick to anger; however, the link between anger and anxiety is often missed or overlooked. Anxiety is often connected with overstimulation from a stressful environment or threat, combined with the perceived inability to deal with that threat. In contrast, anger is often tied to frustration. Often when anxiety is left unacknowledged and unexpressed, it can turn into frustration, which can lead to anger. When anxiety turns to anger, it is because an individual who expresses anger will have an underlying fear about something in their life. When individuals are scared or worried about something, they often choose anger, unconsciously, as a way to feel as though they are in control of their anxiety.

Excessive anxiety has negative effects in many areas of children's lives, both in the short term and long term. Anxiety disorder not only causes heightened distress to the child, parent and school staff, it may also have a significant negative impact on a child's quality of life (Ramsawh & Chavira, 2016) , worse school performance (Owens, Stevenson, Hadwin, & Norgate, 2012a) and social development and persist chronically into adulthood, especially when untreated (Chivara, Stein, Bailey, & Bailey, 2005).

Childhood anxiety disorders are associated with a variety of negative outcomes later in life (Hirshfeld-Becker, Micco, Simoes, & Henin, 2008; Costello et al., 2003). Studies highlight many important consequences of anxiety (Merikangas et al., 2009;

Lowry- Webster et al., 2001; Rapee et al., 2009; Roberts et al., 2007). They impact considerably on children's functioning in family, social, and academic domains i.e. anxious children face more difficulties in family, and social interactions and in school activities with lower academic achievement, excessive school absenteeism and impaired peer relationships (Essau, Conrandt, & Petermann, 2000; Ezpeleta, Keeler, Erkanli, Costello, & Angold, 2001; Owens, Stevenson, Hadwin, & Norgate, 2012b). Children with anxiety disorders were 2.9 times more likely than children without any disorder to fail to complete secondary school (Stoep, Weiss, McKnight, Beresford, & Cohen, 2002). They have a higher rate of loneliness and a higher risk of being bullied or rejected by their peers (Vasey & Dadds, 2001; Morris & March, 2004). They are also more prone to drug abuse problems, psychosomatic illnesses, and suicide, and are more liable to use healthcare services once they become adults (Deas-Nesmith, Brady, & Campbell, 1998; Morris & March, 2004; Bodden, Dirksen, & Bögels, 2008). In families with clinically anxious children, societal costs have been estimated to reach 20 times more than families in the general population (Morris & March, 2004; Bodden et al., 2008).

Research has demonstrated that children with an anxiety disorder were likely to fulfill the diagnostic criteria up to 8 years after the onset of the disorder (Kovacs & Devlin, 1998). Evidence suggests that childhood anxiety may play a casual role in the development of depression among young adults (Cole, Peeke, Martin, Truglio, & Seroczynski, 1998; Ezpeleta et al., 2001). Epidemiological research has shown that in 80% of the young adult cases, social phobia in adolescence preceded depression, substance misuse, or other anxiety disorders (Wittchen, Stein, & Kessler, 1999). In youth it may lead to chronic emotional problems and substance abuse (Pardee, Colder, &

Bowker, 2014), and anxious symptoms often worsen over time (Spence, Barrett, & Turner, 2003; Kendall et al., 2007). Anxiety has been shown to precede the eating disorder in most cases (Godart et al., 2000; Godart et al., 2002). Particularly social anxiety (Blanco, Nissenson, & Liebowitz, 2001) have been found to be strongly associated with eating disorders.

Children with anxiety disorder are at a significantly higher risk to continue to have an anxiety disorder as they transit from childhood to adolescence (Bittner et al., 2007) as well as increased likelihood of psychiatric disorders later in life (Copeland, Shanahan, & Costello, 2009; Bitter et al., 2007; Kovacs & Devlin, 1998). Pediatric anxiety disorders are often unrecognized and untreated (Chivara et al., 2005), and may lead to comorbid disorders later in life (Kendall & Pimentel, 2003). Poor mental health is one of the strongest predictors of unhappiness in adulthood, stronger than income, marital status, or employment status (Clark, Layard, & Senik, 2012). In the United Kingdom, mental illness in adult-hood accounts for 40% of all disability. Layard (2006) reported that the estimated cost of anxiety and depression is £12 billion a year (about $19 billion U.S.) including loss of earnings and expenditure on welfare benefits.

A mild to moderate level of anxiety is vital for learning and can support better adjustment, but excessive anxiety can be detrimental to children's physical as well as psychological health (Brown & Whiteside, 2008; Muris, Mayer, Vermeulen, & Hiemstra, 2007). If left untreated, anxiety disorders are relatively constant, specifing that they are not an experience children outgrow naturally.

Anxiety displays in a unexpected variety of ways in part because it is based on a physiological response to a threat in the environment, a response that maximizes the body's ability to either face danger or escape danger. So while some children exhibit anxiety by shrinking from situations or objects that trigger fears, some react with overwhelming need to break out of an uncomfortable situation. That behavior, which can be unmanageable, is often misread as anger or opposition.

The more commonly recognized symptoms of anxiety in a child are things like trouble sleepinf in his own room or separating from his or her own parents, avoidance of certain activities. Though anyone would recognize those symptoms but in other cases the anxiety can be hidden. When the chief complaint is temper tantrums, or disruption in school, or throwing themselves on the floor while shopping at the mall, it's hard to know what it means. But it's not uncommon, when kids like that come in to the psychologists, for the diagnosis to end up being a pretty profound anxiety.

Anger

Anger is a weakness but people think of it as a strength. In actuality, the person who does not display anger has more inner strength than the one who displays it. First, the sparks set you on fire and then you burn others. So, that fire not only hurts you, but hurts others as well.

Anger is a basic human emotion that is experienced by all people. Typically triggered by an emotional hurt, anger is usually experienced as an unpleasant feeling that occurs when we think we have been injured, mistreated, opposed in our long-held views, or when we are faced with obstacles that keep us from attaining personal goals. The

experience of anger varies widely; how often anger occurs, how intensely it is felt, and how long it lasts are different for each person. People also vary in how easily they get angry (their anger threshold), as well as how comfortable they are with feeling angry. Some people are always getting angry while others seldom feel angry. Some people are very aware of their anger, while others fail to recognize anger when it occurs. Some experts suggest that the average adult gets angry about once a day and annoyed or peeved about three times a day. Other anger management experts suggest that getting angry fifteen times a day is more likely a realistic average. Regardless of how often we actually experience anger, it is a common and unavoidable emotion.

Anger can be constructive or destructive. When well-managed, anger or annoyance has very few detrimental health or interpersonal consequences. At its roots, anger is a signal to you that something in your environment isn't right. It captures your attention and motivates you to take action to correct that wrong thing. How you end up handling the anger signal has very important consequences for your overall health and welfare, however. When you express anger, your actions trigger others to become defensive and angry too. Blood pressures raises and stress hormones flow. Violence can ensue. You may develop a reputation as a dangerous 'loose cannon' whom no one wants to be around.

Out of control anger alienates friends, co-workers and family members. It also has a clear relationship with health problems and early mortality. Hostile, aggressive anger not only increases your risk for an early death, but also your risk for social isolation, which itself is a major risk factor for serious illness and death. These are but two of many reasons why learning to properly manage anger is a good idea.

As long as there is a cause, there will be an effect. Anger is an intense emotion you feel when something has gone wrong or someone has wronged you. It is typically characterized by feelings of stress, frustration, and irritation. Everyone feels anger from time to time. It's a perfectly normal response to frustrating or difficult situations.

Anger only becomes a problem when it's excessively displayed and begins to affect your daily functioning and the way you relate with people. Anger can range in intensity, from a slight annoyance to rage. It can sometimes be excessive or irrational. In these cases, it can be hard to keep the emotion in check and could cause you to behave in ways you wouldn't otherwise behave.

Anger is triggered when a person believes she or he has been doing wrong by someone, that something unfair or unjust has happened, or that their wellbeing and social status are either not being respected or are under threat. No person can make us angry, rather anger is influenced by people's thoughts, their interpretations of events and their coping skills and available supports. Although anger is often seen as a harmful emotion, it can be a healthy emotional response when expressed assertively and respectfully. Sometimes anger can be helpful; it can motivate a person to take positive action to change a situation for the better or to achieve his or her goals. Frequent experiences of anger should not be ignored. Angry outbursts can cause fear, regret and/or work, relationship, and health problems for both oneself and others. When anger prompts someone to use violence, physical injury and even loss of life can occur. Angry people often report regretting their outbursts and wishing they could have expressed themselves in another way.

Anger is a universal emotion—everyone feels it at different times and to varying degrees. Anger arises in many contexts and the experience ranges from mild irritation (often referred to as "frustration" by women since culture doesn't like angry women) to all-consuming rage. Even boredom is a mild form of anger which represents dissatisfaction with whatever is currently happening. Feeling anger is a natural part of life, but is not necessarily an emotion we are comfortable with or have been taught to manage skillfully. While anger is often seen as "bad" or "un-Christian," it is as important to our health as a fever is. A fever is essential because it tells us that something is wrong and is also the body's way of beginning to deal with the infection creating problems. Anger is the body's way of signaling something is wrong and creating energy to help begin addressing the problem. However, too many of us simply act upon our anger rather than seeing it as a symptom signaling a problem. Doing this is similar to taking an aspirin to deal with a fever while never looking for the underlying infection. When the aspirin wears off, the fever is back and often worse than it was at first because the infection has spread unaddressed. The same is true with anger. When anger is avoided or simply acted upon, the underlying issue goes unaddressed, and the anger often reoccurs at inopportune times with increased intensity. Typically, we experience a primary emotion like fear, loss, or sadness first. Because these emotions create feelings of vulnerability and loss of control, they make us uncomfortable. One way of attempting to deal with these feelings is by subconsciously shifting into anger.

Unlike fear and sadness, anger provides a surge of energy and makes us feel powerful and in charge rather than vulnerable and helpless. We have all seen this happen. Think about a hungry infant. The infant's first cry is a cry of distress because the child

legitimately needs to eat and has no capacity to fulfill this need unless someone helps. If this need is not addressed, the infant's cry switches from a cry of distress to an angry cry. When the feeling of hunger, vulnerability, and powerlessness becomes too distressing, the child becomes angry to distance from these feelings and to signal there is a problem. Until the underlying issues of both hunger and vulnerability are attended to, the anger will remain. It is easy to identify the function of anger when it plays out with infants, but we often struggle to identify its function in our own lives. When I begin to feel anger toward my spouse, it is much easier to go with my anger and say things like, "You always sit there watching TV and avoid doing any of the housework," than to figure out what is under the anger and address the underlying issue. It's also easier for parents to yell about how irresponsible their teenage son is when he arrives home after curfew than to own how scared their son's lateness made them.

Anger is a completely normal and typically healthy emotion. However, it can be detrimental to both your emotional and physical health when you lose control of it. When you are angry your body goes through some physiological and biological changes. Your heart rate quickens and your blood pressure spikes. Your body also releases hormones like adrenaline and noradrenaline. Putting your body through these changes often, by repeatedly getting angry, can lead to medical conditions and complications. Anger doesn't look the same in everyone as we all express it differently. For some people, screaming might be an outlet for their anger while others might express it by physically hitting an object or even another person. Anger is a normal human emotion, but it's important to find healthy ways to express it so as not to alienate people around us. Expressing anger healthily is also important for your mental health.

Anger is an intense emotional state that is induced from strong displeasure and rage. Anger involves with a strong uncomfortable feelings and hostile responses toward other. Anger is an emotion characterized. Anger is an emotion characterized by hostility toward someone or something. Sometimes anger can be a positive that bring desirable thing. Anger gives us a way to express negative feeling and emotions. That is healthy but when this is excessive then this can be harmful for anybody. It just blocks the natural diverse way of human thinking. In angry moment we can't take right decision most of the time. It directly harm physical and mental health of human being. Anger make it difficult to think in a positive or a straight way. Contemporary psychologists sight anger as a mature, natural and normal emotion. Uncontrolled anger affects negatively our personal and social wellbeing that creates negative impact on our social surroundings. Physical effects are such as increased heart rate, blood pressure and increased level of adrenaline. It increases anxiety, stress, depression, insomnia and skin problem and it may cause the heart attack also (Alia-Klein et al 2020).

Typically anger arises when someone feels disturbed, threatened by a person or surroundings that spoil someone's internal peaceful emotional state. Other emotions can stay with anger such as jealousy, sadness, unhappiness and hopelessness. Anger is not always negative in sense. Sometimes it motivate person to achieve desirable things, it also work as an inspiration to take step to overcome obstruction. If anger is ongoing on long periods then it can damaged personal and social relationship and it makes life hale. That's why managing anger is so important to maintain healthy life. For the sake of personal well-being this is necessary to deal anger effectively.

Anger is a complex emotion that can happen from different circumstances. Same individuals react differently from same situation at different times. It depends on listener experience and how they perceived the situation. There are three types of expressional way of anger that is passive, aggressive and assertive. In passive anger, person avoid to dealing the situation directly and they try to keep their feeling inside instead of express directly. But anger is still expressed by non-judgmental attitude, expression and comments. In passive way anger is expressed by person.in aggressive anger, expression of anger express in outburst way and directly. Physical violence and physical damage is most common scenario in aggressive anger. Angry person destroy property and hurt persons. In assertive anger, communication is respectful to each other. Here person allow herself to angry but assertively express his need and aware other person feeling also. They resolve the issue in calm way. Person doesn't show their power rather they control their emotion for better communication. Being assertive is not easy, patience and practice is necessary to being assertive. Here persons response in a mature way, respect their relationship and themselves also (Kassinove, Howard 2013).

In case of children and adolescence, they frequently angry and express their anger by physical aggression or shouting or throw the object hardly. They are become impulsive and easily lose their self- control. They have difficulty in express their feelings and need, they can't control their anger. Frustration, fear, depression or anxiety exists behind anger. Angry behavior in children and adolescents can include a wide range of behaviors such as physical aggression, temper tantrum, fighting, pushing, and kicking, cruelty towards animals, and destruction of property. Uncontrolled anger negatively

affects peer relationship. Caregivers need to listen and observe their child so that child and teens can easily express their emotion and help them to resolve their anger issues.

Unprocessed Anger

Anxiety not only presents as a pounding heart, shortness of breath, clammy skin, and racing thoughts, but anxiety can also present in more subtle ways such as anger or frustration. Individuals with undiagnosed anxiety may find themselves lashing out and becoming frustrated over everyday occurrences that usually do not warrant an emotional reaction. Road rage is a perfect example of this. Traffic and crowds are often triggers of anxiety, which can result in becoming angry with people on the road. Maybe they are going to be late for work, are in a bad mood, or have a stressful deadline looming ahead. Sitting in traffic is only adding fuel to their fire. As a result, these people lash out at other cars when, in reality, they are anxious about the stressful environment and personal issues they have going on in their life. Giving in to anger can ruin relationships and have adverse effects on every aspect of an individual's life. It can lead to lashing out, making rash decisions, and engaging in risky behaviors. When individuals feel threatened, their fight or flight response kicks in, and individuals go into defense mode, which sometimes means fighting.

Not all anger is linked to anxiety, but often if individuals take a step back and uncover what is triggering their anger, they may discover that they are showing signs of fear and panic, which may be the root of an anxiety disorder.

Symptoms of Anxiety can Trigger Anger

Individuals with anxiety usually have difficulty falling asleep or staying asleep and, as a result, may be sleep deprived. Over time, lack of sleep can trigger individuals to become more sensitive to small problems and, as a result, are quick to anger. Yelling at the dog for barking, becoming angry in traffic, getting upset because of a long line at the grocery store, or lashing out over an honest mistake are all small triggers that turn into monumental challenges for an individual who is struggling with anxiety and is sleep-deprived. Anger does not have to be intentional, and with individuals who have an anxiety disorder, this anger is often an automatic reaction to an anxious trigger or the effects of long-standing anxiety. Individuals who have an anxiety disorder are often rigid in their daily routines since the fear of the unknown is often a trigger for their anxiety. When something disrupts their daily routine, it is not uncommon for the individual to not know how to cope with the change and, as a result, lash out in anger.

Anger and Anxiety

Anxiety and anger can be a toxic combination. Seeking treatment for the anxiety disorder can help an individual uncover the reasons for their anger. Being mindful about anger outbursts by keeping a journal and taking time to reflect on why this anger occurred can often help individuals realize their anxiety triggers, and then seek therapy to find healthy ways to cope with them. If you or a loved one is in search of treatment for anxiety, please contact Discovery Mood & Anxiety Programs or fill out our mental health evaluation.

Rationale of the study

According to the report of United Nation Population Fund (2014) Bangladesh has an adolescent and youth population of approximately 52 million that is amounting to 1/3rd of the whole country population. This is a significant figure which was assumed that will remain unchanged for very long and this figure will be increasing day by day.

According to the studies on mental health in Bangladesh and study by ICDDRB with the National Institutes of Mental Health, Bangladesh, Liverpool School of Tropical Medicine, UK, and Johns Hopkins Bloomberg School of Public Health, Baltimore, USA (2015), mental health disorders – such as depression, anxiety, addiction, schizophrenia and neurosis have a serious impact on health: they contribute up to 13% to the global burden of disease. In Bangladesh, the review found that the overall prevalence of mental disorders is between 6.5 to 31% among adults, with psychiatric and psychogenic disorders such as depression, anxiety and neurosis most commonly reported. The authors of the study found that data on mental disorders among children are scarce but prevalence is estimated to be between 13.4 to 22.9%. Research reported that prevalence of mental disorders varied from 6.5 to 31.0% among adults and from 13.4 to 22.9% among children. There are 50 outpatient mental health facilities available in the country, of which 4% are for children and adolescents only. Because of this, even with good intention to serve the children with behavioral and emotional problem, we are not being able to serve these children who need special care.

The numbers of mental health professionals are not adequate in the cities let alone in the remote areas. We know that a person is the most vulnerable to his or her surroundings in this time period of his or her life. So, special care is needed for the age

group of 2 to 18 years. In this age level children are not able to take decision considering all aspect also they are reluctant to agree with parent's decision wholeheartedly. They are facing lots of problem for gender, social, political and educational context. Every year, we see that after declaring result of board exam few students commit suicide for not getting the expected result and they feel anxious about their parent's reactions and thus eventually they fall in depression.

In Bangladesh, there is a scarcity of organized and systematic intervention programs in Bangla. In that case, applying and developing interventions for Bangladeshi culture to serve the affected children is of vital importance. We have a small number of adapted scales in Bangla for assessment but it is just the starting point for treatment. For treatment purpose, as an educational psychologist or counselor, we need to have evidence-based intervention program to address issues like how to regain own self-confidence and how to manage anxiety, depression, aggressiveness, anger and trauma etc.

Cognitive behavior therapy (CBT) is a popular form of psychotherapy that is now widely used with a range of mental health problems. CBT is one of the widely used therapies for children but we have to be more careful to apply the therapy on them. Child focused CBT are now one of the effective and highlighted intervention methods for child treatment for anxiety, depression, PTSD, anger and disruptive behavior. Also there are limitations of resources and tools across various locality too. For example, a tool for a certain urban child may not have same effectiveness and impact as it would have on a rural child and vice-versa. Moreover, mental health professionals who work outside the cities and are placed in remote rural places cannot avail training and supervision as required. A structured Bangla version of child focused CBT activities for intervention is

the highest priority for professional development. It would help the professional to serve their young clients (children). It would also increase their skills for dealing the children with anxiety and anger.

Objectives

General Objectives:

The primary objectives of the present study were to -

1) Adapt the Child Focused Cognitive Behavior Therapy as an intervention for children;
2) Assess the effectiveness of adapted Child Focused Cognitive Behavior Therapy as an intervention;

Specific Objectives

Therefore, to endorse the 1st general objective, diverse specific objectives were selected. These were to:

i. Select the child focused cognitive behavior therapy activities for intervention;
ii. Translate the selected activities into Bangla;
iii. Review the language by children and psychologists;
iv. Organize the activities in different sessions;
v. Conduct first trial on children;

For the 2nd general objective, the specific objective was to assess the effectiveness of the adapted child focused CBT activities for intervention by

a) Anxiety and Anger subscales of Bangla adapted Beck Youth Inventory
b) Treatment credibility questionnaires
c) Comparison of case group with 3 control groups

Thesis structure

Chapter wise pragmatically and sequentially total study is presented. The 1st chapter is the general introduction. In this chapter definition of cognition, behavior, intervention and cognitive behavior therapy were operationally defined. The adaptation process and cognitive behavior therapy process have been elaborately discussed and also effectiveness of child focused CBT has been focused. At the end of the chapter, rationale and objectives of the study have been presented.

In chapter 2, literature review and historical background are discussed with emphasis on the present scenario of child focused CBT in national and international level.

Chapter 3 represents the method of the research. Research method is divided into two sections to address the two general objectives. The 1st general objective – adaptation, was discussed and presented in the First Section. This section has two phases. In the 1st phase, the researcher selected, translated and reviewed the language of the activities for intervention. In the 2nd phases, the researcher organized the activities in different sessions and conducted a first trial on children. The Second section addresses the 2nd general objective. To execute the 2nd general objective, the researcher conducted sessions and collected data. The statistical analysis has been conducted both in groups and individually. The researcher also compared the data in different time period like pre and post-test period (with-in group). Also, comparisons were made in case and control groups (Between group).

Chapter 4 portrayed the results of the study. This chapter is divided in two sections to present the findings regarding two general objectives. This chapter incorporates all the results at a glance and imprinted statistically.

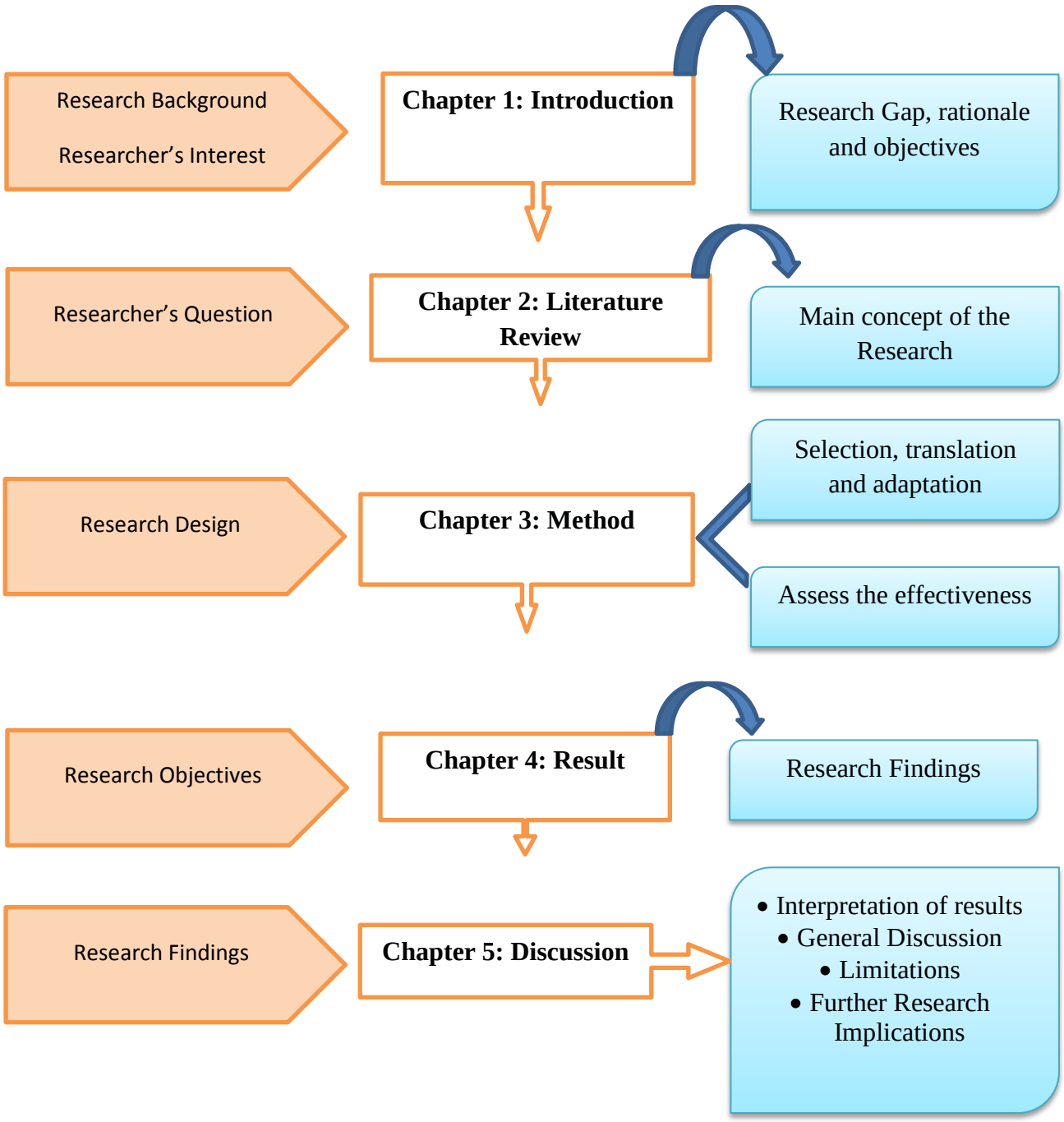
Chapter 5 is dedicated to the general discussion of the study and logically describes the objectives with the findings of credibility test, feedback, verbatim and one case study based on the adapted activities for intervention. Furthermore, distinctiveness of the study, applicability, limitations and further implication has been discussed.

Chapter 6 is concerned with the references. References have been written by following the APA style.

Appendix has been given at the end of the thesis. Bangla adapted activities, data sheet, assent form have been included in appendix.

Figure 1

Flow chart of the thesis structure



Literature Review

The core foundation of CBT treatment approach was pioneered by Albert Ellis who in 1957 make known to the term "rational emotive therapy" (RET) to highlight its attention on emotional consequences. Consecutively, Aaron Beck in 1976 formed "cognitive therapy" (CT), which functioned as the foundations for the advancement of CBT. According to Beck's construction, maladaptive cognitions, which comprise in general beliefs or schemas about the self, the world and the future, contribute to the maintenance of emotional distress and behavioral difficulties. According to this model, specific therapeutic strategies that change maladaptive cognitions lead to change emotional distress and problematic behaviors (Scheeringa et al. 2007).

Meanwhile these initial representations, CBT have established appropriate etiquettes to treat individuals of more or less every single age such as children, adolescent, adults or elderly and for individual, families and couples. The implementation of cognitive-behavioral therapy proceeded gradually over time and was measured contentious throughout its expansion. Dr. Albert Ellis established behavior therapy in the 1950s with his effort on serving patients to detect and encounter illogical beliefs.

Beck's Cognitive Therapy is the furthermost evidence-based, significant and broadly applied cognitive method and greatly organized well planned than any other therapeutic approach (Hankin, Abramson, Miller, & Haeffel, 2004). In the 1960s Dr. Aaron T. Beck developed the exercise for cognitive behavioral therapy. His theories on cognitive distortions facilitated to develop CBT to what we discern currently.

Aaron Beck's approach to psychotherapy was revolutionary and the systematic confirmation nowadays has established the effectiveness of his theories. Dr. Judith S. Beck trailed her father's paths and conducted a noteworthy influence on CBT as well. Beck's cognitive theory consists of four different cognitive constructs: schemata, cognitive errors, cognitive triad, and automatic thoughts (Beck, 1979 ; Clark, Beck, & Alford, 1999; Beck & Dozois, 2011). A schema is a theoretical cognitive structure which performances as a filter on received facts. Schemata are comparatively stable, establishing configurations that direct situational data processing.

Cognitive behavioral therapy (CBT) programs are measured as the furthermost published and available evidenced-based treatment programs for children with anxiety, depression, anger issues (James, James, Chowdrey, Soler, & Choke, 2015). Four explicit cognitive and behavioral features are appeared to be common to all anxiety disorders (Chorpita & Barlow, 1998; Morris & March, 2004; Pilecki & McKay, 2011; Vasey & Dadds, 2001) (a) the belief that uncontrollable conditions are frightening, (b) the belief that the unfamiliar is threatening, (c) apparent self- efficiency to manage with and explain personal problems, and (d) escaping of be frightened circumstances (Vreeke, Muris, Mayer, & Rapee, 2013).

In order to assess the efficiency of a Dutch version of proved based CBT program Coping Cat as an symbolic group-based program, a Randomized Controlled Trial (RCT) was accompanied with primary school children with elevated levels of anxiety. The RCT had two settings: one was Experimental (Coping Cat) and another was control (no program) group. Pre and post tests were ran to test the effectiveness of the program. Results indicate that children in experimental group had reduced level of

anxiety in posttest compared to control group (van Starrenburg, Kuijpers, Hutschemaekers, & Engels, 2013).

A current randomized wait-list (WL) controlled trial was accompanied on Danish children and adolescents (age 7 - 16) with a primary anxiety disorder diagnosis to assess the effectiveness of a Danish form of the Cool Kids program, a regular group CBT program. Outcomes confirmed that the Danish version of the Cool Kids program was operative and effective children. Result showed that 48.2% children were free of all anxiety diagnoses at post-intervention sessiont, compared with 5.7% in the WL condition. Children with a initial diagnosis of social phobia exhibited a smaller amount of enhancement compared with additional anxiety assessment (Arendt, Thastum, & Hougaard, 2016).

In 2019, a study conducted in the Kingdom of Saudi Arabia and Bahrain, researcher applied the same methodology for native clients suffering from depression and anxiety. The objective of the study was to comprehend the opinions of patients with depression and anxiety, caregivers and mental health professionals about CBT to develop guidelines for culturally adapting CBT for depression and anxiety. A semi-structured interview was demonstrated with the patients (n = 42), caregivers (n = 11), and psychiatrists and psychologists (n = 16). The acquired data were analyzed using a thematic framework analysis by categorizing emergent themes and classifications. The themes developing from the studies of discussions by each interviewer were equated and compared with other interviewers. The results emphasized blockades of entrance to and strong point of CBT. Therapists accentuated the necessity for spending native idioms, ethnically suitable paraphrase and slight modifications in therapy. There were not at all

thematic variances between the two approaches. These conclusions will be helpful to adapt CBT manual culturally, which will be verified in a randomized controlled trial (Algahtani, H., Almulhim, A., AlNajjar, F., Ali, M., Irfan, M., Ayub, M., & Naeem, F. 2019).

Canadians of South Asian (SA) source encompass the major racial group in Canada, on behalf of 25.6% of Canada terms "visible minority populations". South Asian Canadians are strangely obstructed by the community elements of health, and the consequence is great degrees of mood and anxiety disorders. Culturally adapted Cognitive Behavior Therapy (CaCBT) is an evidence-based therapy practice. CaCBT is more operative than customary regular CBT. The principal goal of the research is to develop and assess CaCBT for Canadian South Asian persons with depression and anxiety. This varied approaches research used three stages: (1) cultural adaptation of CBT, (2) pilot test for feasibility of CaCBT and (3) application and estimation of CaCBT. Phase 1 used purposive sampling to recruit individuals, Phase 2 conducted the pilot test on the recently developed CaCBT for feasibility, acceptability and effectiveness via quantitative methodology and a randomized controlled trial. Phase 3 recruited therapists to train and assess them in the new CaCBT. Result shows that CaCBT is very effective for the SA population in Canada (Naeem. F., Tuck. A.).

The effectiveness of CBT in children and adolescents with anxiety disorders has been well-known in frequent confirmation grounded research and are considered as the primary intervention option for anxiety disorders (Silverman, Pina, & Viswesvaran, 2008; Walkup, Albano, Piacentini, & Et al., 2008; see meta-analysis Ishikawa, Okajima, Matsuoka, & Sakano, 2007; Ollendick & King, 2004). Randomized controlled trials have

reliably revealed that CBT programs are operative and effective for anxiety disorders of children, with 55% to 60% of children had no longer conditions for an anxiety disorder by following intervention (Cartwright-Hatton et al., 2006; Cartwright-Hatton, Roberts, & Chitsabesan, 2004; James, Soler, & Weatherall, 2008). Schneider et al. (2006) identified 24 randomized clinical trials (RCTs) exploring the treatment of anxious children. These trials examined the effects of CBT delivered individually to children between 7 and 14 years old of age. The children were suffering from various anxiety disorders (e.g. social anxiety disorder, generalized anxiety disorder, social phobia etc.). About 67% of the treated children were diagnosis free at post- intervention, compared with fewer than 10% of those in wait-list control conditions.

Another study investigated a cognitive-behavioral model of anxiety disorders in Japanese children and adolescents. Results illustrated that the clinical group showed more anxiety symptoms, negative self-statements, and cognitive errors than the community group, but no significant difference in positive self-statements. Multi-group structural equation modeling found that cognitive errors generated negative self-statements, aggravating a higher-order factor (childhood anxiety) affecting six anxiety symptoms corresponding to the diagnostic criteria of psychological disorders (Ishikawa, 2015).

An interesting study was carried out on the feasibility and outcome of clinic plus internet delivery of CBT for childhood anxiety. Children aged 7 to 14 years were randomly assigned to different conditions- clinic, clinic plus internet, or wait list control (WL). Children in the clinic and clinic-plus-Internet conditions showed significantly greater reductions in anxiety from pre- to post treatment, compared with the WL group. Reductions were maintained at 12-month follow-up for both therapy conditions (Spence,

Holmes, March, & Lipp, 2006). Internet delivery of CBT for child anxiety offers promise as a way of increasing access to treatment for this population. A very recent study incorporated art therapy and cognitive-behavioral therapy into a treatment, designed for children suffering from high level of anxiety. The effectiveness of this intervention was examined and the findings shows teacher ratings of children's mental health difficulties and self-report ratings of anxiety disorders pointed to a significant disparity from pretest to posttest. Results provide evidence for the effectiveness of eclectic art and CBT to improve children's mental health and reduce anxiety through changing thoughts, beliefs, emotions, and behaviors that may cause fear and anxiety (Ahmadi et al., 2017).

In another major RCT, children aged 8- to 12-years with social phobia were treated in a CBT based intervention. As there are evidence that children with social phobia tend to have few friends, have limited involvement in outside activities, and lack important interpersonal and social skills (Beidal, Turner, & Morris, 1999; Ollendick & Hirshfeld- Becker, 2002) the intervention aimed to rectify these. It was found at post treatment, children demonstrated enhanced social skills, reduced social anxiety, and increased overall social functioning; moreover, 67% no longer met diagnostic criteria for social phobia compared with 5% of children in the control condition (Beidal et al., 1999). At 3-year follow-up, 72% continued to be free of social phobia diagnosis (Beidel, Turner, Young, & Paulson, 2005), and at a 5-year follow-up, 81% were diagnosis free (Beidel, Turner, & Young, 2006). A study conducted to examine the efficacy of a developmentally appropriate parent– child CBT protocol for anxiety disorders in children ages 4 –7 years found that treated children showed a significantly greater decrease in anxiety disorders and increase in parent-rated coping than controls, as well as

significantly better improvement on social phobia, separation anxiety disorder and specific phobia but not on generalized anxiety disorder (Hirshfeld-Becker et al., 2010). Nonetheless, a recent meta-analysis has indicated that general format of CBT may be less effective for youths with primary social phobia, obsessive–compulsive disorder and post-traumatic stress disorder compared with disorder-specific CBT protocols for these disorders (Reynolds et al., 2012).

However, not very studies are conducted with very young children suffering from anxiety disorders. The CBT based protocols addressing childhood anxiety disorders have been evaluated mainly among school-age children and adolescents. Although some studies extended their inclusion age downward to age 5 or 6½ (King, Muris, & Ollendick, 1998; Shortt et al., 2001), yet the under representation of younger children in studies of CBT protocols for major childhood anxiety disorders is evident. They usually included relatively small numbers of the youngest children and did not examine results separately for the youngest age group (see Hirshfeld-Becker et al., 2010). Studies have exhibited that the rate of preschoolers with persistent anxiety disorders was almost as high as older children (Eggar & Angold, 2006; Lavigne et al., 1998), and factor-analytic studies also have shown that the symptom presentations in preschoolers are closely parallel to those found in older children (Eley et al., 2003; Spence et al., 2001). Freeman et al. (2008) examined a family-based CBT protocol for 5- to 8-year-old children with obsessive- compulsive disorder with promising results, advocating that young children can benefit from CBT tailored to their developmental needs. Scheeringa et al. (2007) piloted a CBT protocol for posttraumatic stress disorder in preschoolers and its effectiveness was validated. They found young children can cooperate meaningfully in

structured, trauma- related exposure exercises and they can utilize relaxation techniques successfully. These findings were supported in another study (Salloum et al., 2014).

Two research groups have employed CBT directly with young children with mixed anxiety disorders. First, in an open trial with nine children, a study piloted a CBT intervention meant for 4 to 7 year olds. The treatment was offered to individual families focusing on coping skills training and graduated exposure. It integrated puppet play, games, and specific anxiety management strategies that were found efficacious in treating fears and phobias in preschool-age children (Hirshfeld-Becker & Beiderman, 2002).

Assessments have shown eight of the nine children (89%) to be much or very much improved at post intervention, and six (67%) were free from anxiety disorders at follow-up (Hirshfeld-Becker et al., 2008). Similarly, another openly piloted CBT group treatment geared toward 5 to 7 year olds, offered parallel child and parent groups. Findings revealed 48% of children no longer met criteria for any anxiety disorders at post treatment, and 72% had at least one anxiety disorder remit (Monga, Young, & Owens, 2009).

Commencing intervention earlier provides the opportunity to teach children and parents the skills for managing anxiety before symptoms begin to hamper the child's self-concept, socialization, and learning (Hirshfeld-Becker & Biederman, 2002). Earlier intervention might also be able to help amend some of the factors theorized to maintain anxiety, including parenting factors (Rapee et al., 2009; Hudson, Comer, & Kendall, 2008; Hudson et al., 2013).

Recently two meta-analyses studies analyzed that 48 (Reynolds, Wilson, Austin, & Hooper, 2012) and 41 (James, James, Cowdrey, Soler, & Choke, 2013) randomized controlled trials studies on effectiveness of CBT for youth anxiety. These meta-analysis established that CBT is an operative and effective treatment for minority anxiety disorders.

Individual or group cognitive therapy aims to help clients to challenge their assumptions about the dangerousness of the situations in which they feel anxiety. This involves them learning how to monitor their cognitions and anxiety levels and to test-out their cognitions by collecting information and engaging in experiences that allow the validity of their assumptions to be checked. Beck's theory is supported by evidence which shows that anxiety is associated with a threat-sensitive cognitive style and also by the results of treatment outcome studies with adults and children which support the efficacy of cognitive-behavioral approaches to treatment (Stallard, 2014; Friedberg, McClure, & Garcia, 2014).

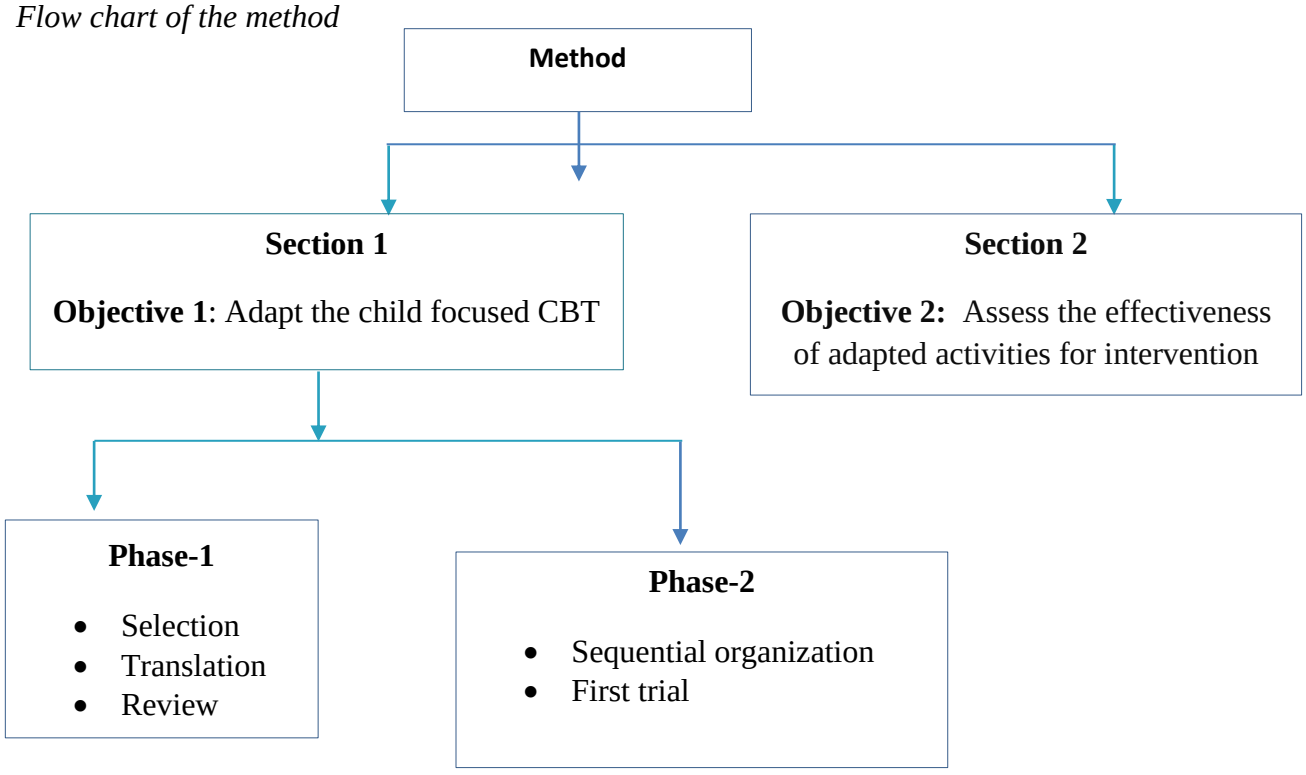
Method

To attain the two general objectives, method has been divided into two sections. In the first section, the methodology of the 1st general objective has been discussed. This section was carried out in the following two phases, in the 1st phase, researcher focused on the selection, translation, review of the language and in the 2nd phase, the activities were organized in different sessions and first trial was conducted. In the second section, methodology for the second general objective has been presented and discussed.

The figure 2 represents the blue print of the method.

Figure 2

Flow chart of the method



Adapt the Child Focused Cognitive Behavior Therapy as an Intervention Program

Section 1 (Phase-1)

For better comprehension, the first objective with its three specific objectives out of five specific objectives is presented below before discussing the methodology for phase 1:

Objective

The 1st general objective of the present study was to adapt the Child Focused Cognitive Behavior Therapy as an intervention for children

In the 1st phase, the researcher conducted the steps to establish the three specific objectives.

These were:

a) Select the child focused cognitive behavior therapy activities for intervention
b) Translate the selected activities into Bangla
c) Review of language by children and psychologists

Methodology

The entire methodology of the 1st phase had been explained here in details:

Study Population

i. Children from 6 to 15 years olds of either sex, does not have behavioral and emotional issues.
ii. Psychologists working with children only.

Study Period for Phase 1

June 2018 to March 2019

Sampling Procedure

Convenient sampling method was used for the 1st phase. These children were not referred. Each child came in contact with the researcher through their parents. Some of them came for their siblings' with NDD, treatment purpose and some of them were researcher's colleagues' children. There was diversity among the samples. Some of them were from urban and some from rural areas.

Study Sample

Children

In phase 1, the current study included a total of 20 children (boys 13 and girls 7) who do not have behavioral or emotional deregulation. They were researcher's colleague's child, and some of them came to the researcher for their sibling's treatment purpose in a tertiary level hospital.

Their age range was from 6 to 15 years and all were schools going children. They were from rural and urban areas and belong to the middle Socio Economic Status (SES).

Figure 3

Frequency distribution of the sample in Phase-1, (N=20)

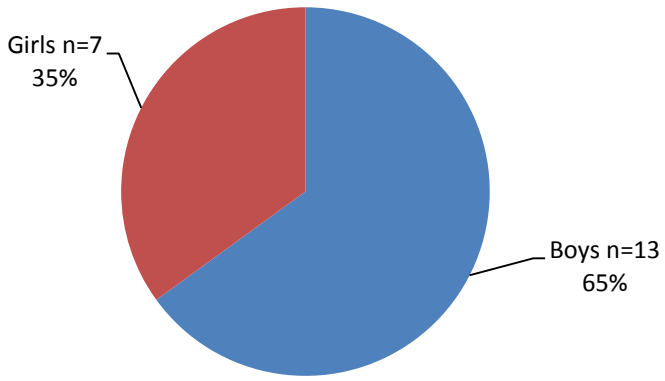


Table1

Frequency distribution of sample according to age, N=20

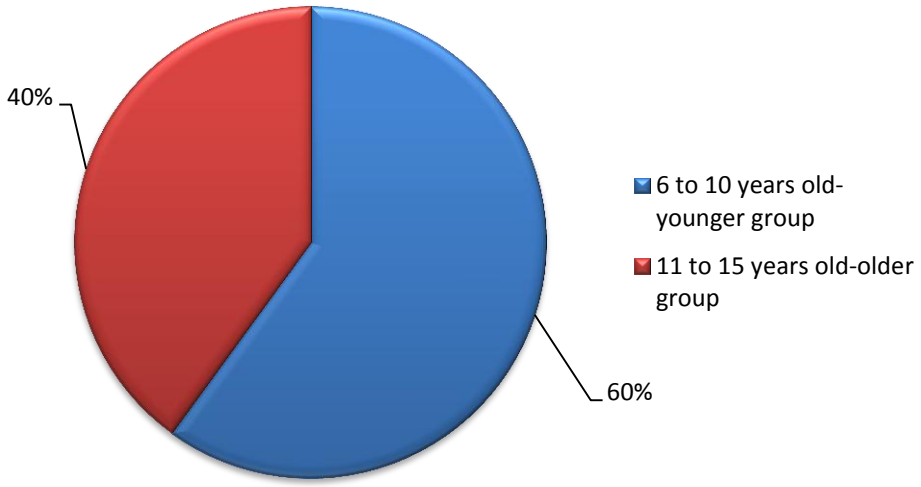
Age	Frequency	Percent (%)
6	3	15
7	3	15
8	2	10
9	2	10
10	2	10
11	1	5
12	2	10
13	2	10
14	2	10
15	1	5
Total	20	

As shown in table 1, the age distribution of 20 random regular children. The age range was from 6 to 15 years old.

As displayed in the pie chart figure 4, there were two groups. One group consisted of 12 children who was defined as younger group and another group which consisted of 8 children that was the older group. The age range was from 6 to 10 years for younger group and for older group from 11 to 15 years.

Figure 4

Frequency distribution in younger and older group, N=20 (phase 1)



Psychologists

Five psychologists who were working with children to treat their emotional and behavioral issues in a tertiary level hospital.

Sample Inclusion Criteria

For Children

- Average IQ level – according to their school performance and parents' report
- Living with parents
- Age range from 6 to 15 years old

For Psychologists

- Psychologists working with children only
- Work experience more than 3 years

Sample Exclusion Criteria

For Children

- Children with Neurodevelopmental disorders (ASD, ADHD, CP, Downs syndrome, epilepsy etc.) and psychotic disorders (PTSD, Mood disorder, Bipolar disorder, Obsessive compulsive disorder)
- Children NOT living with parents
- Taking counseling or psychotherapy session
- Taking medication for emotional and behavioral issues

For Psychologists

- Psychologists working with adult clients only
- Work experience less than 3 years

Study Design

Cross-sectional research design has been applied to conduct phase-1.

Study Instruments

1. **Demographic and personal information questionnaire**

   By this questionnaire, the data on age (children), sex, socio economic status, residential area were collected.

2. **Bangla adapted child focused cognitive behavior activities**

Child Focused CBT activities for Intervention

To accomplish the session, selected child-focused CBT activities had been briefly discussed. The researcher and psychologists explained the activities to the children. Every child did not listen all the activities. Some of the activities were explained to one child and some were listened by others but it was make sure every task was explained to at least 2 children and they practiced the task as much as they could do.

Greeting/orientation Times

At first, both the psychologists/therapists and the children needed to be introduced to each other. Greetings time was allocated for this purpose. During this allotted period, psychologists/therapists explained themselves to the children and the basic information about the session process was shared with them. The child introduced himself or herself as he or she wanted.

Hello times

From sessions 2 to 14, greetings time was not needed but at the starting time of the session, the psychologist/therapist started the session by saying hello, good-morning, assalumualaikum, welcome, etc. They did say these through some activities like playing a different handshake, high five/ten, reciting some rhymes with little bit body dancing, etc.

Setting a goal

Intervention is a mutual work, where therapist, children and family played their own role to achieve a goal. At the beginning of the session, after the assessment, therapists and children set up a goal regarding parents' information. It must be remembered that, goal would be specific, manageable, achievable, reachable and within time period. This goal was set up by the children with the help of parents and therapists/psychologists.

Work Together

To build up a rapport, the psychologist/therapist thought of some ideas, tasks and games which could be done in every session. These tasks made the children think that psychologists/therapists were grounded with him or her and they were working as a team too.

Draw Myself

Children and also therapist drew their picture as they looked at own self. This task made the children think that they had some differences from the therapist.

My World

Through this task, the child drew picture of their own world. Through this picture, they shared their choices and preferences. This world was the children's' imaginations of their mind.

Psychoeducation

Psychoeducation can be well-defined as general, systemic, formatted, informative facts on a specific disorder and also its treatment procedure. It comprises all the aspects which are related to the disorder such as emotional, social, economic, and motivational as much as possible. It helps to enable the young clients as well as family members, and parents to cope with the disorder. Good psychoeducation consists of authenticity, simplicity, objectivity, and optimism with realistic data. In this intervention program, psychologists/therapists discussed psychoeducation on severe anxiety, anger, and behavioral issues with the children and their parents.

My family

To obtain information about the family on the children's thought process, "draw my family" was a very effective task. Through a picture, the children could share their perspectives about their family. It also helped the professionals to find out the relationship structure of the family from the children's point of view.

Heartstrings

To explore the perception of the children about how they interpret others in their lives, the children drew a picture of a heart and placed their family members' and friends'

pictures/names around that heart. The closer a child placed someone to the heart, the more intimate the child perceived that person to his or her life.

Happy, sad, angry

Through these activities, the child could find out the facial expression on the face. She or he also recognized others' feelings and changes on the face.

Mood-o-meter

In this activity, the child could explore his or her emotion at different times in the day by using a handmade clock with emojis, or by using a scale with facial expressions. When a child used it repeatedly, he or she became aware of time and also his/her own emotion.

To explore the body

Children could discover that our body parts have a different feeling at a time for a situation or event. In this activity, the client had to find out the emotion in their own body and put a color for the emotion in the body parts.

Feelings on our face

Our face expresses our emotions. When a child can easily recognize others' emotion by facial expression, the child can easily react with them. A task was conducted for that and it also helped the children to show their own expressions and the emotions accurately.

Unpleasant events

This activity helps the psychologist/therapist to find out child's unpleasant event. Unpleasant events are defined as any situation which makes the child uncomfortable, disturbed mentally, worried, anxious, feared, and aggressive. This is completely child's perspective to realize the event. A task was conducted for that.

Relaxation exercise (drawing own picture, floppy doll, Deep breathing with balloons, through the rain forest, Safe place, let's feel in cloud, Practice mindfulness)

Relaxation remunerates major group of people (adults) as well as minor groups (children). In the CBT program, to make the child calm and stable, different types of relaxation were practiced. Among them, for this intervention program, six techniques have been selected which made the children relaxed and stable in anxious or aggressive moment.

Drawing is one of the best methods to explore the child and to teach an activity to the child. When children draw pictures of a body in relaxed mood and stiff mood, they can see the changes in their body gesture and posture. It also makes them happy to feel like a robot and floppy doll. Breathing with balloons is an activity which makes them laugh and they get a lot of fun doing that. Imaginary relaxations are very effective activities for intervention with children. They can imagine their own worlds as they want. There are no limitations; they can make the image with all their creative ideas which make them comfortable and release their aggressiveness resulting from any deprivations.

Happy elements

During our unpleasant moment, we cannot find out the elements which make us happy. This activity helped children to make a box or bag which carry their pleasurable elements so that they could use them immediately in an anxious or angry moment.

Worry Box

This task is similar to container exercise for adults. This box is used to manage children's severe emotions and prevent them to inundate with countless negative feelings.

Cognitive restructuring

One of the core techniques in child focused CBT is cognitive restructuring. It is a commonly used activity for intervention of depression and anxiety (Mc.Loone, Hudson, & Rapee, 2006). It is a restorative process which is applied to point out and challenge the negative thinking patterns. It helps children to understand that the negative thoughts are disruptive. It also makes the children realize that these thoughts affect negatively on their behavior. One of the most important goals of cognitive restructuring is to modify the negative thinking pattern along with the behavior. It trains up the children on how to figure out the reasons for negative thoughts, how to replace unhelpful and irrational thoughts with comparatively more rational or logical thoughts. In child focused CBT, therapists usually simplify the process to replace irrelevant thoughts with relevant thoughts, and the action or behavior along with rational thoughts.

There are three steps in cognitive restructuring, which are: i) identifying irrational or negative thoughts, ii) irrational thought challenge and iii) replacing irrational

thoughts with logical, allowable, realistic, constructive, optimistic, and rational thoughts. For cognitive restructuring, here some activities have been applied which are: I also can, Check and test the thoughts, Re-structuring the thoughts, Why do I do and Positive glasses.

Rewarding and counting the success rate (Tiny steps=boost up the success, My biggest achievements, Positive self-talk)

Our emotion, feeling, activities, and behavior have been influenced by reward system. Reward is a motivation. Extrinsic and intrinsic motivation or reward encourages us to do better. Children are also affected by it. When they can paint their own success, they feel proud and want to do more. Activities like tiny steps = boost up the success, own success stair, sky or tree helped the children visualize their success easily. These activities are the ingredients for future or further hardworking to do better in life. They can practice it by positive self-talk. Positive self-talk is our inner voice. Our feelings, emotions, actions and behaviors are extremely influenced by our inner voice. When we practice positive self-talk, it reflects our positive perspective in a situation and consequently our behaviors also become positive. However, we practice negative self-talk and thus our activities are reflected by it. So, eventually a negative situation is created. So our success story encourages us to talk positively and positive self-talk motivates us to do better in next step.

Re-assessment (Assess the session plan, re-assessment of the level of anxiety and anger)

To achieve the goal, children, therapist and parents analyzed the pre-set goal and the children were assessed by the same scale (Beck Youth Inventory- sub scale anxiety and anger) at the end of all the sessions.

3. Credibility questionnaire

Credibility questionnaires were applied to measure children, psychologists and parents' attitudes to the bangla adapted child focused CBT activities for intervention. Children, parents and psychologists filled up the questionnaire separately. Children's questionnaire consisted of 6 questions about the language, feasibility, understandability, enjoyment overall children's attitudes to the session and activities. Parent's credibility consisted on their opinion about the activities, whether their child's behavior or emotion has been changed or not, did children likes the activities r not. Total numbers of the question were 7 and it was the uniform set of questions for all parents. In psychologist's credibility questionnaire, their attitudes to the understandability of the activities were measured. Psychologist's feeling and difficulties were measured by 10 questions about easily explain, language fluency, words' appropriateness, activities sequentially, appropriateness accordance to socio-economic and cultural view etc. Parent's and psychologist's questionnaire were constructed by 5 scale likert point and children's score was measured by 3 scale likert point. At the end of the session, credibility questionnaire was filled up.

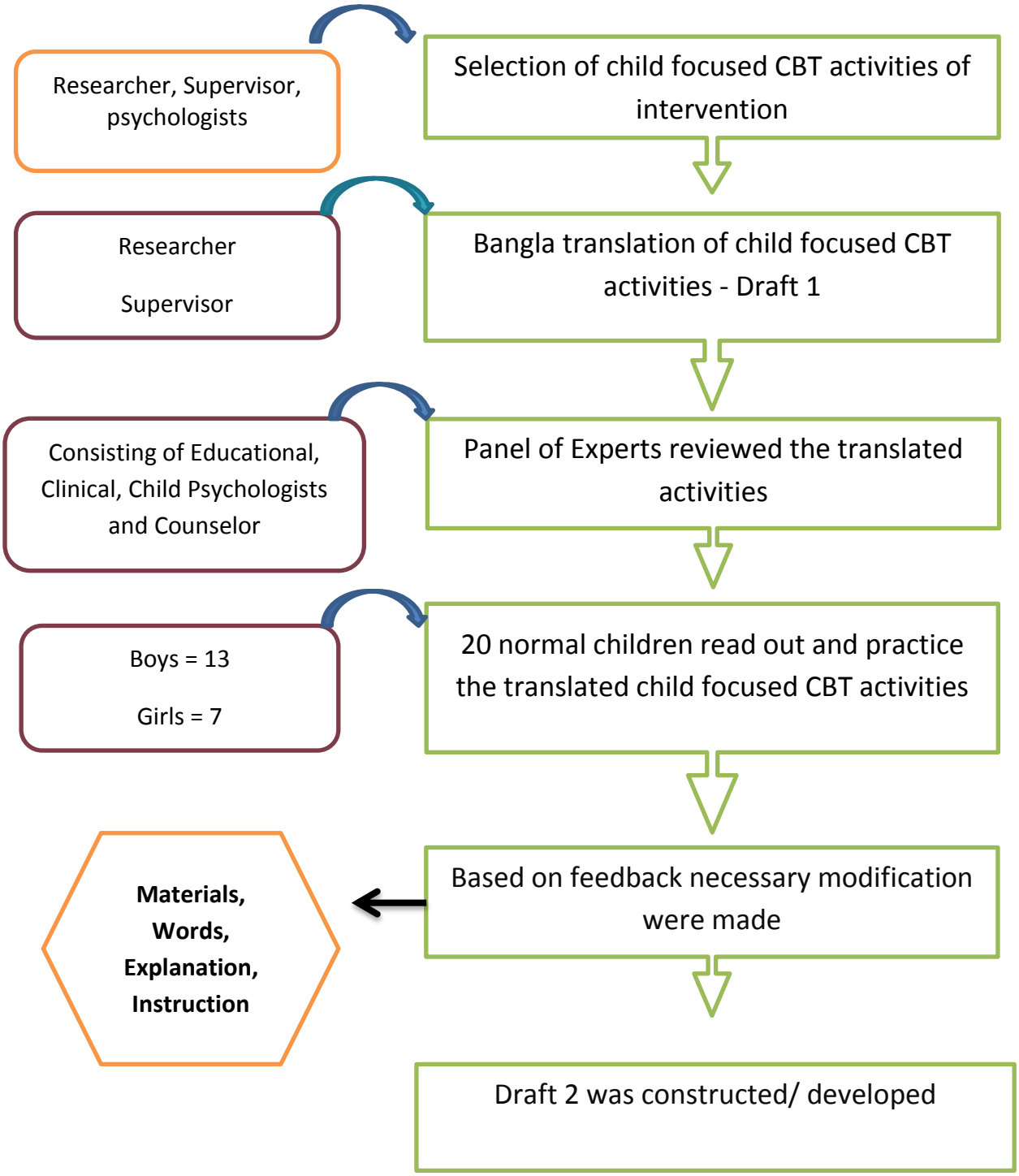
Study Method

To adapt child focused cognitive behavior therapy (CBT) activities for intervention, the researcher selected some activities from intervention books such as A Clinician's Guide to Think Good-Feel Good (Stallard, P. 2005), 3 positive CBT exercise, FRIENDS for life workbook for children (Barrett 2013), your very own TF-CBT workbook, Cognitive Behavior Therapy (CBT) Skills Workbook, activities from creative therapy which has been consulted for adaptation. These interventions have been already used with children all around the word. The researcher discussed about the activities with the supervisor and a number of professionals who work with children for their behavioral and emotional problems. Based on the discussion, the researcher selected some of the activities for children to modify their behavioral issues and regulate their feelings and thinking. A panel of experts consisting of Educational Psychologist, Clinical Psychologist, Child Psychologist and Counselor working with children were approached for their opinion regarding the selected activities. Again after consultation with the supervisor, the researcher finalized 35 activities for translating into Bangla. At first, the researcher translated the activities in Bangla mainly focusing on the theme of the activities. Considering the culture of Bangladesh, the researcher developed some materials to be used in intervention. Then the researcher and the supervisor reviewed all the activities. These were presented to the Expert panel along with the original English format to evaluate the activities. Expert Panel compared the Bangla translation with the English format. They suggested some changes of words, phrases, languages, which are more appropriate for children and also for the therapist to use. These were done to make activities understandable, flexible and enjoyable for the children to do the activities. With

the supervisor's feedback, the revised version was made and the blue print of the sessions was prepared. These activities were arranged in different sessions. After completing all these processes, first draft was prepared for demonstration on normal children. First draft was conducted with conveniently selected 20 children who do not have any behavioral or emotional deregulation. After reading and demonstrating the Bangla activities, children filled up a credibility questionnaire. Credibility questionnaire consisted of 6 questions about the understandability, enjoyment, feasibility, instruction following process and also the process of rapport build up and psychologist appearance. Each child attended face to face 4 to 5 sessions of 1 hour and 30 minutes each and gave their feedback regarding the session activities. After completion of the process, the researcher prepared the second draft on the basis of the comments of the children and the psychologist.

Figure 5

Flow chart of Phase-1 for adaptation of child focused CBT activities for intervention



For better comprehension, the first objective with its two specific objectives out of five specific objectives is presented below before discussing the methodology for phase 2:

Objective

The 1st general objective of the present study was to adapt the Child Focused Cognitive Behavior Therapy as an intervention for children.

In the 2nd phase, the researcher conducted this step to establish the two specific objectives.

Specific objectives

To demonstrate the 1st general objective, out of five specific objectives last two were carried out consequently in the 2nd phase. These were

i. Organize the activities in different sessions;
ii. Conduct a first trial on children;

Methodology

The methodology of the 2nd phase is expounded here in details:

Study Population

a. Children, who had the emotional and behavioral problem and scored highly elevated or mildly elevated anxiety and anger in assessment scale - Beck Youth Inventory and willing to get the treatment in professional counseling session in IPNA, BSMMU.

b. Parents, who had children with behavioral and emotional disturbance of severe anxiety, anger. They came willingly to seek professional counseling help in IPNA, BSMMU.

c. Psychologists, who had providing interventions to children for their behavioral and emotional issue.

Study period

March 2019 to November 2019

Sampling technique

- Children were selected by convenient sampling (before assessment by sub-scales) then purposive sampling was applied (scored extremely elevated or moderately elevated then selected as sample)
- Parents were selected by purposive sampling method
- Convenient sampling technique was applied to select the psychologists
- Overall mixed sampling method was applied for the second phase.

Table 2

Sampling techniques in different group of sample in phase-2

Participant	Children	Parents	Psychologist
Sampling techniques	Convenient → Purposive	Purposive	Convenient

Table 2 represents the sampling techniques in phase-2.

Study Sample

In phase 2, children, parents and psychologists were different sample groups. All three groups were involved in the second phase.

For Children

Inclusion Criteria

- Children with behavioral and emotional problem(s)
- Willing to participate in the study
- Age range 7 to 14 years old
- Average IQ level – according to their school performance and parents' report

Exclusion Criteria

- Children who were under any medication for psychotic and neurotic disorders
- Children who already attended the counseling session
- Children who were not living with parents

- Children of broken family, single parents or divorced parents

For Parents

Inclusion Criteria

- Parents having children with behavioral and emotional problem
- Apparently healthy persons and willing to continue the session

Exclusion Criteria

- Parents who have children with neurotic, psychotic disorder
- Parents who have any psychotic and neurotic disorders
- Parents who are taking psychotic or neurotic medication
- Parents who have separation, legal divorce issues

For Psychologist

Inclusion Criteria

- Working with only children for more than 3 years
- Professionally working in Institutions
- Willing to participate in the study

Exclusion Criteria

- Psychologists working with adult client only
- Practiced less than 3 years

Study sample

In phase 2, for children sample group total numbers of children were 10. Among them, 6 were boys and 4 were girls.

For parents sample group, both mother and father were enlisted as sample. So total frequency was 20 (10 mothers and 10 fathers).

A group of experts consisted of 4 Educational Psychologists, 2 Counselors, 2 Child Psychologists and 2 Clinical Psychologists contributed in this phase.

Sample Distribution

Table 3

Frequency of sample distribution in phase 2, N=38

Category	**Frequency**	**Percentage**
Children	10	26.32%
Parents	18	47.37%
Psychologist	10	26.32%

As demonstrated in Table 3, the frequency distribution of the sample in the second phase. Total number of the sample was 38, among them 10 were children, 18 were corresponding parents of the children and 10 were psychologists.

Table 4

Frequency of sex in sample of children in phase 2; N=10

Gender	Frequency	Percentage
Boys	6	60%
Girls	4	40%

As shown in Table 4, frequency distribution of sex of 10 children, among the 10 children 6 were boys and 4 were girls.

Table 5

Frequency of age distribution of children in phase 2, N=10

Age	Frequency	Percentage (%)
7	2	20
8	2	20
9	1	10
11	1	10
12	1	10
13	2	20
14	1	10

As exhibited in Table 5, the age distribution of 10 children with extremely elevated anxiety or anger or both, in phase 2, section 1.

Table 6

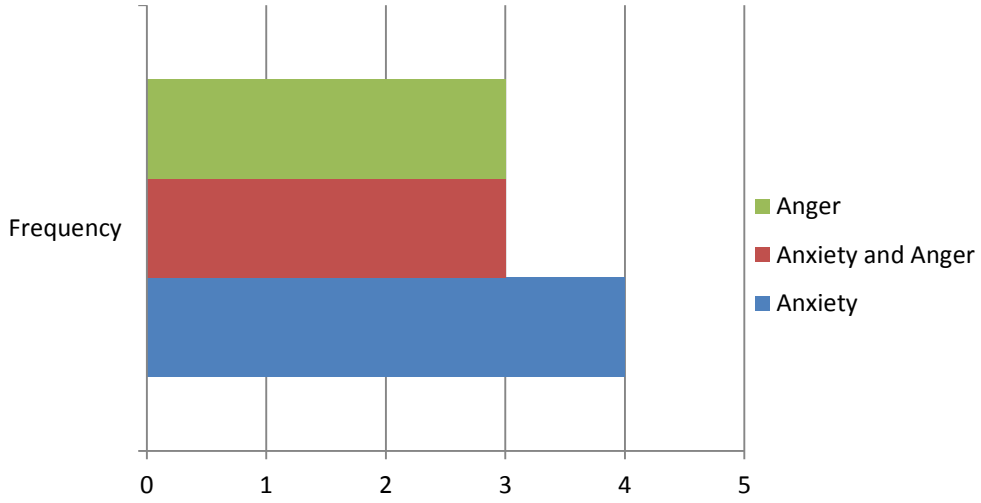
Frequency of distribution in age group, n=10

Age group	Frequency	Percentage (%)
Younger Group (7 to 10) years	5	50
Older group (11 to 14) years	5	50

As shown in table 6, both the younger and older group has 5 children each.

Figure 6

Frequency distribution of the sample in section 1 phase 2:(N=10)



In phase 2, among 10 children, 4 had extremely elevated anxiety by BAI-Y, 3 had extremely elevated anger BANI-Y and rest of them scored extremely elevated in both sub-scales anxiety and anger (BAI-Y and BANI-Y).

Table 7

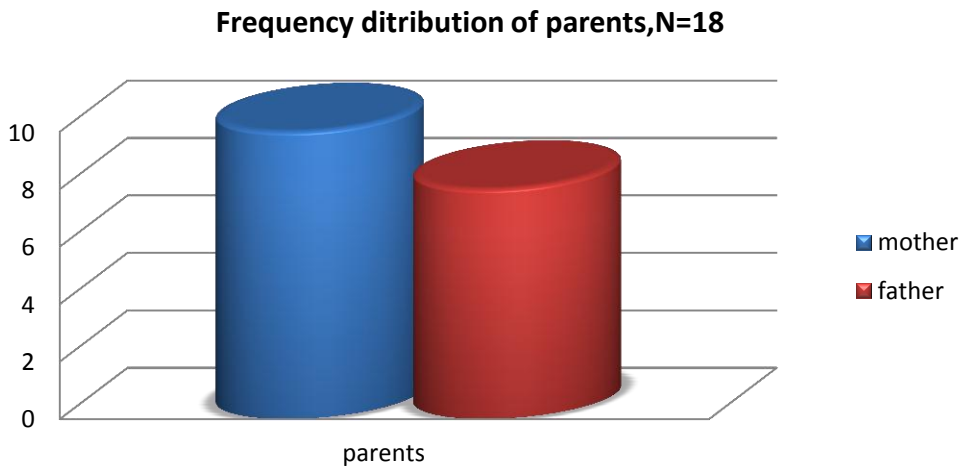
Frequency distribution of sex in sample of parents; N=18

Parents' Sex/gender	Frequency	Percentage
Father	8	44.44%
Mother	10	55.56%

Distribution of sex in the sample of parents in phase 2 was illustrated in table 7.

Figure 7

Frequency distribution of the sample parents N=18



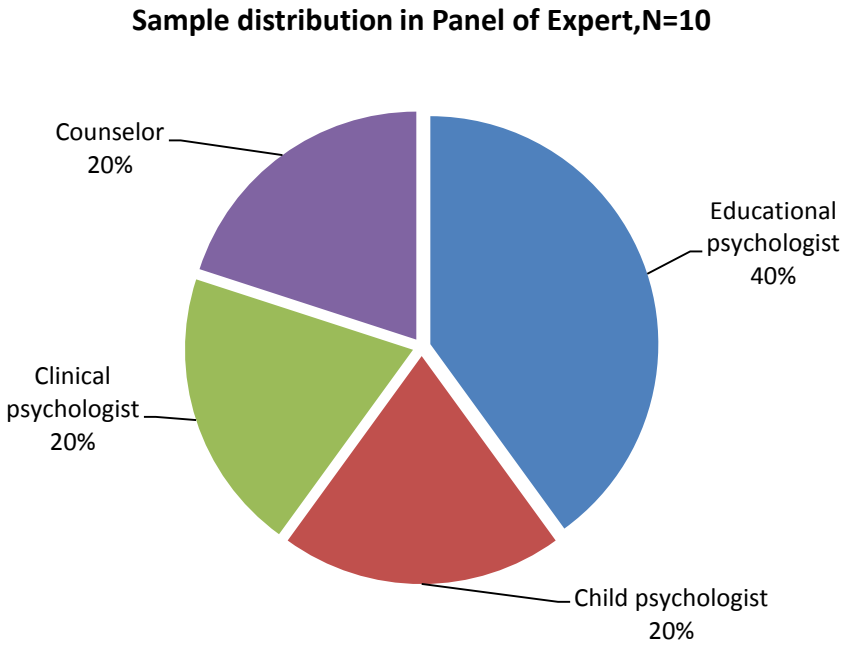
As shown in figure 7, the frequency distribution according to sex. Here, the frequency of mother was 10 and father was 8.

Among the panel of experts, 4 were educational psychologists and each group of clinical psychologists, child psychologist and counselor consisted of 2 members each.

Figure 8, shows the sample distribution in group 3 – panel of experts.

Figure 8

Frequency distribution of panel of expert



Study Design

Cross-sectional research design has been applied to conduct phase-2.

Study Instruments

1. **Demographic and personal information questionnaire**

   By this questionnaire, the data on age (parents, children), sex, socio economic status, residential area, parents' occupation, educational background were collected.

2. **Bangla adapted child focused cognitive behavior activities**

   See appendix

3. **Anxiety and Anger sub-scales of Beck Youth Inventory (BYI)**

Beck Youth Inventory (Anxiety, Depression, Anger, Disruptive Behavior, and Self-concept) was established by Beck et. al. (2001). This scale measure depression, anxiety, anger, disruptive behavior, and self-concept of children and adolescents, the internal consistency reliability of BYI appeared acceptable and the Cronbach's alpha ranged between 0.86 and 0.96 and concurrent validity is 0.74 to 0.93. Three Likert scale was used to score. The Bangla Beck Youth Inventory (BYI) was adapted on a sample of 198 children and adolescents. This scale assesses depression, anxiety, anger, disruptive behavior, and self-concept of children and adolescents. All these are defines as sub-scales, so this scale consists of five sub-scales. The internal consistency reliability of the Bangla BYI appeared high as the Cronbach's alpha ranged between .77 and 0.88. Test-retest reliability and validity of the scale were satisfactory (Uddin, Huque, & Shimul, 2011). This scale consists of total 100 items. Each sub-scale has 20 items. Three (3) point likert scale is applied to score the level of self-concept, anxiety, depression, disruptive behavior and anger. If the total score is below 55 (T < 55), it is considered as the average score. If the total score is between 55 and 59 (T = 55-59),

it is considered as the Mildly elevated level and if the total score is between 60 and 69 (T = 60-69). it is considered as the Moderately elevated level. If the total score is above 70 ($T = 70^{+}$), it is considered as the Extremely Elevated level. T-scores are Equivalents for raw score according to the tables for Beck Youth Inventories.

4. Credibility questionnaire

Credibility questionnaires were applied to measure children, psychologists and parents' attitudes to the bangla adapted child focused CBT activities for intervention. Children, parents and psychologists filled up the questionnaire separately. Children's questionnaire consisted of 6 questions about the language, feasibility, understandability, enjoyment overall children's attitudes to the session and activities. Parent's credibility consisted on their opinion about the activities, whether their child's behavior or emotion has been changed or not, did children likes the activities r not. Total numbers of the question were 7 and it was the uniform set of questions for all parents. In psychologist's credibility questionnaire, their attitudes to the understandability of the activities were measured. Psychologist's feeling and difficulties were measured by 10 questions about easily explain, language fluency, words' appropriateness, activities sequentially, appropriateness accordance to socio-economic and cultural view etc. Parent's and psychologist's questionnaire were constructed by 5 scale likert point and children's score was measured by 3 scale likert point. At the end of the session, credibility questionnaire was filled up.

Study Procedure

In a tertiary level hospital (IPNA BSMMU), parents regularly come to take treatment for their child's neurological and behavioral problems. Among the children, Paediatric Neurologists referred some of them to psychologists for the patients' behavioral problem. Among these children, researcher selected a group of children who had extremely elevated or moderately elevated anxiety and anger. Draft 2, which constructed in phase 1, was applied to all of them sequentially on extremely elevated anxiety and anger issues of the children. Only 10 children were selected who met the inclusion criteria for administering the draft 2 for further review and modification. To assess children's anxiety and anger, Educational Psychologists applied Bangla adapted Beck Youth Inventory. The Bangla Beck Youth Inventory (BYI) was adapted on a sample of 198 children and adolescents. This scale assesses depression, anxiety, anger, disruptive behavior, and self-concept of children and adolescents. All these are defines as sub-scales, so this scale consists of five sub-scales. The internal consistency reliability of the Bangla BYI appeared high as the Cronbach's alpha ranged between .77 and 0.88. Test-retest reliability and validity of the scale were satisfactory (Uddin, Huque, & Shimul, 2011). This scale consists of total 100 items. Each sub-scale has 20 items. Three (3) point likert scale is applied to score the level of self-concept, anxiety, depression, disruptive behavior and anger. If the total score is below 55 ($T < 55$), it is considered as the average score. If the total score is between 55 and 59 ($T = 55\text{-}59$), it is considered as the Mildly elevated level and if the total score is between 60 and 69 ($T = 60\text{-}69$). it is considered as the Moderately elevated level. If the total score is above 70 ($T = 70^{+}$), it is considered as the Extremely Elevated level. T-scores are Equivalents for raw score

according to the tables for Beck Youth Inventories. Total 50 children were diagnosed by following the Beck Youth Inventories scale through an oral interview conducted by professional Educational Psychologists in 2 sub-scales of anxiety and anger among five sub-scales in BYI. For applying the activities of intervention in the 2nd phase, finally 10 children were selected. After selecting the children, their parents' assent was signed and their socio-economic data were filled up by a semi-structured questionnaire. Each child's father and mother both were aware with the study aim. Every week each of the children attended 1 session. The time duration was 1.5 hour for every session. Each child took 14 sessions. So total number of the sessions was 140. Among the 10 children, 4 had extremely elevated anxiety, 3 had extremely anger issues and 3 had extremely elevated anxiety with anger. In every session, psychologists explained the activities and children practiced the activities in the face to face session. With child's consent, Psychologists explained the activities to the parents too so that they were aware about their children's conditions and helped the children to do the activities. Parents and children also practiced the task at home and gave their feedback in consecutive session. At the end of the 14 sessions, a credibility questionnaire was filled up by the parents as well as the children. Psychologist's observational data and child-parent's feedback were accumulated. The researcher incorporated all the suggestion for further review of the activities. Psychologists also filled up a separate credibility questionnaire. The expert panel reviewed all the suggestions and a final draft (draft 3) of Child focused CBT activities for intervention of anxiety and anger was prepared for further Field Test. Panel of experts also prepared the session plan according to standard protocol of counseling and CBT.

To prepare session plan, researcher discussed with the group of experts and the supervisor, then framed out the activities for intervention in different sessions to fulfill different purposes of the constructive counseling session. The main purposes of the intervention program were:

- 1st purpose was to introduce psychologist to client, build up rapport, give psychoeducation to child and parents about anxiety, anger, counseling process and child focused cognitive behavior therapy.

- 2nd aim was to introduce the children to their feelings and to teach how to feel good.

- 3rd intention was to let them talk about events and thoughts for any negative event (past, present and future).

- 4th motive was to teach the children to relax themselves for stabilization in different situation.

- 5th aim was to teach the children how to change unhelpful thought to helpful thought.

- 6th purpose was to teach the children how to explore various solutions and how to divide these solutions into smaller steps

- 7th intention was to teach the children how to get the rewards from self and others.

- 8th objective was to practice being successful.

To achieve these purposes, the researcher applied 30 activities along with psychologist to the target children who assessed extremely elevated or moderately anxiety and anger. All the tasks were aimed to teach the children to handle their irrational unhelpful thought process which created the negative behavior and emotion. These purposes are the ultimate goal of all the sessions. (14 sessions). To achieve these aims different activities were applied with different tools. Table 8 represents objective of the activities and materials list for the activities.

Table 8

Child focused CBT activities for intervention with objectives and materials/tools.

Activities	Materials/Tools	Objectives
Greetings time	Picture of hand shaking	Orientation to psychologist and client
Work Together	Paper, color pen, glue	To find out child's likings disliking To build up rapport
Draw myself	Paper, pencil, color	To initiate to find out the difference between own self and therapist
My world	Paper, color pen, round-shaped plate or hard paper	To explore children's choices and own world
Psychoeducation	Narration by the psychologist	To introduce the counseling process, details about the session
My Family	Paper and pen	To explore the family patterns
Heartstring	Paper, pen, color pencil, heart-shaped paper	To mark out child's close support group and child's perspective about her/his near and dear
Happy, Sad, Angry	Paper, pencil, color pen	How to express own emotion to draw the face

Activities	Tools	Objectives
Mood-o-Meter	Scale, Paper, pen, Pencil, Clock-shaped pattern, emoji	Children can find out own emotion in different times in a day and week
To explore the body	Picture (human body), Dolls (boys, girls), color pen-pencil, paper, highlighte	To be acquainted to own body part and feelings
Feelings on our face	Paper, pencil, color pen, emoji,	To realize how face shows our emotion
Unpleasant events	Paper, color pen,	To discover the life events of the children which makes him/her unhappy
Relaxation by draw own picture	Paper and pen, pencil	To realize how body looks like in an anxious on anger moment
Floppy doll	Color pen/pencil, paper, Soft medium size doll.	To relax body parts
Deep breath	Ballon picture, ballon, hand-made breathing tools	To take the deep breath

Activities	Tools	Objectives
Through the rain forest	Paper, pencil, picture of nice place, recorder	To teach the children to be relax with the help a picture of shooting place
Safe Place	Paper, Pen, pencil	To help children to find out his/her safe place (imaginary)
Let's feel in cloud	Relaxing chair	To teach the children to practice own self in the cloud
Happy elements	Paper, color pen, pencil, bag or box	To help the children to make a first-aid box for shifting unhappy moment to happy moment
Worry box	Paper and pen, 8x8 inch box	To assist the children to keep their worries in a box
Re-structuring the thoughts	Paper, pen/pencil	To help the children to think differently for a specific event
Why do I do	Paper, pencil, color pen, glue	To identify the reason behind a behavior

Activities	Tools	Objectives
Positive glasses	5x4 inch hard white paper, pen (black, blue, yellow/lemon green)	To indoctrinate the event from a different perspective
Tiny step = boost up the success	Wood stairs, paper, pencil, pen	To coach the children to reach a final destination by small steps
My biggest achievements	Picture of the sky or tree, sticker (stars/flowers/leaves) Paper, pencil, color	To exercise to make a bigger staff (sky/tree) for own success
Positive self-talk	Paper, color pen, notebook, mirror	To rehearse to say praises to own-self
I also can	Paper, pen pencil	To teach the children to find out the trigger, antecedent and reframe
Check and test your thoughts	Paper, pen, plastic jar or bowl	To lesson the children to measure and experiment the negative thoughts
Practice mindfulness	Narration of the therapist and recorder	To teach the children to shift the attention to surroundings
Assess the Counseling plan	Paper and pen	To check the all activities for intervention for further application

To achieve these purposes researcher along with psychologist, applied the child focused CBT activities for intervention to the selected child. Each child attended 14 sessions in every week. So, the total number of the sessions were 1498 (107 participants multiplied by 14 sessions).Table 9 had been represented the relevant activities' sequence in every session with time duration. There is a primary blue print for the treatment schedule.

Table 9

Activities list in every session with time duration

Session num.	**Activities**	**Time Duration**
Session 1:	Greetings	15 min.
	Work Together	25 min
	Draw Myself	25 min
	Psychoeducation	20 min
	Closing/say good bye	5 min
Session 2:	Hello time	5 min
	Work Together	10 min
	My world	30 min
	My family	30 min
	Psychoeducation	10 min
	Closing/say good bye	5 min
Session 3:	Hello time	5 min
	Work Together	10 min
	Deep Breathing by balloon	30 min
	Explore the Body	30 min

	Psychoeducation	10 min
	Closing/say good bye	5 min
Session 4:	Hello time	5 min
	Work Together	10 min
	Worry Box	35 min
	Feeling on the face	35 min
	Closing/say good bye	5 min
Session 5:	Hello time	5 min
	Work Together	10 min
	Floppy Doll	30 min
	Worry box	25 min
	Feeling on the face	15 min
	Closing/say good bye	5 min
Session 6:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Unpleasant events	35 min
	Let's to be on the cloud	20 min
	Closing/say good bye	5 min
Session 7:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Happy, sad, angry	30 min
	Drawing own body for relaxation	25 min
	Closing/say good bye	5 min

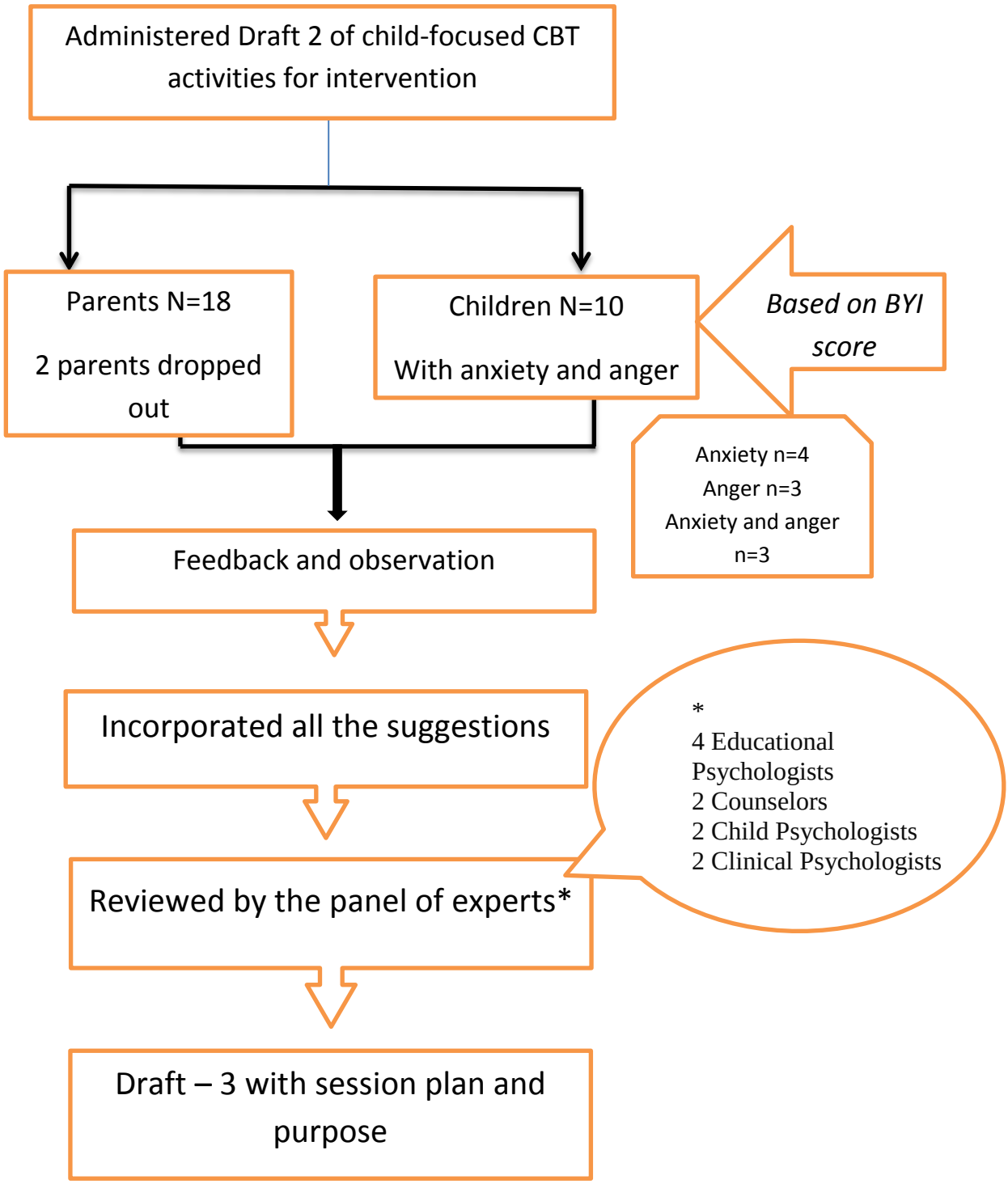
Session 8:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Mood-o meter	30 min
	Happy elements	25 min
	Closing/say good bye	5 min
Session 9:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	I also can	20 min
	Through the rain forest	35 min
	Closing/say good bye	5 min
Session 10:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Check and test the thoughts	30 min
	Practice to be mindful	25 min
	Closing/say good bye	5 min
Session 11:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Re-structuring the thoughts	30 min
	Safe place	25 min
	Closing/say good bye	5 min

Session 12:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Why do I do	30 min
	My biggest achievements	25 min
	Closing/say good bye	5 min
Session 13:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Positive glass	30 min
	Positive self-talk	25 min
	Closing/say good bye	5 min
Session 14:	Hello time	5 min
	Work Together	10 min
	Review of the previous tasks	15 min
	Tiny steps=boost up the success	25 min
	Re-assessment	20 min
	Closing/say good bye	25 min

Through a treatment credibility questionnaire, researcher found out the credibility of the child focused cognitive behavior therapy activities for intervention whether these activities were helpful, effective for the child or not. Parents, child and also psychologist filled up the credibility questionnaires separately.

Figure 9

Flow chart of Phase 2 Adapting the child focused CBT activities for intervention



Assess the Effectiveness of Adapted Child Focused Cognitive Behavior Therapy as an intervention

To make it clear, the second general objective and the specific objectives beneath the second objective are presented here

General Objective:

The 2nd primary objective of the present study was to assess the effectiveness of adapted Child Focused Cognitive Behavior Therapy as an intervention. In the second section of the method the researcher accomplished the three specific objectives which were covered by 2nd general objectives inwardly. For the second general objective, the specific objective was to assess the effectiveness of the adapted child focused CBT activities for intervention by

a) Anxiety and Anger subscales of Bangla adapted Beck Youth Inventory
b) Treatment credibility questionnaires
c) Comparison of case group with 3 control groups

Methodology

The exhaustive methodology of the second section had been illustrated here in details:

Study Population

- Children, who had the emotional and behavioral problems and scored extremely elevated or moderately elevated by BAI-Y (anxiety sub scale) and BANI-Y

(anger sub scale) in assessment scale - Beck Youth Inventory and willing to get the treatment in professional counseling session in IPNA, BSMMU.

- Parents, who had children with behavioral and emotional deregulation of severe anxiety, anger. They came willingly to seek professional counseling help in IPNA, BSMMU.
- Psychologists, who were conducting counseling with children for intervening their behavioral and emotional issues.

Study Period

October 2019 to June 2020

Sampling techniques

- Children were selected by purposive sampling then random sampling was applied for Case group, Control Group-2 and Control Group-3. For Control Group-1, convenient sampling technique was applied.
- Parents were selected by purposive sampling method.
- Convenient sampling technique was applied to select the psychologists.
- Overall mixed sampling method was exerted for this section 2.

Table 10

Sampling techniques in different groups of sample in section 2

Participant		Sampling techniques
Children	**Case group**	Purposively → Randomly
	Control group-1	Conveniently
	Control group-2	Purposively → Randomly
	Control group-3	Purposively → Randomly
Parents		Purposively
Psychologist		Convenient

Study Sample

For Children:

A total number of 134 children partook in the present section of the research. The number of children in Case and three Control groups was 49 and 85 consecutively. Among the 134 children, 73 were boys and 61 were girls. Their age range was from 7 to 14 years belonging to different socio-economic status. The residential area was both rural and urban. All of them were school going children. The researcher divided them into 2 age groups. For younger group the age limit was from 7 to 10 years (N= 67), and for the older group the age length was from 11 to 14 years (N = 67).

Table 11

Frequency of children according to condition, age and sex in section 2 (N = 134)

Group	Age	Boys	Girls	Total
Case	Younger 7 to 10 years	16	9	25
	Older 11 to 14 years	13	11	24
Control	Younger 7 to 10 years	20	22	42
	Older 11 to 14 years	24	19	43
Grand Total		73	61	134

For Children

Sample Inclusion Criteria

- Extremely Elevated or Mildly elevated anxiety and anger
- Age range from 7 to 14 years old (boys and girls)
- Average IQ level- according to their school performance and parents' report
- Living with their parents

Sample Exclusion Criteria

- Children who were under any medication for psychotic and neurotic disorders
- Children who already continued the counseling session
- Children who were not living with parents
- Adopted children
- Children of broken family, single or homosexual parents, divorced parents and re-married couple

Sample Distribution

Selected children were distributed randomly into 3 groups – Case Group, Control Group-2 and Control Group-3. In control group 1- children were selected purposefully among 50 regular random children.

As presented in table 12, for children sample 134 individuals were in an exhaustive sample group in the section-2. Among them 73 were boys and 61 were girls. In Case Group, total participants were 49, among them 29 were boys and 20 were girls. In Control Group-1, total number of children were 27, boys and girls were 13 and 14 consecutively. In Control Group-2, gross number of the sample were 28, boys and girls were 17 and 11 respectively. In Control Group-3, the entire sample were 30, among them 14 were boys and 16 were girls.

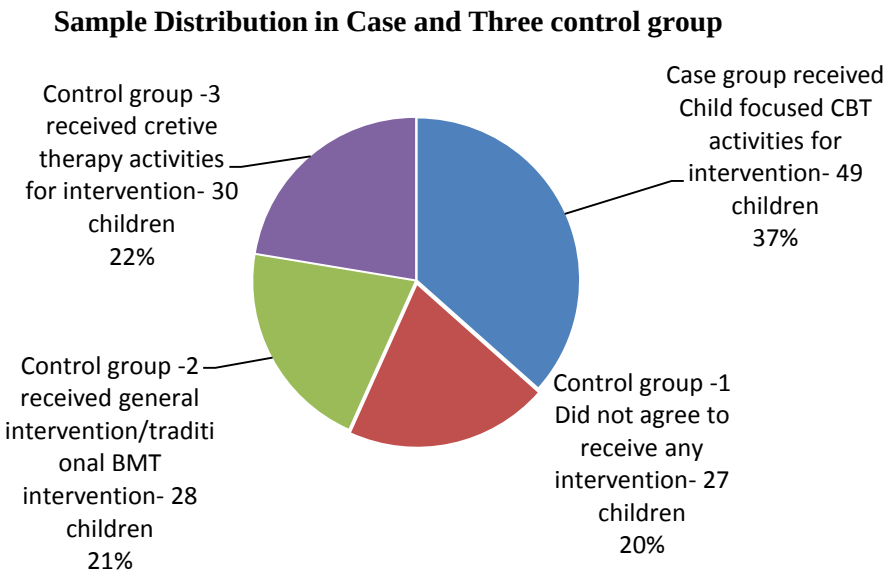
Table 12

Sample distribution according to sex in 4 groups (Case Group, Control Group-1, Control Group-2 and Control Group-3)

	Condition	Boys	Girls	Total
Case	**Case Group**	29	20	49
Control	**Control group 1**	13	14	27
	Control group 2	17	11	28
	Control group 3	14	16	30
Grand Total		**73**	**61**	**134**

Figure 10

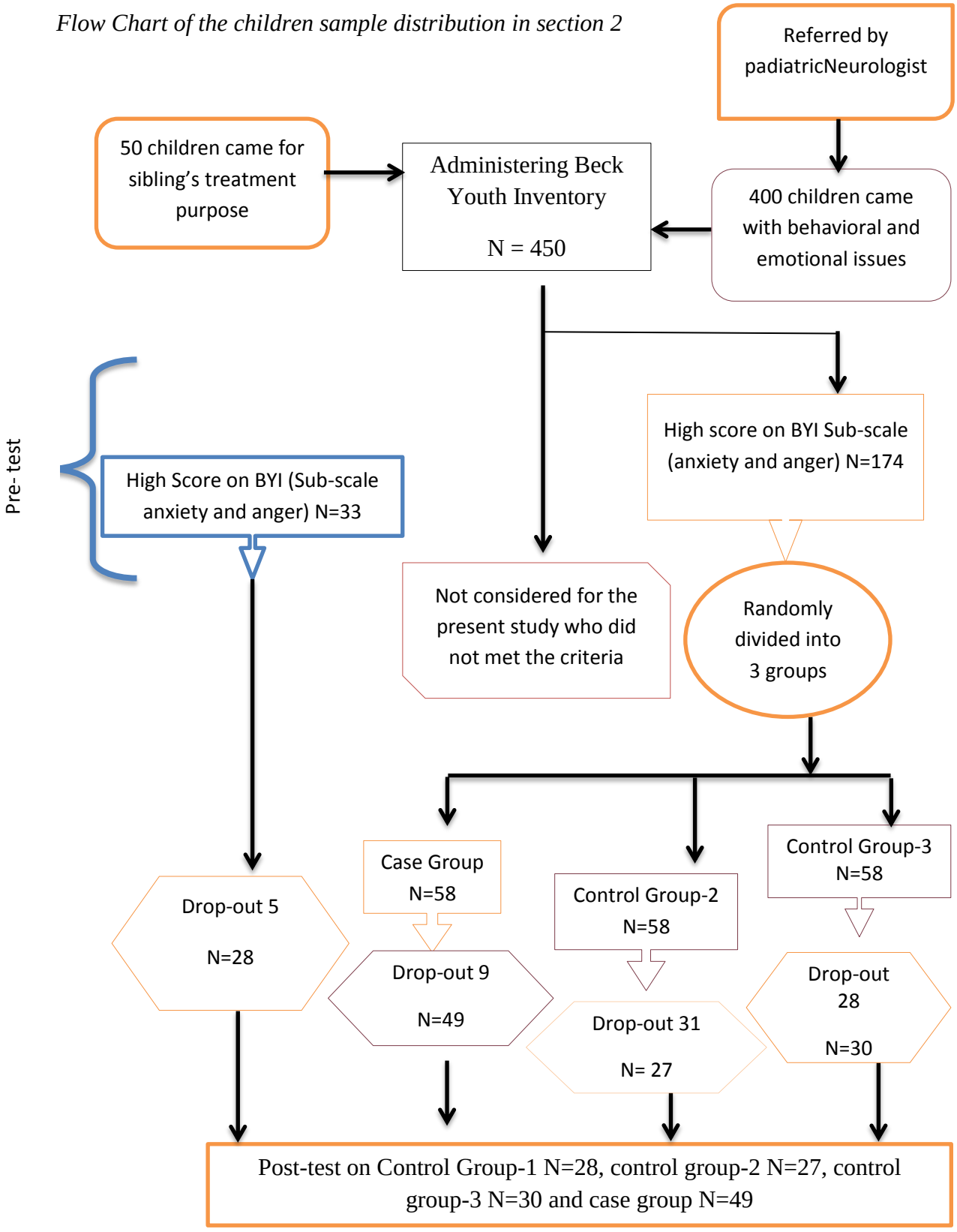
Sample distribution in 4 groups N=134



As displayed in figure 10, that 37% children were in Case Group, 20 % children were in Control Group-1. 21% and 22% children were in Control Group-2 and Control Group-3 consequently.

Figure 11

Flow Chart of the children sample distribution in section 2



Case group

The current study included 49 children among them 29 were boys and 20were girls. All of them were enrolled in Institute of Paediatric Neuro-disorder and Autism (IPNA), BSMMU, aged from 7 to 14 years with behavioral and emotional issues such as extremely elevated or mildly elevated anxiety and anger.

Table 13

The frequency of sex in case group (N=49)

Sex	Frequency	Percentage N=49	Percentage N=134
Boys	29	59.18%	21.64
Girls	20	40.81%	14.93

As shown in Table 13, the ratio of sex in 49 participants, here 29 were boys and 20 were girls, and the percentage was 59.18% for boys and 40.81% for girls within Case Group. Among 134 children, the percentage was 21.64% for boys and 14.93% for girls.

As appeared in Figure 12, there were two age groups. One group consisted of 25 children (boys were 16 and girls were 9) who were in younger group and another group consisted of 24 children (boys were 13 and girls were 11) that is the older age group. The age range was from 7 to 10 years for younger group and for older group from 11 to 15 years.

Figure 12

Age distribution of Case Group (N=49)

Control Group

To find out the effectiveness of child focused CBT activities for intervention the researcher also included 3 Control Groups.

Control Group-1

Control Group-1 consisted with 27 children, who came to IPNA to get the treatment of their siblings (children with NDDs), along with their parents. Parents

did not give assent to take intervention for their regular random children but they agree to assess the children's level of behavioral and emotional issues. Among 50 regular random children, only 33 child's parents gave their consent to do the assessment on that very moment (while visiting the hospital) and an assessment was done on that moment by following Beck Youth Inventory anxiety and anger sub-scale. After 14 weeks, again an assessment was done. This time 27 children showed up. They would be referred as Control Group-1 who did not get any psychological treatment.

Table14

The frequency of sex in the Control Group-1 (Parents did not agree to receive intervention), (N=27)

Sex	Frequency	Percentage % (N=27)	Percentage % (N=134)
Boys	13	48.15	9.70
Girls	14	51.85	10.45

As shown in table 14, among the 27 participants, the numbers of boys were 13 and girls were 14. They also divided into two age groups, the age range was from 7 to 10 years for younger group and for older group from 11 to 15. In younger group total number of children were 14 among them 6 participants were boys and 8 were girls. Among 27 participants, 13 children were in older group. Among the 13 children 7 were boys and 6 were girls.

Figure 13

Sex and age distribution of Control Group-1

Figure 13, shows the percentage of the sex and age in Control Group-1 (N=27). There were 22% boys and 30% girls were in younger group. In the older group, the ratio of boy and girls were 26% and 22% consecutively.

In the Control Group-2

In the Control Group-2, there were total 28 children, among them 17 were boys and 11 were girls.

Table 15

The frequency of sex in Control Group-2 (received general behavior modification therapy as intervention or Traditional BMT intervention)

Sex	Frequency	Percentage % (N=28)	Percentage % (N=134)
Boys	17	60.71	12.69
Girls	11	39.29	8.21

Table 15, displayed the percentage of the sample among 28 children and also in 134 children. Among 28 children, the percentage was 60.71% for boys and 39.29% for girls. The numbers of boy and girl participants were 17 and 11 respectively.

Figure 14

Frequency distribution of age and sex in Control Group-2

As exhibited in the figure 14, that there were also two age groups. One group consisted of 13 participants (boys were 8 and girls were 5) who were in younger group and another group consisted of 15 children (boys were 9 and girls were 5) that was the older age group. The age range was from 7 to 10 years for younger group and for older group from 11 to 15 years.

Control Group-3

Control Group-3 composited with 30 children, among them 14 were boys and 16 were girls.

Table 16

The frequency distribution of sex in Control Group-3 (received Creative Therapy as intervention), (N=30)

Sex	Frequency	Percentage (N=30)	Percentage (N=134)
Boys	14	46.67%	10.45
Girls	16	53.33%	11.94

As displayed in table 16, among 30 children 46.67 percent were boys and 53.33 percent were girls. Among the total number of the sample (N=134), 10.54% were boys and 11.94 % were girls.

Figure 15

Sex and age distribution of children in Control Group-3

As displayed in the figure 15, that there were also two age groups. One group consisted of 15 participants (boys were 6 and girls were 9) who were in younger group and another group consisted of 15 children (boys were 8 and girls were 7) that was the older age group. The age range was from 7 to 10 years for younger group and for older group from 11 to 15 years.

For Parents:

The parents of consecutive 134 children were also the participants in the study. For parents sample group, only father or mother was enrolled in the second section for giving the feedback, credibility because most of the time only one parents came with the children. For socio-economic demographic information such as parents' educational level, parent's occupation both parents were encounter as sample because these are the parents' individual identity as sex, age.

Sample Criteria

For Parents

Inclusion Criteria

- Parents had children with behavioral and emotional issues (anxiety and anger)
- Willing to take participate in the research
- Lives with family

Exclusion Criteria

- Parents with psychotic or neurotic disorder
- Under medication for physical or mental issues
- Legal problem
- Single parents

Sample Distribution

In all the four groups, among 134 children's parents 47 were father and 87 were mother attended the session with children.

Table 17

Frequency distribution of sex of the parents came with children in the session (N=134)

Condition	Father		Mother	
	Frequency	Percentage	Frequency	Percentage
Case Group	14	10.45	35	26.12
Control Group 1	10	7.50	17	12.69
Control Group 2	11	8.20	17	12.69
Control Group 3	12	8.96	18	13.43
Total	47	35.07	87	64.92

As shown in the table 17, 64.92% mother came with their children whereas 35.0% father came with their children.

Mean score of father's age was 38.77 years and mother's age was 34.24 years old. The SD value was 6.97 and 5.03 respectively.

Table 18

Frequency distribution of parents' age in different range (N=268)

Age range (years old)	**Case Group**		**Control Group 1**		**Control Group 2**		**Control Group 3**		**Grand total**
	Father	Mother	Father	Mother	Father	Mother	Father	Mother	
<25	3	7	2	5	2	4	4	9	37
26-30	4	12	1	8	2	8	4	8	47
31-35	7	13	8	8	3	6	5	9	59
36-40	8	7	4	3	3	5	3	2	35
41-45	8	7	5	3	6	4	5	2	40
46-50	8	2	3		6	1	6		26
51-55	7	1	3		3		3		17
60>	4		1		3				8

Table 18, represents that the frequency of father and mother in 4 groups. 59 parents age level was from 31 to 35 years old, 47 parents were from 26 to 30 years old. In the age level of 36 to 40 years, 35 parents were in this level. In the age level from 41 to 45 years old, 40 parents were in this level. 26 parents were in the age from 46 to 50 years old. In the age level from 51 to 55 and above 60, 17 parents and 8 parents were in this level sequentially.

Table 19

Frequency of parents' Occupation (N=268)

Age range (years old)	**Case Group**		**Control Group 1**		**Control Group 2**		**Control Group 3**	
	Father	Mother	Father	Mother	Father	Mother	Father	Mother
Gov. Employee	7	10	4	6	4	4	4	5
Non-Gov Employee	18	14	10	5	11	6	10	5
Businessman	21	7	11	4	12	5	14	5
Father unemployed /Mother House wife	3	18	2	12	1	13	2	15

Table 19, presented that, in case group 21 fathers were businessmen and 18 mothers were housewives, in Control Group-1, 11 fathers were businessmen and 12 mothers were housewives. In Control Group-2 and Control Group-3, the frequency of businessmen and housewives were high respectively 14 and 15. The frequency of non-govt. employee is high in the Case Group (18).

Table 20

Frequency of parents' educational background (N=268)

Age range (years old)	**Case Group**		**Control Group 1**		**Control Group 2**		**Control Group 3**		**Grand Total**
	Father	Mother	Father	Mother	Father	Mother	Father	Mother	
Uneducated	1	1		1	1	1		1	6
>Primary		3		2	10	2		5	22
>Secondary	15	14	4	7	8	8	4	6	66
>Higher Secondary	14	15	11	11	6	7	16	10	90
>Graduate	17	14	11	4	4	8	9	6	73
<Graduate		2	2	2		2	1	2	11

As shown in table 20, the frequency of parents' education level is highest in below higher secondary level and 73 parents have been in under graduation level. 11 parents were in post-graduation level.

Table 21

Frequency of family's socio economical background (N=134)

Age range (years old)	**Case Group**	**Control Group 1**	**Control Group 2**	**Control Group 3**	**Grand Total**	**Percentage**
Lower class	2	1	1	1	5	3.73
Lower Middle class	7	6	3	4	20	14.92
Middle class	21	10	11	16	58	43.28
Higher Middle class	17	10	10	8	45	33.58
Higher class	2		3	1	6	4.47

As exhibited in the table 21, 58 families belong to middle class status the percentage is 43.28% and 45 families belong to higher middle class the percentage shows 33.58% of the sample.

For Psychologist

Psychologist's sample group was same as section 1, phase 2.

Inclusion Criteria

- Giving intervention to children
- Practice under institutions
- Willing to participate in the research

Exclusion Criteria

- Privately practice
- Dealing with adult clients only

Study Design

A randomized controlled trial study design was applied to conduct this section. Randomized Control Trial (RCT) is defined as participants are allocated to control and case (treatment) group randomly and measures outcome for both groups where two phases (pre-test vs post-test) was conducted within subjects, variables. In this section, the researcher allocated the sample group on case and two control groups. In this study the conditions were (control vs case), gender (girls vs boys), age (young 7-10 yrs. vs older 11-14 yrs.), and residence area (rural vs urban) in the sample.

Table 22

Study design in the section 2

Group		Pre-test	Intervention	Post-test
Case Group		BAI-Y BANI-Y	Bangla adapted child focused CBT activities for intervention	BAI-Y BANI-Y
Control Group	Group 1	BAI-Y BANI-Y	did not get any intervention	BAI-Y BANI-Y
	Group 2	BAI-Y BANI-Y	intervention based on general instruction	BAI-Y BANI-Y
	Group 3	BAI-Y BANI-Y	intervention based on creative therapy	BAI-Y BANI-Y

There were three Control Groups. Control Group-1 did not receive any intervention. They were selected from a tertiary level hospital where they came with patient who were children with NDDs, as sibling or attendee, Control Group-2 received intervention techniques which used generally based on learning theory, ecological theory, attachment theory, social-learning theory, and Control Group-3 got the intervention techniques based on creative therapy techniques adapted into Bangla. All groups were selected after the completion of the assessment by Bangla adapted Beck Youth Inventory

(anxiety and anger sub-scale). Sample who scored moderately elevated and extremely elevated level were allocated randomly in different groups. Case group were intervening by the selected techniques of Child Focused Cognitive Behavior Therapy which were adapted in Bangla language –draft 3 in phase 2.

Study Plan

To testify the effectiveness of child focused CBT activities for intervention 4 sample groups were involved at a time.

Group 1: Case group who get the Bangla adapted child focused CBT activities for intervention.

Group 2: Control group 1 who did not get any intervention and their parents actually did not give the consent to participate in research.

Group 3: Control group 2 who received the general intervention/Traditional Behavior Modification Therapy which are applied in tertiary level hospital in Bangladesh.

Group 4: Control group 3 who received the creative therapy activities for intervention.

All the groups were assessed before first session, after meeting all the sample inclusion criteria sample had been allocated in three groups (Case Group, Control Group-2 and Control Group-3 and after 14 weeks all of them were reassessed by the Beck Youth Inventory (anxiety and anger) again.

Table 23

Study Plan of section 2 for case group

Pre-Intervention assessment	Intervention	Post-test
Assess the child behavioral and emotional issues through Beck Youth Inventory (before 1st session)	Child Focused Cognitive Behavior Therapy Activities for Intervention Session 1 to 14.	Assess the child behavioral and emotional issues by Beck Youth Inventory (14th session)

Study Instrument

Study instruments are same as section 1, phase 2. The description of the study instrument has been already given in section 1 phase 2.

Study Procedure

At first, the Researcher and other psychologists assessed approximately 400 children (with bahvioral and emotional problems) who were referred by paediatric neurologist. They came to IPNA for their treatment purpose of behavioral and emotional problems. The researcher also proposed 50 other regular random children who came to the hospital for sibling's treatment purpose to be assessed by BYI to measure their level of anxiety and anger. Among 50 regular random children, only 33 child's parents gave their consent to do the assessment on that very moment (while visiting the hospital) and

an assessment was done on that moment by following Beck Youth Inventory anxiety and anger sub-scale. After 14 weeks, again an assessment was done. This time 28 children showed up. They would be referred as Control Group-1 who did not get any psychological treatment. Out of the 400 children with behavioral and emotional problems who were interviewed by Beck Youth Inventory, 174 children scored extremely high in the assessment. These 174 children were divided into three groups randomly – Case Group, Control Group-2 and Control Group-3. Each of these groups consisted of 58 children each. The researcher then applied activities for intervention (draft-3) on the 58 children of the Case Group. General behavior modification techniques were applied on the 58 children of the Control Group-2. Creative therapy was applied 58 children of the Control Group-3. The researcher made sure that the parents of these children signed the assent paper. Their socio-demographic information was collected by semi-structured questionnaire from child as well as parents. Each week, every child of these three groups had to attend 14 sessions. Each of the sessions were 1.5 hour long.

Throughout these activities, the below common steps were followed:

- **Pre-test:** Administering Beck Youth Inventory at the initial stage.
- **Intervention (child focused cognitive behavior therapy activities for intervention, traditional BMT, creative therapy):** Duration of per session was one and half hour consecutive 14 sessions were conducted (Case, Control Group-2 and Control Group-3).
- **Post-test:** Moreover, administering the Beck Youth Inventory (Anxiety and anger) along with the credibility questionnaires at the closing session.

In these 14 sessions, In Case Group, 9 children dropped out. In Control Group-1, 5 children dropped out. In Control Group-2, 31 children dropped out. In Control Group-3, 28 children dropped out.

Children and parents gave feedback for the activities after completion of each of the sessions. After completion of all sessions (session module is given in Table 9), the researcher gave thanks to the participants and informed them if they need any professional help for their mental health. They were assured that they could communicate with the researcher for any further assistance. All the participants filled up credibility questionnaire separately.

The total procedure of section 2 is presented in figure 16.

Figure 16

Flow chart of methodology in section 2

Result

Result is the statistical representation of the study. To prepare the result, the researcher analyzed all the data by computer program SPSS version 16. The data scrutinizes were done in several steps. At first all collected data were screened manually to find-out inadequate or abstruse data. To get a total portrayal of the data descriptive statistics were calculated. To describe categorical variables, frequency and percentage were used and by comparing the frequency in pre and post period and also the percentage the researcher found out a proper view of the effectiveness for the Bangla adapted child focused CBT activities for intervention. The researcher also calculated the mean and standard deviation used to continuous variables. To evaluate the mean difference t-statistics were applied in within group and between group also. Qualitative data were also counted as result of the research, parents', children and also psychologist's feedback were collected to explicit the effectiveness of the intervention. Children's and parents verbatim are presented in the result section. Credibility questionnaires were applied to ensure the opinion of the children, parents and psychologist. For all the group, the credibility questionnaires were different. At the end of the all sessions, the credibility questionnaires were filled up separately. The result of the credibility questionnaires were analyzed in quantitive statistics (percentage).

For the clarity, the researcher discussed the result into two sections:

- Section -1 addressed the 1st general objective
- Section-2, result was discussed for 2nd general objective.

General Objective

The 1st general objective of the present study was to -

1) Adapt the Child Focused Cognitive Behavior Therapy as an intervention for children.

Section 1

Section 1 was divided in two phases:

- Phase 1- attain specific objective iii
- Phase 2- attain specific objective iv

Section 1: Phase 1

In the 1st phase, findings conducted to achieve the 3rd specific objective. The 3rd specific objective was:

Specific Objective

a) Review of the language by children and psychologists

To find out the opinion of the children and psychologists, credibility questionnaires and feedback were collected to represent the result for the phase-1 in section-1.

Credibility Score from children (section 1: phase 1)

Table 24

Percentage of credibility from children ((N=20)

	Item	No (%)	Sometimes (%)	Yes (%)
1	I enjoyed the activities	25	55	20
2	Instructions language were easy to understand	30	60	10
3	Steps of the activities were easy to followed	20	45	35
4	Psychologist's appearance were friendly when activities were administered	10	30	60
5	I felt good to listen and to do the activities	25	60	15

As shown in table 24, children expressed their opinion about the activities for intervention. Children has been chosen the option among “yes”, “Sometimes”’ and “No”. Percentage shows that, children were not totally satisfied for the entire item that indicates Bangla activities need to be more reviewed also with session structure and psychologist’s appearance.

Credibility from psychologists (section 1: phase 1)

Table 25

Percentage of credibility from psychologists (N=5)

	Item	Totally disagree (%)	Disagree (%)	Sometimes (%)	Agree (%)	Totally agree (%)
1	Easy to explain the activities	20	20	40	20	
2	Language was fluent and comfortable		20	60	20	
3	Language was appropriate to child's age		20	60	20	
4	Words were very feasible and harmonious			60	20	20
5	Activities sequence was appropriate for the session		20	20	40	20
6	Activities were socio-economically and culturally appropriate	20	20	40	20	
7	Child's behavioral and mental issues were easily identified and solvable by the activities		20	40	40	
8	Activities were structured	20		40	20	20
9	Activities were completed within time		20	40	40	
10	Children can do the activities practically	20	20	40	20	

As shown in Table 25, psychologists gave their opinion about the activities for intervention, there were five options: totally disagree, disagree, sometimes, agree and

totally agree. Most of them chose sometimes option that point out more modification has to be done for further session.

Feedback

In all sessions, attendance annals were kept by a pre-structured record form. In every session, children gave opinion about the words, phrases, sentence structure, instruction's steps etc., researcher recorded all these in written format then with supervisor all the feedbacks were analyzed. After all analysis, modification had been done in the activities for intervention. Children's personal opinions were recorded as verbatim that was counted qualitative record. Some of the verbatim had been presented as documents.

Verbatim is defined as an exact repetition without changing the words. It is following the original word for word.

Following are some of the verbatim comments of the children:

- *I enjoyed the breathing exercise with balloon, feel like a frog. (Session 1)*
- *I liked to draw my heart, when I write down the names to near my heart I can visualize them to close to my heart. (Session 3)*
- *When I draw my success tree, I can feel the time when I did it. (Session 4)*
- *I liked to draw my family picture and now I understand how much they love me. (Session 3)*
- *I enjoyed to floating in the cloud. (Session 3)*
- *I liked to play with faces, now I look at the mirror and make the gesture, really I enjoyed it. (Session 3)*

- *It took lot of time, I want to play mobile not this games. (Session 4)*
- *I don't understand the aim of the activities. (Session 3)*
- *I don't think so, these activities make any differences. (Session 3)*

Observation of the psychologists

Researcher observed that children responded well to the role playing activities. They also enjoyed using different materials like balloon, bubbles, soft doll, and wood stairs. They felt comfortable to talk to the psychologists. Psychologists showed respect to the children's decision that makes the children, they also had an individual importance and they could share their choices. Overall their feedback was constructive; they liked most the activities to do. In end of the every activity there was a record for psychologist's observation, they recorder children's gesture, posture, facial expression. All these records had been analyzed by the researcher with supervisor and expert panels to modify the activities. Data from psychologists' observation was very helpful for further modification. Based on the psychologists' observation new materials were developed and applied. Psychologists observed the child with professional skills so their information about child's gesture, posture, facial expression helped the researcher to reconstruct the session and activities again and again. From their opinion, in every session "observation by the psychologists" part was added so that psychologist can record child's expression during the session.

Section 1: Phase 2

Before discussing phase 2, here 1st general objective is presented again with the specific objective which result portion has been discussing in phase , result section.

General Objective

The 1st general objective of the present study was to -

1. Adapt the Child Focused Cognitive Behavior Therapy as an intervention for children.

The sustained result of the 1st general objective has been presented in two sections (section 1 & 2).

Section 1

Section 1 was divided in two phases:

- Phase 1- attain specific objective iii
- Phase 2- attain specific objective iv

The supported result of the phase 1 has been already discussed. In the 2nd phase of the result the researcher focused on 5th specific objective in section one, this was

a) Conduct a first trial on children

Organization of activities in different session has been already discussed in table 9.

Here a result of first trial on 10 children has been represented by statistically and descriptively.

Table 26

Frequency distribution of the sample in anxiety, anger group (N=10)

Behavioral and emotional issues	**Frequency**	**Percentage (%)**
Extremely elevated Anxiety	4	40
Extremely elevated Anger	3	30
Extremely elevated Anxiety and Anger	3	30

Table 26, demonstrated the frequency of 10 children. Children were selected for first trial of the activities for intervention, here 4 (40%) have extremely elevated anxiety, 3 (30%) have extremely elevated anger and 3 (30%) have both anxiety and anger in extremely elevated level

Table 27

Frequency distribution of anxiety level in pre and post intervention (N=10)

Anxiety level	Frequency of the sample		Percentage of the sample (%)	
	Pre-intervention	Post-Intervention	Pre-intervention	Post-Intervention
Extremely Elevated	7		70	
Moderately Elevated	3		30	
Mildly Elevated		3		30
Average		7		70

As shown in table 27, the frequency of the children in pre and post intervention assessment of anxiety sub scale.

Figure 17

Frequency distribution of anxiety level in pre and post intervention (N=10)

Figure 17, shows that the frequency distribution of the sample in first trial, N=10.

Table 28

Difference between pre and post intervention mean scores of sub-scale anxiety within group (N=10)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	**SD**	**Mean**	**SD**	**t-value**
Boys	**7 to 10**	45	5.86	22	3.89	1.9*
	11 to 14	44.33	6.24	19	5.67	4.9
Girls	**7 to 10**	43	3.54	18	4.11	0.6**
	11 to 14	35	4.24	16	3.54	3.3*

*level of significance is 0.5

**level of significance is 0.1

As demonstrated in the table 28, in the pre-intervention assessment the mean score of anxiety for boys of younger group is 45 and in the post-intervention assessment the mean score is 22, t-value is 1.9*, for girls in younger group mean value is 43 in pre-intervention assessment and in post-intervention assessment the mean value is18, t-value is 0.6**.

For older group, the mean score is 44.33 and 19 for boys in pre and post intervention assessment consecutively, t-value is 4.9 (CI: -.50 to 3.47) which is non-significant t value. In the girls' group the mean score is 35 and 16 in pre and post intervention assessment respectively, t-value is 3.3*.

Table 29

Frequency distribution of anger level in pre and post intervention (N=10)

Anger level	Frequency of the sample		Percentage of the sample (%)	
	Pre-intervention	Post-Intervention	Pre-intervention	Post-Intervention
Extremely Elevated	6		60	
Moderately Elevated	4		40	
Mildly Elevated		4		40
Average		6		60

As shown in Table 29, in pre-intervention assessment, among the 10 children 6 were in extremely elevated level of anger and 4 were in moderately elevated level, in post-intervention assessment no one in extremely or moderately elevated level. In post-intervention assessment 4 (40%) children were in mildly elevated level and 6 (60%) children were in average level.

Figure 18

Frequency distribution of anger level in pre and post intervention in first trial, N=10

Table 30

Difference between pre and post intervention scores of sub-scale anger (N=10)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	43.67	4.58	22.67	5.65	2.9**
	11 to 14	40.33	2.33	21.67	4.76	4.5
Girls	**7 to 10**	42.50	4.95	20	3.49	3.6*
	11 to 14	44	.70	19.50	4.33	4.8

*level of significance is 0.5

**level of significance is 0.1

As demonstrated in the table 30, in the pre-intervention assessment the mean score of anger for boys of younger group is 43.67 and in the post-intervention assessment the mean score is 22.67, t-value is 2.9**, for girls in younger group mean value is 42.50in pre-intervention and in post-intervention assessment the mean value is 20, t-value is 3.6*.

For older group, the mean score is 40.33 and 21.67 for boys in pre and post intervention assessment consecutively, t-value is 4.5 (CI: -1.47 to 2.95). In the girls group the mean score is 44 and 19.50 in pre and post intervention assessment respectively, 4.8 is the t-value (CI: 1.37 to 3.96).

To find out the appropriateness of the activities credibility test was very helpful. The percentage of the credibility in the phase-2 from children, psychologists and parents had been shown with the items.

Credibility from child (section 1: phase 2)

Table 31

Percentage of credibility from children (N=10)

	Item	No (%)	Sometimes (%)	Yes (%)
1	I enjoyed the activities	20	30	50
2	Instructions language were easy to understand	10	30	60
3	Steps of the activities were easy to followed	20	30	50
4	Psychologist's appearance were friendly when activities were administered	10	20	70
5	I felt good to listen and to do the activities	20	30	50

As shown in table 31, children articulated their opinion about the activities for intervention. In this phase, their opinion was comparatively satisfactory than phase 1. 50% children said they enjoyed the activities. More than 50% children understand the language, they followed easily the steps. 70% was satisfied with psychologists' appearance. 50% children totally enjoyed the activities to do. 1 (10%) or 2 (20%) children did not satisfied with the activities.

Credibility from psychologist (section 1: phase 2)

Table 32

Percentage of credibility from psychologists (N=10)

	Item	Totally disagree (%)	Disagree (%)	Sometimes (%)	Agree (%)	Totally agree (%)
1	Easy to explain the activities		10	20	10	60
2	Language was fluent and comfortable		10	10	10	70
3	Language was appropriate to child's age			20	10	70
4	Words were very feasible and harmonious		10	10	20	60
5	Activities sequence was appropriate for the session		10	10	20	60
6	Activities were socio-economically and culturally appropriate		10	10	20	60
7	Child's behavioral and mental issues were easily identified and solvable by the activities		20	10	10	60
8	Activities were structured			20	20	60
9	Activities were completed within time frame		10	20	20	50
10	Children can do the activities practically		10	10	20	60

As shown in the table 32, more than 50% psychologists totally agreed to all the items. 1(10%) or 2 (20%) psychologists choose disagree to agree option, no one choose totally disagree option.

Credibility from parents (section 1: phase 2)

Table 33

Percentage of credibility from parents (N=18)

	Item	Totally disagree (%)	Disagree (%)	Sometimes (%)	Agree (%)	Totally agree (%)
1	My child enjoyed the task	5.55	5.55	55.55	33.35	
2	Activities were appropriate for child's age	5.55	11.11	55.55	33.34	
3	Instruction for the activities were easy to understand for the child		5.55	22.22	11.11	61.12
4	Materials for the activities were easy to collect and within ability		11.11	16.66	33.33	38.90
5	My child felt good to do the activities		5.55	11.11	22.22	61.12
6	My child's anxiety level is decreasing		5.55	5.55	27.77	61.11
7	My child's anger level is decreasing		5.55	22.22	16.66	55.55

As exhibited in table 33, total 18 parents attended all the session. From 20 parents including father and mother of 10 children, 2 fathers were dropout in respectively 2nd and 3rd session so that their statement were not included in the credibility test. Total 18 parents attended all the session regularly. Out of 18 parents 10 (55.55%) parents were "totally agree" to the items of enjoyment of the activities, appropriateness of the

activities, understandability and 11 (61.11%) parents gave opinion that their children's level of anxiety was decreasing and 10 (55.55) parents accounted that the level of anger of the children was decreasing. For the item children also liked to do the activities, parents' opinion was to "agree" was 61.12%. 55.55% parents said their children enjoyed the activities "sometimes", out of 18 parents 6 gave the opinion they agree to the of item their children enjoyed the activities. 55.55% parents think that the activities were appropriate to decrease the anxiety and anger level. Out of 18 parents 7 (38.90%) shared that the materials which were used to do the activities were easy to collect and those were economically affordable. 16.66% gave opinion materials were sometimes available but all the materials were not economically affordable. Three parents out of 18 said, they faced difficulties to collect the materials that means 16.66% parents choose the "sometimes" option. Out of 18 parents 4 (22.22%) parents did not think that the level of anger was decreasing slowly, they choose the option "sometimes", 5.55% parents thought the level of anger was not changed. So, out of 18 parents 7 to 11 parents shared their opinion that the selected and applied activities for intervention were effective for decreasing the level of anxiety, anger and the language –instruction were understandable for the children.

Feedback

"Presence registers" was collected for all the sessions. At the completion of the intervention session children, parents, psychologists had to mandatory to complete treatment credibility questionnaire subsequent/former session. Also vivid feedback also collected for improvising the intervention activities. Some selected numbers of the descriptive/verbatim included in the research in the end of the result section for better/clear understanding for the effectiveness of the treatment.

Section 2

To attain the 2nd general objective, section 2 was imputed in the result section. Before starting the section 2 result, have a look at the 2nd general objective:

General Objective:

The 2nd primary objective of the present study was to -

1) Assess the effectiveness of adapted Child Focused Cognitive Behavior Therapy as an intervention.

Specific Objective

For the second general objective, the specific objective was to assess the effectiveness of the adapted child focused CBT activities for intervention by

a) Anxiety and Anger subscales of Bangla adapted Beck Youth Inventory
b) Comparison of case group with 3 control groups
c) Treatment credibility questionnaires

Table 34

Frequency distribution of anxiety level in pre and post intervention of Case Group (N=49)

Anxiety level	**Frequency of the sample**		**Percentage of the sample (%)**	
	Pre-intervention	**Post-Intervention**	**Pre-intervention**	**Post-Intervention**
Extremely Elevated	42		85.7	
Moderately Elevated	7	3	14.3	6.1
Mildly Elevated		11		22.4
Average		35		71.4

As shown in Table 34, the frequency distribution of the 49 children who were allocated in case group randomly.

Figure 19

Frequency distribution of anxiety level in pre and post intervention of Case Group (N=49)

Table 35

Difference between pre and post intervention mean scores of sub-scale anxiety of Case Group, N=49

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	48.75	10.48	18.88	3.27	5.39**
	11 to 14	48.08	9.69	19.31	5.32	-1.69 *
Girls	**7 to 10**	48.89	8.67	19.56	2.89	3.14*
	11 to 14	46.27	5.36	16.27	4.55	-2.75*

*level of significance is 0.5
**level of significance is 0.1

As demonstrated in the table 35, in the pre-intervention assessment the mean score of anxiety for boys of younger group is 48.75 and in the post-intervention assessment the mean score is 18.88. The t-value is 11.39* for the boy's younger group. For girls in younger group, the mean value is 48.89 in pre-intervention session and in post-intervention session, the mean value is 19.56, t-value is 3.14*.

For older group, the mean score is 48.08 and 19.31 for boys in pre and post intervention assessment consecutively, t-value is -1.69 *. In the girls group the mean score is 46.27 and 16.27 in pre and post intervention session respectively, t-value is -2.75*.

Table 36

Frequency distribution of anger level in pre and post intervention of Case Group (N=49)

Anger level	Frequency of the sample		Percentage of the sample (%)	
	Pre-intervention	Post-Intervention	Pre-intervention	Post-Intervention
Extremely Elevated	42		85.7	
Moderately Elevated	7	3	14.3	6.1
Mildly Elevated		18		36.7
Average		28		57.1

As shown in Table 36, the frequency of the case group in anger sub-scale. In the pre-intervention assessment among 49 children, 42 were in extremely elevated level of anger and 7 were in moderately elevated level. In post-intervention assessment 3 children were in moderately elevated level, 18 were in mildly elevated level and 28 children were in average level.

Figure 20

Frequency distribution of anger level in pre and post intervention (N=49)

Table 37

Difference between pre and post intervention mean scores of sub-scale anger of within Case Group (N=49)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	48.12	8.38	20.69	3.57	13.09*
	11 to 14	48.92	11.44	19.62	4.98	9.23 **
Girls	**7 to 10**	49.11	7.86	20.00	2.34	11.10*
	11 to 14	47.36	13.11	18.91	3.67	7.19*

*level of significance is 0.5
**level of significance is 0.1

As demonstrated in the table 37, in the pre-intervention assessment the mean score of anger for boys of younger group is 48.12 and in the post-intervention the mean score is 20.69, t-value is 13.09*, for girls in younger group mean value is 49.11 in pre-intervention and in post-intervention the mean value is 20, t-value is 11.10*. For older group, the mean score is 48.92 and 19.62 for boys in pre and post intervention consecutively, t-value is 9.23 **. In the girls group the mean score is 47.36 and 18.91 in pre and post intervention respectively, t-value is 7.19*.

Table 38

Difference between pre and post intervention mean scores of sub-scale anxiety in between group (Case Group- Boys and girls, N=49)

Age	**Pre-Intervention**			**Post-Intervention**		
	Boys	**Girls**	**t**	**Boys**	**Girls**	**t**
7 to 10	48.75	48.89	0.54	18.88	19.31	7.56**
11 to 14	48.08	46.27	1.37	19.31	16.27	6.98*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 38, in the pre-intervention assessment the mean score of anxiety for boys of younger group is 48.75 and girls in younger group mean value is 48.89, t-value is 0.54. In the post-intervention assessment, the mean score is 18.88 younger boys and 19.31 for younger girls, t-value is 7.56**. For older group, the mean score is 48.08 for boys' group and 46.27 for girls' group in pre-intervention assessment, t-value is 1.37. In post-intervention session, for boys' group mean score is 19.31 and for the girls group the mean score is 16.27, t-value is 6.98*.

Table 39

Difference between pre and post intervention mean scores of sub-scale anger in between group (Case Group- Boys and girls, N=49)

Age	**Pre-Intervention**			**Post-Intervention**		
	Boys	**Girls**	**t**	**Boys**	**Girls**	**t**
7 to 10	48.12	49.11	10.09	20.69	20.00	5.86*
11 to 14	48.92	47.36	9.76	19.62	18.91	7.83*

*level of significance is 0.5

**level of significance is 0.1

As revealed in the table 39, in the pre-intervention assessment the mean score of anger sub-scale for boys of younger group is 48.12 and girls in younger group mean value is 49.11, t-value is 10.09. In the post-intervention assessment, the mean score is 20.69 younger boys and 20.00 for younger girls, t-value is 5.86*. For older group, the mean score is 48.92 for boys' group and 47.36 for girls' group in pre-intervention assessment, t-value is 9.76. In post-intervention session, for boys' group mean score is 19.62 and for the girls group the mean score is 18.91, t-value is 7.83*.

Table 40

Frequency distribution between pre and post intervention of sub-scale anxiety in within group (Case Group- urban and rural, N=49)

		Pre-Intervention		**Post-Intervention**			
Groups	Residence	Extremely Elevated	Moderately Elevated	Extremely Elevated	Moderately Elevated	Mildly Elevated	Average
Case	Urban	18	6	0	3	7	14
	Rural	24	1	0	0	4	21
Control Group	Urban	18	3	18	3		
	Rural	5	1	5	1		
Control Group2	Urban	12	2	0	11	3	
	Rural	11	3	8	5	1	
Control Group3	Urban	21	3	3	5	13	3
	Rural	5	1	1	3	2	0

As displayed in table 40, for anxiety sub-scale, the frequency of the children according to the residential area (rural and urban) in four groups (case group, control group-1, control group-2, control group-3)

Table 41

Frequency distribution between pre and post intervention of sub-scale anger in within group (Case Group- urban and rural, N=49)

Groups	Residence	Pre-Intervention		Post-Intervention			
		Extremely Elevated	Moderately Elevated	Extremely Elevated	Moderately Elevated	Mildly Elevated	Average
Case	Urban	20	4		2	10	12
	Rural	22	3		1	8	16
Control Group1	Urban	20	1	19	2	0	
	Rural	3	3	5	1	0	
Control Group2	Urban	11	3	4	7	3	
	Rural	12	2	3	8	3	
Control Group3	Urban	20	4	3	6	12	3
	Rural	4	2	0	3	3	0

As displayed in table 41, for anger sub-scale, the frequency of the children according to the residential area (rural and urban) in four groups (case group, control group-1, control group-2, control group-3)

Table 42

Difference between pre and post intervention mean scores in within group (Case Group- 7 to 10 years boys, N=16)

Sub-scales	Residential Area	Pre-Intervention		Post Intervention		t
		Mean	SD	Mean	SD	
Anxiety	Urban	46.1	7.41	20.57	7.11	3.04*
	Rural	50.33	6.50	17.56	4.47	5.98**
Anger	Urban	47.71	7.41	21.57	3.40	3.19*
	Rural	48.44	7.03	20.00	4.18	4.80*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 42, in the pre-intervention assessment the mean score of anxiety sub-scale for urban younger boys' sample group is 46.1 and 20.57 for post-intervention assessment, t-value is 3.04*. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural younger boys' sample group is 50.33 and 17.56 for post-intervention assessment, t-value is 5.98**. For anger sub-scale, in the pre-intervention assessment the mean score of anger sub-scale for urban younger boys' sample group is 47.71 and 21.57for post-intervention assessment, t-value is 3.19*. In the pre-intervention assessment, the mean score of anger sub-scale for rural younger boys' sample group is 48.44 and 20.00 for post-intervention assessment, t-value is 4.80*.

Table 43

Difference between pre and post intervention mean scores in within variable (Case Group- 11 to 14 years boys, N=13)

Sub-scales	Residential Area	Pre-Intervention		Post Intervention		t
		Mean	SD	Mean	SD	
Anxiety	Urban	46.50	6.71	20.75	6.60	1.24*
	Rural	50.60	4.15	17.00	4.24	3.33**
Anger	Urban	49.62	7.08	20.38	4.13	5.78**
	Rural	47.80	5.28	18.40	4.82	-.807*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 43, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older boys' sample group is 46.50 and 20.75 for post-intervention assessment, t-value is 1.24*. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural older boys' sample group is 50.60 and 17.00 for post-intervention assessment, t-value is 3.33**.

For older group, in the pre-intervention assessment the mean score of anger sub-scale for urban younger boys' sample group is 49.62 and 20.38 for post-intervention assessment, t-value is 5.78**. In the pre-intervention assessment, the mean score of anger sub-scale for rural older boys' sample group is 47.80 and 18.40for post-intervention assessment, t-value is -.807*.

Table 44

Difference between pre and post intervention mean scores in within variable residential area (urban, rural) (Case Group- 7 to 10 years girls, N=9)

Sub-scales	Residential Area	Pre-Intervention		Post Intervention		t
		Mean	SD	Mean	SD	
Anxiety	Urban	45.67	10.12	20.67	3.78	-1.08*
	Rural	50.50	3.78	19.00	4.98	.50**
Anger	Urban	51.67	7.02	18.33	6.50	3.57*
	Rural	47.83	10.62	20.83	4.26	-.70**

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 44, in the pre-intervention assessment the mean score of anxiety sub-scale for urban younger girls' sample group is 45.67 and 20.67 for post-intervention assessment, t-value is -1.08*. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural younger girls' sample group is 50.50 and 19.00 for post-intervention assessment, t-value is .50**.

For older group, in the pre-intervention assessment the mean score of anger sub-scale for urban younger girls' sample group is 51.67 and 18.33 for post-intervention assessment, t-value is 3.57*. In the pre-intervention assessment, the mean score of anger sub-scale for rural younger girls' sample group is 47.83 and 20.83 for post-intervention assessment, t-value is -.70**.

Table 45

Difference between pre and post intervention mean scores in within group (Case Group- 11 to 14 years girls, N=11)

Sub-scales	Residential Area	Pre-Intervention		Post Intervention		t
		Mean	SD	Mean	SD	
Anxiety	Urban	44.33	5.16	16.67	5.42	3.75
	Rural	48.60	3.36	15.80	3.34	1.31*
Anger	Urban	46.67	4.70	20.17	4.70	-2.23**
	Rural	48.20	6.33	17.40	5.12	4.93*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 45, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older girls' sample group is 44.33 and 16.67 for post-intervention assessment, t-value is 3.75. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural older girls' sample group is 48.60 and 15.80 for post-intervention assessment, t-value is 1.31*.

For older group, in the pre-intervention assessment the mean score of anger sub-scale for urban younger girls' sample group is 46.67 and 20.17 for post-intervention assessment, t-value is -2.23**. In the pre-intervention assessment, the mean score of anger sub-scale for rural older girls' sample group is 48.20 and 17.40 for post-intervention assessment, t-value is 4.93*.

Table 46

Mean difference within group (Case Group- 7 to 10 years boys; urban and rural; N=16)

Sub-scales	Pre-Intervention mean			Post Intervention mean		
	Urban	**Rural**	**t**	**Urban**	**Rural**	**t**
Anxiety	46.1	50.33	4.79	20.57	17.56	3.53*
Anger	47.71	48.44	-1.69	21.57	20.00	7.49**

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 46, in the pre-intervention assessment the mean score of anxiety sub-scale for urban younger boys' sample group is 46.1 and for rural younger boys' sample group is 50.33, t value is 4.79. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 20.57 and in rural group is 17.56, t-value is 3.53*.

In the pre-intervention assessment, the mean score of anger sub-scale for urban younger boys' sample group is 47.71 and for rural sample mean score is 48.44, t value is -1.69. In the post-intervention assessment, the mean score of anger sub-scale for urban younger boys' sample group is 21.57 and in rural group is 20.00, t-value is 7.49**.

Table 47

Mean difference within group (Case Group- 11 to 14 years boys; urban and rural; N=13)

Sub-scales	Pre-Intervention mean			Post Intervention mean		
	Urban	**Rural**	**t**	**Urban**	**Rural**	**t**
Anxiety	46.50	50.60	3.29	20.75	17.00	2.75*
Anger	49.62	47.80	1.93	20.38	18.40	3.95*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 47, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older boys' sample group is 46.50 and for rural older boys' sample group is 50.60, t value is 3.29. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 20.75 and in rural group is 17.00, t-value is 2.75*.

In the pre-intervention assessment, the mean score of anger sub-scale for urban older boys' sample group is 49.62 and for rural sample mean score is 47.80 t value is 1.93. In the post-intervention assessment, the mean score of anger sub-scale for urban younger boys' sample group is 20.38 and in rural group is 18.40, t-value is 3.95*.

Table 48

Mean difference within group (Case Group- 7 to 10 years girls; urban and rural; N=9)

Sub-scales	Pre-Intervention mean			Post Intervention mean		
	Urban	**Rural**	**t**	**Urban**	**Rural**	**t**
Anxiety	45.67	50.50	4.68*	20.67	19.00	4.32*
Anger	51.67	47.83	2.95**	18.33	20.83	6.83*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 47, in the pre-intervention assessment the mean score of anxiety sub-scale for urban younger girls sample group is 45.67 and for rural younger girls' sample group is 50.50, t value is 4.68. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 20.67 and in rural group is 19.00, t-value is 4.32*.

In the pre-intervention assessment, the mean score of anger sub-scale for urban older boys' sample group is 51.67 and for rural sample mean score is 47.83, t value is 2.95*, In the post-intervention assessment, the mean score of anger sub-scale for urban younger girls' sample group is 18.33 and in rural group is 20.83, t-value is 6.83*.

Table 49

Mean difference within group (Case Group- 11 to 14 years girls; urban and rural; N=11)

Sub-scales	Pre-Intervention mean			Post Intervention mean		
	Urban	**Rural**	**t**	**Urban**	**Rural**	**t**
Anxiety	44.33	48.60	4.68	16.67	15.80	4.32*
Anger	46.67	48.20	2.95	20.17	17.40	6.83*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 49, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older girls' sample group is 44.33 and for rural older girls' sample group is 48.60, t value is 4.68. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 16.67 and in rural group is 15.80, t-value is 4.32*.

In the pre-intervention assessment, the mean score of anger sub-scale for urban older girls' sample group is 46.67 and for rural sample mean score is 48.20 t value is 2.95. In the post-intervention assessment, the mean score of anger sub-scale for urban older girls' sample group is 20.17 and in rural group is 17.40, t-value is 6.83*.

Table 50

Frequency distribution of anxiety level in pre and post intervention within Control Group-1 (N=27)

Anxiety level	Frequency of the sample		Percentage of the sample (%)	
	Pre-intervention	Post-Intervention	Pre-intervention	Post-Intervention
Extremely Elevated	23	23	82.1	82.1
Moderately Elevated	4	4	14.3	14.3
Mildly Elevated				
Average				

As shown in table 50, in pre intervention assessment among 27 children 23 were in extremely elevated level of anxiety and 4 were in moderately elevated level, in post intervention assessment 23 were in extremely elevated level and 4 were in moderately elevated level.

Figure 21

Frequency distribution of anxiety level in pre and post intervention within Control Group-1 (N=27)

Table 51

Difference between pre and post intervention mean scores of sub-scale anxiety within Control Group-1 (N=27)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	51.17	5.63	47.17	4.56	.77
	11 to 14	43.86	7.44	44.43	5.34	-.13
Girls	**7 to 10**	47.50	7.21	40.00	2.48	1.89
	11 to 14	49.17	8.73	32.50	3.79	4.19

*level of significance is 0.5

**level of significance is 0.1

As demonstrated in the table 51, in the pre-intervention assessment the mean score of anxiety for boys of younger group is 51.17 and in the post-intervention the mean score is 47.17, t-value is .77, for girls in younger group mean value were 47.50 in pre-intervention and in post-intervention the mean value is 40.00, t-value is 1.89.

For older group, the mean score is 43.86 and 44.43 for boys in pre and post intervention consecutively, t-value is -.13. In the girls group the mean score is 49.17 and 32.50 in pre and post intervention respectively, t-value is 4.19.

Table 52

Frequency distribution of anger level in pre and post intervention within Control Group-1 (N=27)

Anger level	**Frequency of the sample**		**Percentage of the sample (%)**	
	Pre-intervention	**Post-Intervention**	**Pre-intervention**	**Post-Intervention**
Extremely Elevated	23	24	82.1	85.7
Moderately Elevated	4	3	14.3	10.7
Mildly Elevated				
Average				

As shown in Table 52, in pre intervention assessment among 27 children 23 (82.1%) were in extremely elevated level of anger and 4 (14.3%) were in moderately elevated level, in post intervention assessment 24 (85.7%) in extremely elevated level and 3 (10.7%) were in moderately elevated level.

Figure 22

Frequency distribution of anger level in pre and post intervention within Control Group-1 (N=27)

Table 53

Difference between pre and post intervention mean scores of sub-scale anger within Control Group-1 (N=27)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	52.17	10.48	41.83	6.87	2.41
	11 to 14	48.71	12.69	42.86	4.55	1.22
Girls	**7 to 10**	46.50	5.83	42.50	7.34	1.94
	11 to 14	44.17	8.16	44.67	3.59	-.15

**level of significance is 0.1

*level of significance is 0.5

As demonstrated in the table 53, in the pre-intervention assessment the mean score of anger for boys of younger group is 52.17 and in the post-intervention the mean score is 41.83, t-value is 2.41, for girls in younger group mean value is 46.50 in pre-intervention and in post-intervention the mean value is 42.50, t-value is 1.94.

For older group, the mean score is 48.71 and 42.86 for boys in pre and post intervention consecutively, t-value is 1.22. In the girls group the mean score is 44.17 and 44.67 in pre and post intervention respectively, t-value is -.15.

Table 54

Frequency distribution of anxiety level in pre and post intervention within Control Group-2 (N=28)

Anxiety level	**Frequency of the sample**		**Percentage of the sample (%)**	
	Pre-intervention	**Post-Intervention**	**Pre-intervention**	**Post-Intervention**
Extremely Elevated	23	8	82.1	28.6
Moderately Elevated	5	16	17.9	57.1
Mildly Elevated		4		14.3
Average				

As shown in table 54, in pre intervention assessment among 28 children 23 (82.1%) were in extremely elevated level of anxiety and 5 (17.9%) were in moderately elevated level, in post intervention assessment 4 (14.3%) children were in average level, 16 (17.9%) children were in moderately elevated level and 8 (28.6%) were in extremely elevated level.

Figure 23

Frequency distribution of anxiety level in pre and post intervention within Control Group-2 (N=28)

Table 55

Difference between pre and post intervention scores of sub-scale anxiety within Control Group-2 (N=28)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	46.5	5.64	34.62	5.76	5.95
	11 to 14	45.33	6.05	30.78	3.25	2.72
Girls	**7 to 10**	46.40	4.24	34.00	6.78	1.94
	11 to 14	45.17	6.61	29.17	2.57	4.07*

*level of significance is 0.5

**level of significance is 0.1

As demonstrated in the table 55, in the pre-intervention assessment the mean score of anxiety for boys of younger group is 46.50 and in the post-intervention the mean score is 34.62, t-value is 5.95, for girls in younger group mean value is 46.40 in pre-intervention and in post-intervention the mean value is 34.00, t-value is 1.94.

For older group, the mean score is 45.33 and 30.78 for boys in pre and post intervention consecutively, t-value is 2.72. In the girls group the mean score is 45.17 and 29.17 in pre and post intervention assessment respectively, t-value is 4.07*.

Table 56

Frequency distribution of anger level in pre and post intervention within Control Group-2 (N=28)

Anger level	Frequency of the sample		Percentage of the sample (%)	
	Pre-intervention	Post-Intervention	Pre-intervention	Post-Intervention
Extremely Elevated	23	7	82.1	25.0
Moderately Elevated	5	15	17.9	53.6
Mildly Elevated		6		21.4
Average				

As shown in table 56, in pre intervention assessment among 28 children 23 (82.1%) were in extremely elevated level of anger and 5 (17.9%) were in moderately elevated level, in post intervention assessment 7 (25.0%) were in extremely elevated level, 15 (53.6%) were in moderately elevated level and 6 (21.4%) were in mildly elevated level.

Figure 24

Frequency distribution of anger level in pre and post intervention within Control Group-2 (N=49)

Table 57

Difference between pre and post intervention scores of sub-scale anger within Control Group-2 (N=28)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	**SD**	**Mean**	**SD**	**t-value**
Boys	**7 to 10**	50.00	5.32	35.00	3.65	4.55*
	11 to 14	47.78	3.39	28.00	3.85	5.06
Girls	**7 to 10**	45.40	6.10	30.00	1.45	5.63
	11 to 14	45.17	4.47	30.17	2.36	2.94*

*level of significance is 0.5

**level of significance is 0.1

As demonstrated in the table 57, in the pre-intervention assessment the mean score of anger for boys of younger group is 50.00 and in the post-intervention the mean score is 35.00, t-value is 4.55*, for girls in younger group mean value is 45.40 in pre-intervention and in post-intervention the mean value is 30.00, t-value is 5.63.

For older group of boys, the mean score is 47.78 and 28.00 in pre and post intervention consecutively, t-value is 5.63. In the girls group the mean score is 45.17 and 30.17 in pre and post intervention assessment respectively, t-value is 2.94*.

Table 58

Frequency distribution of anxiety level in pre and post intervention within Control Group-3 (N=30)

Anxiety level	**Frequency of the sample**		**Percentage of the sample (%)**	
	Pre-intervention	**Post-Intervention**	**Pre-intervention**	**Post-Intervention**
Extremely Elevated	25		83.3	
Moderately Elevated	5	3	16.6	10.00
Mildly Elevated		11		36.66
Average		16		53.33

As shown in table 58, in pre intervention assessment among 30 children 25 (83.3%) were in extremely elevated level of anxiety and 5 (16.6%) were in moderately elevated level, in post intervention assessment 3 (10.00%) were in moderately elevated level, 11 (36.6%) were in mildly elevated level and 16 (53.33%) were in average level.

Figure 25

Frequency distribution of anxiety level in pre and post intervention within Control Group-3 (N=30)

Table 59

Difference between pre and post intervention mean scores of sub-scale anxiety within Control Group-3 (N=30)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	48.00	7.58	30.33	5.98	5.70*
	11 to 14	46.00	5.05	32.12	4.33	3.25*
Girls	**7 to 10**	47.33	7.63	28.33	6.73	7.46
	11 to 14	46.43	6.87	21.57	3.86	0.57**

*level of significance is 0.5

**level of significance is 0.1

As demonstrated in the table 59, the mean score of anxiety in the pre-intervention assessment for boys of younger group is 48.00 and in the post-intervention the mean score is 30.33, t-value is 5.70*, for girls in younger group mean value is 47.33 in pre-intervention and in post-intervention the mean value is 28.33, t-value is 7.46.

For older group, the mean score is 46.00 and 32.12 for boys in pre and post intervention consecutively, t-value is 3.25*. In the girls' group the mean score is 46.43 and 21.57 in pre and post intervention assessment respectively, t-value is 9.57**.

Table 60

Frequency distribution of anger level in pre and post intervention within Control Group-3 (N=30)

Anxiety level	**Frequency of the sample**		**Percentage of the sample (%)**	
	Pre-intervention	**Post-Intervention**	**Pre-intervention**	**Post-Intervention**
Extremely Elevated	22		73.33	
Moderately Elevated	8		26.66	
Mildly Elevated		19		63.33
Average		11		36.66

As shown in table 60, in pre intervention assessment among 30 children 22 (73.33%) were in extremely elevated level of anger and 8 (26.66%) were in moderately elevated level, in post intervention assessment no one in extremely or moderately elevated level. In post-intervention assessment 19 (63.33%) children were in mildly elevated level and 11 (36.66) children were in average level.

Figure 26

Frequency distribution of anger level in pre and post intervention within Control Group-3 (N=30)

Table 61

Difference between pre and post intervention scores of sub-scale anger within Control Group-3 (N=30)

Sex	Age (years)	Pre-Intervention		Post-intervention		
		Mean	SD	Mean	SD	t-value
Boys	**7 to 10**	53.83	10.63	30.17	6.79	5.45**
	11 to 14	48.62	7.25	28.50	3.38	7.84
Girls	**7 to 10**	45.11	5.99	27.00	5.64	4.94*
	11 to 14	44.14	6.97	20.57	2.94	5.21**

*level of significance is 0.5

**level of significance is 0.1

As demonstrated in the table 61, in the pre-intervention assessment the mean score of anger for boys of younger group is 53.83 and in the post-intervention the mean score is 30.17, t-value is 5.45**, for girls in younger group mean value is 45.11 in pre-intervention and in post-intervention the mean value is 27.00, t-value is 4.94*.

For older group of boys, the mean score is 48.62 and 28.50 in pre and post intervention consecutively, t-value is 7.84. In the girls group the mean score is 44.14 and 20.57 in pre and post intervention assessment respectively, t-value is 5.21**.

Table 62

Mean score of all four groups in pre and post intervention assessment according to age, sex in sub scale- anxiety (case group n=49, control group-1 n=27, control group-2 n=28 and control group-3 n=30, N=134)

Sex	Age (yrs.)	Pre-Intervention				Post-intervention			
		Case g.	Control group 1	Control group 2	Control group 3	Case g.	Control group 1	Control group 2	Control group 3
Boys	7-10	48.75	51.17	46.5	48.00	18.88	47.17	34.62	30.33
	11-14	48.08	43.86	45.33	46.00	19.31	44.43	30.78	32.12
Girls	7-10	48.89	47.50	46.40	47.33	19.56	40.00	34.00	28.33
	11-14	46.27	49.17	45.17	46.43	16.27	32.50	29.17	21.57

Table 62 demonstrated the mean score of all the groups in anxiety sub-scale. Mean score in pre-intervention and post-intervention has been presented in this table. Total number of the sample is 134, among them 107 children received different intervention techniques in different session, only 27 children in control group-1 did not receive any intervention. Mean value is decreasing in the post intervention assessment.

Table 63

Mean score of all four groups in pre and post intervention assessment according to age, sex in sub scale- anger (case group n=49, control group-1 n=27, control group-2 n=28 and control group-3 n=30, N=134)

Sex	Age (yrs.)	Pre-Intervention				Post-intervention			
		Case g.	Control group 1	Control group 2	Control group 3	Case g.	Control group 1	Control group 2	Control group 3
Boys	7-10	48.12	52.17	50.00	53.83	20.69	41.83	35.00	30.17
	11-14	48.92	48.71	47.78	48.62	19.62	42.86	28.00	28.50
Girls	7-10	49.11	46.50	45.40	45.11	20.00	42.50	30.00	27.00
	11-14	47.36	44.17	45.17	44.14	18.91	44.67	30.17	20.57

Table 63 demonstrated the mean score of all the groups in anger sub-scale.

Mean score in pre-intervention and post-intervention has been presented in this table.

Table 64

Mean score difference between groups (case group vs control group-1, n=77; case group vs control group-2, n=76; case group vs control group-3, n=79) age level from 7 to 10 years boys

	Groups	Pre-intervention			Post-intervention		
		Mean	SD	t	Mean	SD	t
Anxiety	Case g.	48.75	10.48		18.88	3.27	
	ControlG1	51.17	12.63	.14	47.17	4.56	9.90*
	Case g.	48.75	10.48		18.88	3.27	
	ControlG2	46.5	5.64	1.39	34.62	5.76	7.64**
	Case g.	48.75	10.48		18.88	3.27	
	ControlG3	48.00	7.58	1.32	30.33	5.98	3.16*
Anger	Case g.	48.12	8.38		20.69	3.57	
	ControlG1	52.17	10.48	-.87	41.83	6.8	10.63*
	Case g.	48.12	8.38		20.69	3.57	
	ControlG2	50.00	9.32	.54	35.00	7.65	8.65*
	Case g.	48.12	8.38		20.69	3.57	
	ControlG3	53.83	10.63	1.29	30.17	6.79	3.44*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 64, t statistics calculated the difference among the mean score in the between group. The age range of the group was from 7 years to 10 years. This table had shown the statistics of the boy's group. The groups are: Case group vs Control Group-1, Case Group vs Control Group-2 and Case Group vs Control Group-3.

Table 65

Mean score difference between groups (case group vs control group-1,n=77; case group vs control group-2, n=76; case group vs control group-3,n=79) age level from 11 to 14 years boys

	Groups	**Pre-intervention**			**Post-intervention**		
		Mean	SD	t	Mean	SD	t
Anxiety	Case g.	48.08	9.69		19.31	5.32	
	ControlG1	43.86	11.44	1.54	44.43	5.34	10.32*
	Case g.	48.08	9.69		19.31	5.32	
	ControlG2	45.33	16.05	.42	30.78	3.25	3.31*
	Case g.	48.08	9.69		19.31	5.32	
	ControlG3	46.00	12.05	.09	32.12	4.33	3.75**
Anger	Case g.	48.92	11.44		19.62	6.98	
	ControlG1	48.71	12.69	1.00	42.86	4.55	8.40*
	Case g.	48.92	11.44		19.62	6.98	
	ControlG2	47.78	8.39	.63	28.00	3.85	4.33*
	Case g.	48.92	11.44		19.62	6.98	
	ControlG3	48.62	7.25	.21	28.50	3.38	-3.10**

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 65, t statistics calculated the difference among the mean score in the between group. The age range of the group was from 11 years to 14 years. This table had shown the t-statistics of the boy's group.

Table 66

Mean score difference between groups (case group vs control group-1,n=77; case group vs control group-2, n=76; case group vs control group-3,n=79) age level from 7 to 10 years girls

	Groups	Pre-intervention			Post-intervention		
		Mean	SD	t	Mean	SD	t
Anxiety	Case g.	48.89	8.67		19.56	2.89	
	ControlG1	47.50	11.21	.48	40.00	2.48	-2.71*
	Case g.	48.89	8.67		19.56	2.89	
	ControlG2	46.40	14.24	-.90	34.00	6.78	6.18*
	Case g.	48.89	8.67		19.56	2.89	
	ControlG3	47.33	7.63	.66	28.33	6.73	3.52*
Anger	Case g.	49.11	7.86		20.00	2.34	
	ControlG1	46.50	5.83	.45	42.50	7.34	5.61*
	Case g.	49.11	7.86		20.00	2.34	
	ControlG2	45.40	6.10	1.73	30.00	6.45	3.53**
	Case g.	49.11	7.86		20.00	2.34	
	ControlG3	45.11	10.99	.95	27.00	5.64	0.56*

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 66, t statistics calculated the difference among the mean score in the between groups. The age range of the group was from 7 years to 10 years. This table had shown the statistics of the girls' group.

Table 67

Mean score difference between groups (case group vs control group-1,n=77; case group vs control group-2, n=76; case group vs control group-3,n=79) age level from 11 to 14 years girls

	Groups	Pre-intervention			Post-intervention		
		Mean	SD	t	Mean	SD	t
Anxiety	Case g.	46.27	11.36	-.35	16.27	4.55	7.18*
	ControlG1	49.17	9.73		32.50	3.79	
	Case g.	46.27	11.36	1.75	16.27	4.55	3.54*
	ControlG2	45.17	9.61		29.17	2.57	
	Case g.	46.27	11.36	.21	16.27	4.55	0.87**
	ControlG3	46.43	6.87		21.57	3.86	
Anger	Case g.	47.36	13.11	.08	18.91	3.67	3.53*
	ControlG1	44.17	8.16		44.67	3.59	
	Case g.	47.36	13.11	-.13	18.91	3.67	4.44**
	ControlG2	45.17	12.47		30.17	2.36	
	Case g.	47.36	13.11	.39	18.91	3.67	1.34*
	ControlG3	44.14	11.97		20.57	2.94	

*level of significance is 0.5

**level of significance is 0.1

As shown in the table 67, t statistics calculated the difference among the mean score ointhe between group. The groups are: Case group vs Control Group 1, Case Group vs Control Group 2 and Case Group vs Control Group 3. The age range of the group was from 11 years to 14 years. This table had shown the statistics of the girl's group.

Qualitative assessment of the activities for intervention

In addition to quantitative approach, the effectiveness of the child focused cognitive behavior therapy activities for intervention was also examined with treatment credibility questionnaires.

Credibility from child (section 2)

Table 68

Percentage of credibility from children ((N=49)

	Item	No (%)	Sometimes (%)	Yes (%)
1	I enjoyed the activities	4.08	12.24	83.68
2	Instructions language were easy to understand		10.20	89.80
3	Steps of the activities were easy to followed	8.16	6.12	85.72
4	Psychologist's appearance was friendly when activities were administered	4.08		95.92
5	I felt good to listen and to do the activities	6.12	4.08	89.80

As shown in table 68, children articulated their opinion about the activities for intervention. This group was the case group who practiced the Bangla adapted child focused CBT activities for the intervention. Out of 49 children most of them chose “yes” option for the five statement in the credibility test.

Credibility from psychologist (section 2)

Table 69

Percentage of credibility from psychologists ((N=10)

	Item	Totally disagree (%)	Disagree (%)	Sometimes (%)	Agree (%)	Totally agree (%)
1	Easy to explain the activities			10	10	80
2	Language was fluent and comfortable				10	90
3	Language was appropriate to child's age				10	90
4	Words were very feasible and harmonious				10	90
5	Activities sequence was appropriate for the session			10		90
6	Activities were socio-economically and culturally appropriate			10		90
7	Child's behavioral and mental issues were easily identified and solvable by the activities				10	90
8	Activities were structured				10	90
9	Activities were completed within time frame			10		90
10	Children can do the activities practically				10	90

As shown in the table 69, 1(10%) psychologist gave opinion by "sometimes" option for the statement that indicates they are satisfied with the Bangla adapted child focused CBT activities.

Credibility from parents (section 2)

Table 70

Percentage of credibility from parents ((N=49)

	Item	Totally disagree (%)	Disagree (%)	Sometimes (%)	Agree (%)	Totally agree (%)
1	My child enjoyed the task			2.04	4.08	93.88
2	Activities were appropriate for child's age				6.12	93.88
3	Instruction for the activities were easy to understand for the child			2.04	8.16	89.80
4	Materials for the activities were easy to collect and within our ability			10.20	2.04	87.86
5	My child felt good to do the activities			2.04	2.04	95.92
6	My child’s anxiety level is decreasing				6.12	93.88
7	My child's anger level is decreasing				4.08	95.92

As exhibited in table 70, only the parents from case group gave their opinion about the activities, session and the changes of the children. Here, only one parents either father or mother filled up the credibility questionnaires who came with the child in the session regularly.

Feedback:

- To find out the ratings of effectiveness, in addition to quantitative approach, the researcher also wanted to focus on child's feedback. Their feedback was recorded in written format with credibility questionnaires. Their feedback was satisfactory enough that the psychologists might apply those activities for intervention in field level.
- In particular when the children practiced relaxation by balloon, rag doll they were making lots of fun activities with balloon, doll and when conducted imaginary relaxation their expression was so much peaceful, their eyes were like they were in another world and enjoy their calm place, safe place, be in cloud. When they came back to the room they felt the energy in their body and asked to do other activities and repeatedly said to their parents to give them the paper, pen, board to do the activities in home.
- In younger group they were happy to be relaxed and do the fun tasks. They also enjoyed the time with their parents and family members.
- In older group they enjoyed that they can think about their surrounding differently and they tried to change their point of view. They focused on their value of relationship, their nurturing patterns, and parent's efforts. They tried to find out the negative trap and broke up the tie and looked at the reason to solve the problem and their success was their reward. They practiced positive self-talk to give reward to them self's. They found out the way to praise own self and to accept others' also.

Verbatim

Verbatim is the using of exactly the same words or corresponding word for word. It is following the original word for word. In this result section verbatim were recorded as qualitative references to see the effectiveness of the child focused CBT activities for intervention.

From children

1. *I enjoyed breathing through the hand gloves and balloons.(3rd session)*
2. *It was hard to understand the speech of the psychologist but I enjoyed while doing the activities or tasks. (5th session)*
3. *If more time was given, it would have better. (7th session)*
4. *If I get upset at home, I can now relax myself. (6th session)*
5. *I was excited drawing the picture of Heart. I now know who is my dearest friend. (6th session)*
6. *While on bed before sleeping, I dream of myself to be in the forest. (5th session)*
7. *I do not lose my temper very easily nowadays. (7th session)*
8. *Now, I do not face any difficulty in breathing. (8th session)*
9. *Now, I can recognize anger on my mother's face. (9th session)*
10. *When I am bombarded with negative thoughts into my head, I can confine them in the "Worry Box". Then I take a long breath through balloons and I get relaxed. (8th session)*
11. *I seem like accomplishing many more things by looking at my Success Stair. (10th session)*

12. Now, I do not worry as like before and I do not feel that much pain as like before. *(11th session)*
13. When I walk along the rain forest, I think that I am roaming around in my dream world. *(9th session)*
14. I feel so very light when I think that I am gliding on the clouds. *(8th session)*
15. Now, I myself can find out why I get angry. *(7th session)*
16. Now, by looking at the face of my father, I can understand his anger beforehand. *(5th session)*
17. I can appraise myself standing before the mirror. *(5th session)*
18. When I feel upset, I open my bag of happy elements and by seeing those beautiful things, I forget my sorrows. *(13th session)*

From parents'

1. The child sleeps well now and if told to sleep alone, he/she does not get angry. *(5th session)*
2. It takes much time to do the works. *(6th session)*
3. Do you really think that this time maintenance for sessions is possible because we have works to do at home?! *(7th session)*
4. After doing these works and tasks, the child always wants to play nowadays. *(9th session)*
5. If something happens otherwise, he/she says that he/she would remove us from his/her heart. *(5th session)*
6. He/she always thinks that whatever he/she wants, we would provide him/her with that. Is it possible, what you say? *(8th session)*

7. If he/she spends this much time in drawing, when will he/she read? *(9th session)*
8. He/she wants to do the 'relaxation' impermanently frequently. How many times are possible? *(7th session)*
9. He/she always wants to create something new. *(12th session)*
10. He/she always wants to measure the mood of him/her and mine. *(13th session)*
11. He/she is always asking questions about something. We are tired of giving answers to his/her meaningless questions about anything and everything. *(9th session)*
12. I do not feel good about doing sessions for this long time. *(6th session)*
13. Aunty always gives me something or anything one after another. The tasks are playful but I do not like doing this much of work at one go. *(5th session)*

Observation of the researcher and psychologists

It was observed that the children responded well to play with puppets dolls. They liked to paint the emotions on the faces, family pictures, heartstrings. Now they can place the person according to closeness in their heart. They especially liked making paper puppets, success tree; they liked to draw the stairs of their success. Older children were more engrossed in the positive self-talk, positive glass experiments. Most young aged children enjoyed the happy elements bag and they open up the bag whenever they want.

Discussion

CBT is more about discovering thought patterns; it is focused on applying various techniques to assist the client to overcome these negative thoughts. With the collaboration of CT and BT, Cognitive-behavioral therapy is a form of conversation concentrated on explaining, analyzing, and rationalizing a client's destructive, irrational or illogical beliefs, thinking processes, and activities. This goal is accomplished by thought-provoking and challenging cognitive dysfunction and reframing irrational thoughts to more rational thoughts. Child-focused CBT is beached on an ever-evolving structure of patients' difficulties. In cognitive terms, it is an individual conceptualization of every single client or child. The existing thinking configurations of the child or client and challenging behaviors are identified and acknowledged. Several features must be well-thought-out with the clients' or child's life experiences. To construct a whole accurate view of the child's present situation or behavior, based on the information gathered by parents, caregiver, and child Conceptualization of the case is formulated. Child-focused CBT demonstrates children or clients to detect, estimate, and react to their maladaptive behavior or challenging behavior, dysfunctional or irrational thought processes, and core negative beliefs. The psychologist or therapist plays the role of assistance to the child or clients to detect the key cognitions and embrace additional accurate, balanced, rational thoughts and perspectives.

In a UNICEF report in 2017, we see that there are 57 million accounted for children and adolescents. Another research published by Statista research department on 17 February 2020, rounds about 26.57 percent of the population in Bangladesh was aged up to 14 years old in 2020. According to the Statista research department, the young

population rate is decreasing, the percentage was 32 in 2011. Bangladesh, home to 160 million people, is one of the most densely populated countries in the world. The size of the urban population in Bangladesh is 53 million. Of them, around 40 percent are children. The representation of anxiety disorder occurrence in Bangladesh is somewhat similar to the developing country's rate. A Bangladeshi study showed that 16.14% of outpatients of the National Institute of Mental Health (NIMH) had anxiety disorders (Mohit et al., 2001). In a Bangladeshi sample of 5 to 10 years, the prevalence rate for psychopathology was11 to 21% (Mullick & Goodman, 2005). The prevalence is probably higher in adolescents (Ford et al., 2003). The conservative assumption was that 10% of Bangladeshi children and adolescents showed childhood psychopathology (Mullick & Goodman, 2005) though the statistics only on anxiety disorders are not available. In a nationwide community survey prevalence of psychopathology was found to be 16.05%. Among them 2.9% had GAD, 1.3% panic disorder, 0.9% agoraphobia, 0.5% obsessive compulsive disorder (OCD) and 0.3% simple phobia (Firoz et al., 2006). Another study reported that among 206 mentally ill patients, 7.3% had anxiety neurosis, 6.8% GAD, 4.9% OCD, 2% panic disorder, 1% agoraphobia, 0.4% phobia, and 0.4% mixed anxiety and depressive disorder (Chowdhury, Yasmeen, Chowdhury & Hakim, 2011).

WHO-AIMS report on mental health system in Bangladesh: A report of the assessment of the mental health system in Bangladesh using the World Health Organization – Assessment Instrument for Mental Health Systems (WHO-AIMS). *Dhaka, Bangladesh 2007* reported that the total number of human resources working in mental health facilities or private practice per 100,000 populations is 0.49. The breakdown according to profession is as follows: 0.007142857 psychologists,

0.002142857 social workers. The numbers of mental health professionals are not adequate in the cities let alone in the remote areas. In recent years, we have faced social reforms, religious and ethnic suppression, bullying, ragging etc. in schools, colleges, and even in the family. Children and students who face these directly in his or her life or indirectly exposed to those stories by social contacts, social media (facebook, youtube etc.), newspaper, TV news etc. get depressed, anxious, aggressive, violent and traumatized. In this era of free journalism through mobile camera, facebook posts, youtube video etc., it is very easy for any child to be exposed to these kinds of content, posts and events. In a nutshell, there is no filtering whatsoever in terms of content consumption over the internet and mobile. Because of this, disruptive behavior and anger issues among the children are very likely to spread and increase in an alarmingly growing rate. Following strong ethical rules in our national media is a segment where we should have been more careful too. For all these, children are badly affected by anxiety, anger, depression and PTSD. For treatment purpose, as an educational psychologist or counselor, we need to have evidence-based intervention program to address issues like how to regain own self-confidance and how to manage anxiety, depression, aggressiveness, anger and trauma etc. A structured Bangla version of child focused CBT activities for intervention is the highest priority for professional development.

Experiencing emotional states such as anxiety is a universal phenomenon (Spielberger, 2006). Today, the most prevalent mental health problems affecting children and adolescents are anxiety disorders (Beesdo et al., 2009; Waters et al., 2008; Baumeister & Härter, 2007). Anxiety disorders produce adverse social and educational outcomes for youths and interfere with most areas of their lives, the effects of which

might continue to adulthood (Spence et al., 2001). Anxiety and anger can be a toxic combination. seeking treatment for the anxiety disorder can help an individual uncover the reasons for their anger. Being mindful about anger outbursts by keeping a journal and taking time to reflect on why this anger occurred can often help individuals realize their anxiety triggers, and then seek therapy to find healthy ways to cope with them. Anger does not have to be intentional, and with individuals who have an anxiety disorder, this anger is often an automatic reaction to an anxious trigger or the effects of long-standing anxiety. Individuals who have an anxiety disorder are often rigid in their daily routines since the fear of the unknown is often a trigger for their anxiety.

The main objectives of the present study were to adapt the Child Focused Cognitive Behavior Therapy as an intervention for children and assess the effectiveness of adapted Child Focused Cognitive Behavior Therapy as an intervention. To attain these two objectives, the research has been divided in two sections (section 1 & 2). In accordance with the first general objective of the present study, some activities for intervention were translated from different workbooks of CBT which are used world widely. All those activities were reviewed 2 times by children (two groups: one was random regular children and another was children with extremely elevated anxiety, anger level) and professional psychologist working with children. Again, the researcher has divided section-1 in two phases (Phase 1 & 2). To accomplish the phase 1, a number of child focused activities were selected, translated and reviewed. 20 regular random children were taught some techniques. These children also practiced the activities in several sessions. With their feedback and psychologists' constructive opinion by

credibility questionnaires, bangla activities were reviewed and re-constructed which was the researcher's draf-2In phase 2, purposively selected 10 children were skilled with draft-2. After their comments and review, draft-3 was developed.

General objective 2 was administered in section 2 with 3 specific objectives. In section 2, draft-3 was applied to 49 children, who the researcher has termed as Case Group, with extremely elevated or moderately elevated anxiety and anger. There were 3 control groups. Control Group-1 did not receive any intervention; they also did not come to the hospital for their treatment purpose. Control group-2 and 3 were already assessed by other psychologists. There were extremely elevated or moderately elevated anxiety and anger in these children and they received intervention by general instruction and creative therapy respectively. 49 children from the Case group, 28 children from control group 2, and 30 children from control group 3, all attended 14 sessions in 14 weeks. The time duration was 1 hour and 30 minutes for each of the sessions. So, the total number of sessions was 1498 (107 participants multiplied by 14 sessions). After all reviews, draft-3 was applied to 49 children to find out the effectiveness of the intervention which was the 2nd general objective of the research. To assess the effectiveness of adapted Child Focused Cognitive Behavior Therapy as an intervention the acquired scores of 49 children (Case Group) of anxiety and anger levels were compared with three control groups. The session module and activities for intervention have been displayed in table 9 and table 8 respectively. The Bangla adapted activities for intervention has been attached in appendix . The assent form was collected from all of the parents in all 4 groups. All children did not get the intervention at a time in the case group but the same tools were applied for the same issues at different times. The study place is a tertiary level hospital

that's why children are available for treatment purposes but they came here all over Bangladesh. Their language, culture, and socio-economic status are different which also helps the researcher to modify the language, and phrases in the activities. Before allocating the children into three groups (case group, control group 2, and 3) they have been selected purposively by the researcher based on their extremely elevated or mildly elevated level of anxiety and anger by Bangla adapted Beck Youth Inventory. They attended 14 sessions individually in 14 weeks, after completing the sessions all of them were assessed again by the same assessment tool. Their pre and post-assessment scores were compared statistically by descriptive statistics (mean score, SD value, percentage, frequency) and t-test (mean the difference between and within the group). The result is the statistical representation of the study. To prepare the result, the researcher analyzed all the data by computer program SPSS version 16. The data scrutinization was done in several steps. At first, all collected data were screened manually to find out inadequate or abstruse data. To get a total portrayal of the data descriptive statistics were calculated. To describe categorical variables, frequency and percentage were used and by comparing the frequency in pre and post-period and also the percentage the researcher found a proper view of the effectiveness of the Bangla-adapted child-focused CBT activities for intervention. The researcher also calculated the mean and standard deviation used for continuous variables. To evaluate the mean difference t-statistics were applied within the group and between groups also. Qualitative data were also counted as a result of the research, parents, children's, and also psychologists' feedback was collected to explicit the effectiveness of the intervention. Children's and parents' verbatim are presented in the result section. Credibility questionnaires were applied to ensure the opinion of the

children, parents, and psychologists. For all the groups, the credibility questionnaires were different. At the end of the sessions, the credibility questionnaires were filled up separately. The result of the credibility questionnaires was analyzed in quantitative statistics (percentage).

Table 24 and 25 comprises the third specific objectives in first general that was to adapt the child focused CBT activities as an intervention for children. The third specific objective was the review of the language by children and psychologists. The credibility test confirms the review of the language.

As shown in table 24, children articulated their attitudes about the activities for intervention. Most of them chose the "sometimes" option for most of the items. The percentage of their opinion about enjoyment, understandability, instruction following, and feelings was concerning 30% to 60%. That indicates among 20 children 5 (25%) children didn't enjoy the activities. Out of the 20 children, 12 (60%) children thought that the psychologist's appearance was friendly. 11 (55%) enjoyed the activities sometimes and 4 (20%) children enjoyed the activities fully. 12 (60%) children gave the opinion they could understand the instruction whereas 6 (30%) said that they could not understand the instructions and only 2 (10%) shared that they understand the instruction properly.9 (45%) children said that sometimes they could follow the steps whereas (35%) said they could follow the steps easily and 4 (20%) said they did not follow the steps. 6 (30%) children were satisfied with psychologists' appearance but 2 (10%) did not like the appearance of the psychologists. 12 (60%) children said that they felt good listening and doing the activities sometimes whereas 5 (25%) shared the opinion that they did not feel

good doing or listening to the activities at all, 3 (15 %) children totally felt good to do and listen to the activities.

As shown in Table 25, psychologists gave their opinion about the activities for intervention, there were five options: totally disagree, disagree, sometimes, agree and totally agree. For the item of "easy to explain", 2 (40%) psychologists told that activities for intervention were "easy to explain", which corresponds to their choosing of "sometimes". 3 (60%) psychologist gave opinion that language was fluent "sometimes", 1 (20%) gave opinion that language was not fluent, 1 psychologist (20%) agreed that language was fluent. For the item appropriateness of the language, 60% choose sometimes option; in item word's feasibility 60% choose sometimes option. About the activities sequence they only 40% agreed with the presented sequence, only one psychologist (20%) totally agreed with the sequence. 40% gave opinion that sometimes the activities were socio-economically appropriate, 40% psychologist sometimes thought that children's behavior has been solvable, 20 % thought that activities were structured, 40% gave opinion that activities were completed within time they choose "agree" option and 2 psychologists (40%) gave opinion that "sometimes" activities had been completed within time. 20% psychologists gave opinion that activities were practically done by the children.

Table 26 to 33 comprises the fifth specific objectives in first general that was to adapt the child focused CBT activities as an intervention for children. The fifth specific objective was to conduct the first trial of the Bangla adapted child focused CBT activities.

Table 26, demonstrated the frequency of 10 children who were selected purposively for the first trial of Bangla adapted child focused CBT activities for intervention. The researcher selected a small group for the first trial because each child had to attend 14 session and parents also be present with the child. The researcher wanted to make sure all children attended all the session in the first trial. In the tertiary level hospital the dropout rate is very high that interfere the session outcome. The researcher selected only those children whose parents were fully committed to continue the session regularly. The researcher ensured the children didn't dropout in the session so that the continuity of the session had to be maintained strictly. In this group, 4 (40%) children had extremely elevated anxiety with mildly elevated anger, 3 (30%) had extremely elevated anger with mildly elevated anxiety and rest of them, 3 (30%) children had anxiety and anger in extremely elevated level.

As shown in table 27, the frequency of the sample (N=10) in pre and post intervention. In the pre-intervention assessment among 10 children 70% were in extremely elevated level of anxiety and 30% were in moderately elevated level, in post intervention assessment children's level of anxiety was decreasing. The frequency shows that after 14 weeks intervention, 70% children were in average anxiety level and 30% were in mildly elevated anxiety level that indicates no one in extremely or moderately elevated level. It shows that, in pre-intervention assessment children were in extremely elevated level and mildly elevated level and in post-intervention children were in average and mildly elevated level of anxiety after getting 14 weeks intervention session.

As demonstrated in the table 28, the mean score of 10 children in the first trial. There were four groups according to age and sex. Boys were divided in two groups also were girls. In the younger group the age ranges from 7 to 10 years and in older group from 11 to 14 years. In the pre-intervention assessment the mean score of anxiety for boys of younger group is 45, the SD was 5.86 and in the post-intervention assessment the mean score is 22, SD was 3.89. The t-value is 1.9* which is statistically significant at 0.5 level of significance. For the girls in younger group, the mean value is 43 with the SD 3.54 in pre-intervention assessment and in post-intervention assessment the mean value is 18 the SD value is 4.11. The t-value is 0.6** which is statistically significant at 0.1 level of significance.

For older group, the mean score is 44.33, SD is 6.24 and mean score is 19, SD is 5.6 for boys in pre and post intervention assessment consecutively, t-value is 4.9 (CI: -.50 to 3.47) which is non-significant t value. In the girls' group the mean score is 35, SD is 4.24 and mean value 16, SD is 3.54 in pre and post intervention assessment respectively, t-value is 3.3* which is statistically significant at 0.5 level of significance . Here, girl's mean score for anxiety is lower than boys mean score for both younger and older group.

As shown in Table 29, the frequency of the sample (N=10) in pre and post intervention. In the pre-intervention assessment among 10 children 60% were in extremely elevated level of anger and 40% were in moderately elevated level of anger, in post intervention assessment children's level of anger was decreasing. The frequency shows that after 14 weeks intervention, 60% children were in average anger level and 40% were in mildly elevated anger level that indicates no one in extremely or moderately elevated level of anger.

As demonstrated in the table 30, the mean score of 10 children in the first trial. There were four groups according to age and sex. Boys were divided in two groups also were girls. In the younger group the age ranges from 7 to 10 years and in older group from 11 to 14 years. In the pre-intervention assessment the mean score of anger for boys of younger group is 43.67, the SD was 4.58 and in the post-intervention assessment the mean score is 22.67, SD was 5.65. The t-value is 2.9** which is statistically significant at 0.1 level of significance. For the girls in younger group, the mean value is 42.50 with the SD 4.95 in pre-intervention assessment and in post-intervention assessment the mean value is 20 the SD value is 3.49. The t-value is 3.6* which is statistically significant at 0.5 level of significance.

For older group, the mean score is 40.33, SD is 2.33 and mean score is 21.67, SD is 5.6 for boys in pre and post intervention assessment consecutively, t-value is 4.76 (CI: -2.50 to 1.19) which is non-significant t value. In the girls' group the mean score is 44, SD is .70 and mean value 19.50, SD is 4.33 in pre and post intervention assessment respectively, t-value is 4.80 (CI: 2.25 to 4.19) which is not statistically significant. Here, girl's mean score for anxiety is lower than boys mean score for both younger and older group.

In the section 1 phase 2, all of the children, parents and the psychologist had to fill up a credibility questionnaire. Children's credibility questionnaire contained 5 questions about the enjoyment, understandability, easiness to understand the steps, psychologist's appearance and their feelings. As shown in table 31, children articulated their opinion about the activities for intervention. Most of them chose the "yes" option for most of the items. 50% to more children enjoyed the activities, easily understand the

instruction, followed the steps, felt good to hear or do the activities. Their opinion about enjoyment, understandability, instruction following and feelings was, in most of the times, "Yes" which is in between 50% to 70%. Out of the 10 children, out of 10, seven children (70% children) thought that psychologist appearance was friendly. 20% children did not enjoy the activities to do, 30% enjoyed the activities sometimes and 50% children enjoyed the activities fully. 30% children gave the opinion they could understand the instruction sometimes where 10% said that they could not understand the instructions and 60% shared that they understand the instruction properly. 30% children said that sometimes they could follow the steps whereas 50% said they could follow the steps easily and only one child (10%) gave opinion that they did not follow the steps. 70% children were satisfied for psychologists' appearance but 5% did not like the appearance of the psychologists. 50% children said that they felt good to listen and do the activities whereas 30% shared opinion that they feel good to do or listen the activities sometimes not always, 50 % children totally felt good to do and listen the activities.

Compare the percentage with phase 1 credibility shows that, in phase 1, 20% children enjoyed the activities whereas in phase 2, 50% enjoyed the activities totally. 10% children understand the instruction easily in phase 1 and 60% children understand the instruction easily in phase 2. 35% children easily followed the steps in phase 1 whereas 50% children easily followed the steps in phase 2. Their opinion about psychologist's appearance was 60% were satisfied in phase 1 but in phase 2, 70% were satisfied totally. 15% children felt good to do the activities in phase 1 but in phase to 50% felt good to do and to listen the activities.

Psychologists also filled up credibility questionnaires, it contained 10 questions. In section 1 phase 2 the credibility of the activities were shown in the table 32. No one choose the "totally disagree" option in phase 2. 2 (20%) psychologists said that children behavioral and mental issues were not find out easily whereas 60% said they totally agree that children's behavior and mental issues were easily find out by the activities. 7 (70%) gave opinion that the language was appropriate for the children. 3 psychologists (30%) said they were agree to the fluency of the language. 1 psychologist (10%) chose the option "disagree" for the items of easy to explain, fluency of the language, age appropriateness of the language, feasibility of the words, appropriateness of the words, cultural-socio economical appropriateness, time frame and practice based activities. 1 or 2 psychologist chose the option sometimes for these items that indicates the activities, words, sequences, materials, practice based tasks need to be reviewed. These percentages can be compared with phase 1 credibility of the psychologists. In the phase 1, 0% chose totally agree option for easy to explain the activities whereas in the phase 2, 60% chose "totally agree option" for the item. In the phase 1, 0% said they were "totally agree" that the language was fluent, comfortable, age appropriate for the children and in the phase 2, 70% was totally agree with the statement. For the statement, words were feasible and harmonious 60% psychologists were totally agreed with the statement in the phase 2 whereas 20% psychologists were totally agreed in the phase 1. In the phase 2, 60% psychologists totally agreed that activities sequence was appropriate for the session, activities were socio-economically and culturally appropriate, children's behavioral mental issues were easily identified and solvable by the activities, activities were structured, children can do the activities practically in contrast no one was totally agreed

to this statement in the phase 1. For the statement, activities were completed within time frame 50% psychologists were totally agreed with the statement in the phase 2 whereas no psychologists were totally agreed in the phase 1. These comparison shows that, activities were more appropriate for the children in the phase 2 than the phase 1.

As exhibited in table 33, out of 18 parents 10 (55.55%) parents were "totally agree" to the items of enjoyment of the activities, appropriateness of the activities, understandability and 11 (61.11%) parents gave opinion that their children's level of anxiety was decreasing and 10 (55.55) parents accounted that the level of anger of the children was decreasing. For the item children also liked to do the activities, parents' opinion was to "agree" was 61.12%. 55.55% parents said their children enjoyed the activities "sometimes", out of 18 parents 6 gave the opinion they agree to the of item their children enjoyed the activities. 55.55% parents think that the activities were appropriate to decrease the anxiety and anger level. Out of 18 parents 7 (38.90%) shared that the materials which were used to do the activities were easy to collect and those were economically affordable. 16.66% gave opinion materials were sometimes available but all the materials were not economically affordable. Three parents out of 18 said, they faced difficulties to collect the materials that means 16.66% parents choose the "sometimes" option. Out of 18 parents 4 (22.22%) parents did not think that the level of anger was decreasing as much they want, they choose the option "sometimes", 5.55% parents thought the level of anger was not changed. So, out of 18 parents 7 to 11 parents shared their opinion that the selected and applied activities for intervention were effective for decreasing the level of anxiety, anger and the language –instruction were understandable for the children.

According to the children's, psychologist's and parent's statement activities were reviewed and the researcher consulted with the supervisor and panel of experts then some word, activities steps, materials had been modified to make the activities more easy and flexible for the children. After all modifications draft-3 were constructed for further session on new sample group.

Table 34 to 70 comprises the second general objective that was to assess the effectiveness of adapted Child Focused Cognitive Behavior Therapy as an intervention. For the 2nd general objective, the specific objective was to assess the effectiveness of the adapted child focused CBT activities for intervention by Anxiety and Anger subscales of Bangla adapted Beck Youth Inventory, Treatment credibility questionnaires, Comparison of case group with 3 control groups.

As shown in Table 34, in pre-intervention assessment among 49 children 42 (85%) were in extremely elevated level of anxiety and 7 (14.3%) were in moderately elevated level, in post-intervention assessment no one in extremely or moderately elevated level. In post-intervention assessment 3 children were in moderately elevated level, 11(22.4%) children were in mildly elevated level and 35 (1.4%) children were in average level. Among 49 children, frequency shows that before intervention children's level of anxiety was extremely elevated but after intervention level of anxiety was in average for most of the children.

As demonstrated in the table 35, boys had been divide into two groups according to age one is younger group another was older group. Girls also had been divided as boys group. In the pre-intervention assessment the mean score of anxiety for

boys of younger group is 48.75, SD is 10.48 and in the post-intervention assessment the mean score is 18.88, SD is 3.27. The t-value is 5.39** for the boys of younger group which is statistically significant at 0.1 level of significance. For girls in younger group, the mean value is 48.89, SD is 8.67 in pre-intervention session and in post-intervention session, the mean value is 19.56, SD is 2.89. The t-value is 3.14* which is statistically significant at 0.5 level of significance. For older group of boys, the mean score is 48.08, SD is 9.69 and the mean is 19.31, SD is 5.32 in pre and post intervention assessment consecutively, t-value is -1.69 * which is statistically significant at 0.5 level of significance. In the girls group the mean score is 46.27, SD is 5.36 and the mean is 16.27, SD is 4.55 in pre and post intervention session respectively, t-value is -2.75* which is statistically significant at 0.5 level of significance. The t value shows that the difference between mean value of the pre and post intervention assessment, it indicates the differences was statistically significant and the level of anxiety was decreasing after getting the intervention by child focused CBT activities.

As shown in Table 36, in pre-intervention assessment among 49 children, 42 (85.7%) were in extremely elevated level of anger and 7 (14.3%) were in moderately elevated level, in post intervention assessment no one in extremely or moderately elevated level. In post-intervention assessment 3 (6.1%) children were in moderately elevated level, 18 (36.7%) were in mildly elevated level and 28 (57.1%) children were in average level. The frequency indicates that, the percentage was decreasing after the session. In post intervention, children can handle their anger with the practice of the activities.

As demonstrated in the table 37, according to the age boys and girls were divided in two groups, younger and older. In the younger group the age range was from 7 to 10 years and in the older group the age range was from 11 to 14 years. In the pre-intervention assessment the mean score of anger for the boys of younger group is 48.12, SD is 8.38 and in the post-intervention assessment the mean score is 20.69, SD is 3,57 . The t-value is 13.09*,the level of significance was 0.5 (CI 95%). For the girls in younger group, the mean value is 49.11, SD is 7.86 in pre-intervention assessment and in post-intervention assessment the mean value is 20, SD is 2.34. The t-value is 11.10* which is statistically significant in the level of significance of 0.05.

For the older group of boys, the mean score is 48.92, SD is 11.44 and the mean is 19.62, SD is 4.98 for boys in pre and post intervention consecutively, t-value is 9.23 ** which is statistically significant in the level of 0.1 In the girls' group the mean score is 47.36, SD is 13.11 and the mean is 18.91, SD is 3.67 in pre and post intervention respectively, t-value is 7.19* which is statistically significant in the level of significance of 0.05.

The t value indicates the differences between pre and post intervention is statistically significant, that means the intervention activities of child focused CBT decreases the level of anger in the case group.

As shown in the table 38 and 39, t value has been calculated in between group of boys and girls. Here the mean in the pre-intervention assessment the mean score of anxiety for boys of younger group is 48.75 and girls in younger group mean value is 48.89, t-value is 0.54 which is not statistically significant that indicates the baseline of the two groups were same. In the post-intervention assessment, the mean score of the

younger group of boys is 18.88 and 19.31 for girls, t-value is 7.56** which is statistically significant in the level of 0.1.

For older group, the mean score is 48.08 for boys' group and 46.27 for girls' group in pre-intervention assessment; t-value is 10.37 which is not statistically significant. In post-intervention session, for boys' group mean score is 19.31 and for the girls group the mean score is 16.27, t-value is 6.98* the confidence interval is 95% so the level of significance is 0.5.

As revealed in the table 39, in the pre-intervention assessment the mean score of anger sub-scale for boys of younger group is 48.12 and girls in younger group mean value is 49.11, t-value is 10.09. In the post-intervention assessment, the mean score is 20.69 younger boys and 20.00 for younger girls, t-value is 5.86*. The t value in pre-intervention assessment is not statistically significant that indicate the base level was same for the both group. After getting the session of child focused CBT activities for intervention the mean value was decreasing, the t value in post-intervention assessment between the boys and girls group is statistically significant which indicate the activities for intervention affect to decrease the anger level.

For older group, the mean score is 48.92 for boys' group and 47.36 for girls' group in pre-intervention assessment; t-value is 9.76, which is non-significant value (CI-1.93 to 5.74). In post-intervention session, for boys' group mean score is 19.62 and for the girls group the mean score is 18.91, t-value is 7.83* which is statistically significant in the level of 0.5.

As displayed in table 40, in the tertiary level hospital patients were came from every corner of the country. All the children of the four groups have been categorized

into two residential areas one is urban and another is rural. For the anxiety sub-scale, the frequency of the children was shown according to the residential area (rural and urban) in four groups (case group, control group-1, control group-2, control group-3). In the table 40 and 41, in the pre intervention session only two levels was showed because sample has been selected only from these two level so that the base level of all four groups had to be same. As shown in the tables 40, in the anxiety sub-scale the frequency of the sample was in 4 groups. In the case group, 24 children were from urban areas and 25 were from the rural area. In the control group-1, 21 were from an urban area and 6 were from a rural area. In the control group-2, 14 were from the urban area and 14 were from the rural area. In the control group-3, 24 were from the urban area and 6 were from a rural areas. As shown in the tables 41, in the anger sub-scale the frequency of the sample was in 4 groups. In the case group, 24 children were from an urban area and 25 were from a rural area. In the control group-1, 21 from urban area and 6 were from rural area. In the control group-2, 14 were from an urban area and 14 were from a rural area. In the control group-3, 24 were from an urban area and 6 were from a rural area. The total frequency of the sample was same in the group, only their level of anxiety or anger was different but both group had same base level of anxiety or anger. After getting the intervention for the anxiety, the frequency of the sample of the case group no children were in extremely elevated level. In the post-intervention assessment, for the urban group, 14 were in average level, 7 were in mildly elevated level and 3 were in moderately elevated level whereas in rural residential 21 children were in average level, 4 were in mildly elevated level and no one was in the moderately elevated level. The frequency distribution of the case group shows, that children in the rural area were decreasing their anxiety levels

more than urban children. In the control group 1 and 2, no children were on average level. In the control group 1, no children were in mildly elevated level at all, they were not receiving any intervention though 3 children were in moderately elevated level after a 14-week assessment. In the control group 3, 21 urban and 5 rural children were in extremely elevated level of anxiety, 3 urban and 1 rural children were in moderately elevated level in the pre intervention assessment. In the post-intervention assessment, 3 urban children were in average level, 13 urban and 2 rural children were in mildly elevated level; 5 urban and 3 rural children were in moderately elevated level of anxiety; 3 urban children and 1 rural child were in extremely elevated level. So, it could be summarized that in the case group the level of anxiety is decreasing than in other groups. After getting the intervention for the anger, the frequency of the sample of the case group no children was in extremely elevated level. In the post-intervention assessment, for the urban group 12 were in average level, 10 were in mildly elevated level and 2 were in moderately elevated level whereas in rural residential 16 children were in average level, 8 were in mildly elevated level and 1 was in moderately elevated level. The frequency distribution of the case group shows, that children in the rural area were decreasing their anger level more than urban children. In the control group 1 and 2, no children were in average level. In the control group 1, no children were in mildly elevated level at all, they were not receiving any intervention though 3 children were in moderately elevated level after a 14-week assessment. In the control group 3, 20 urban and 4 rural children were in extremely elevated level of anger, and 4 urban and 2 rural children were in moderately elevated level in the pre-intervention assessment. In the post-intervention assessment, 3 urban children were in average level, 12 urban and 3 rural children were in mildly

elevated level; 6 urban and 3 rural children were in moderately elevated level of anger and 3 urban children were in extremely elevated level. So, it could be summarized that in the case group the level of anger is decreasing than in other groups.

As shown in the table 42, 43, 44 and 45, the mean difference in within group of case group, the variable is the residential area. Here the mean difference between the urban and rural children. In the pre-intervention assessment the mean score of anxiety sub-scale for urban younger boys' sample group is 46.1, SD is 7.41 and in the post-intervention assessment the mean score is 20.57, SD 7.11 t-value is 3.04* which is significant in the level of 0.5. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural younger boys' sample group is 50.33, SD is 6.50 and the mean is 17.56, SD is 4.47 in the post-intervention assessment, t-value is 5.98** which is significant in the level of 0.1.

For the subscale anger, in the pre-intervention assessment the mean score of anger sub-scale for urban younger boys' is 47.71, SD is 7.41 and the mean is 21.57, SD is 3.40 in post-intervention assessment. The t-value is 3.19*; the level of significance is 0.5. In the pre-intervention assessment, the mean score of anger sub-scale for rural younger boys' sample group is 48.44, SD is 7.03 and the mean is 20.00, SD is 4.18 in the post-intervention assessment, t-value is 4.80* which is significant in the level of 0.5.

As shown in the table 43, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older boys' sample group is 46.50, SD is 6.71 and in the post-intervention assessment the mean score is 20.75, SD is 6.60 t-value is 1.24* which is significant in the level of 0.5. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural older boys' sample group is 50.60, SD is 4.15 and the mean is

17.00, SD is 4.24 in the post-intervention assessment, t-value is 3.33** which is significant in the level of 0.1.

For the sub scale anger, in the pre-intervention assessment the mean score of anger sub-scale for urban older boys' is 49.62, SD is 7.08 and the mean is 20.38, SD is 4.13 in post-intervention assessment. The t-value is 5.78**; the level of significance is 0.1. In the pre-intervention assessment, the mean score of anger sub-scale for rural older boys' sample group is 47.80, SD is 5.28 and the mean is 18.40, SD is 4.82 in the post-intervention assessment, t-value is -.807* which is significant in the level of 0.5.

As shown in the table 44, in the pre-intervention assessment the mean score of anxiety sub-scale for urban younger girls' sample group is 45.67, SD is 10.12 and in the post-intervention assessment the mean score is 20.67, SD 3.78 t-value is -1.08* which is significant in the level of 0.5. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural younger girls' sample group is 50.50, SD is 3.78 and the mean is 19.00, SD is 4.98 in the post-intervention assessment, t-value is .50** which is significant in the level of 0.1.

For the sub scale anger, in the pre-intervention assessment the mean score of anger sub-scale for urban younger girls' is 51.67, SD is 7.02 and the mean is 18.33, SD is 6.50 in post-intervention assessment. The t-value is 3.57*; the level of significance is 0.5. In the pre-intervention assessment, the mean score of anger sub-scale for rural younger girls' sample group is 47.83, SD is 10.62 and the mean is 20.83, SD is 4.26 in the post-intervention assessment, t-value is -.70** which is significant in the level of 0.1.

As shown in the table 45, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older girls' sample group is 44.33, SD is 5.16 and in the post-

intervention assessment the mean score is 16.67, SD is 5.42 t-value is 3.75 which is non-significant t value. In the pre-intervention assessment, the mean score of anxiety sub-scale for rural older girls' sample group is 48.60, SD is 3.36 and the mean is 15.80, SD is 3.34 in the post-intervention assessment, t-value is 1.31* which is significant in the level of 0.5.

For the sub scale anger, in the pre-intervention assessment the mean score of anger sub-scale for urban older girls' is 46.67, SD is 4.70 and the mean is 20.17, SD is 4.70 in post-intervention assessment. The t-value is -2.23**; the level of significance is 0.1. In the pre-intervention assessment, the mean score of anger sub-scale for rural older girls' sample group is 48.20, SD is 6.33 and the mean is 17.40, SD is 5.12 in the post-intervention assessment, t-value is 4.93* which is significant in the level of 0.5.

As shown in the table 46, 47, 48 and 49 the mean difference within group, there had 4 groups according to age and sex. The variable was the residential area (urban and rural). Table 46 shows the mean difference within case group, the age range from 7 to 10 years boys; total number of the sample was 16. Table 47 shows the mean difference within case group, the age range from 11 to 14 years boys; total number of the sample was 13. Table 48 shows the mean difference within case group, the age range from 7 to 10 years girls; total number of the sample was 9. Table 49 shows the mean difference within case group, the age range from 11 to 14 years girls; total number of the sample was 11. As shown in the table 46, in the pre-intervention assessment the mean score of anxiety sub-scale for urban younger boys' sample group is 46.1 and for rural younger boys' sample group is 50.33, t value is 4.79. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 20.57 and in rural group is 17.56, t-value is 3.53* which is

statistically significant in the level of 0.5. In the pre-intervention assessment, the mean score of anger sub-scale for urban younger boys' sample group is 47.71 and for rural sample mean score is 48.44, t value is -1.69. In the post-intervention assessment, the mean score of anger sub-scale for urban younger boys' sample group is 21.57 and in rural group is 20.00, t-value is 7.49** which is statistically significant in the level of 0.1. The t value in the pre-intervention assessment was not statistically significant that indicates the base level of anxiety and anger was same for the sample of rural and urban children.

As shown in the table 47, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older boys' sample group is 46.50 and for rural older boys' sample group is 50.60, t value is 3.29. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 20.75 and in rural group is 17.00, t-value is 2.75* which is statistically significant in the level of 0.5. In the pre-intervention assessment, the mean score of anger sub-scale for urban older boys' sample group is 49.62 and for rural sample mean score is 47.80 t value is 1.93. In the post-intervention assessment, the mean score of anger sub-scale for urban younger boys' sample group is 20.38 and in rural group is 18.40, t-value is 3.95* which is statistically significant in the level of 0.1. The t value in the pre-intervention assessment was not statistically significant that indicates the base level of anxiety and anger was same for the sample of rural and urban children.

As shown in the table 47, in the pre-intervention assessment the mean score of anxiety sub-scale for urban younger girls sample group is 45.67 and for rural younger girls' sample group is 50.50, t value is 4.68. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 20.67 and in rural group is 19.00, t-value is 4.32* which is statistically significant in the level of 0.5. In the pre-intervention

assessment, the mean score of anger sub-scale for urban older boys' sample group is 51.67 and for rural sample mean score is 47.83, t value is 2.95*, In the post-intervention assessment, the mean score of anger sub-scale for urban younger girls' sample group is 18.33 and in rural group is 20.83, t-value is 6.83* which is statistically significant in the level of 0.5. The t value in the pre-intervention assessment was not statistically significant that indicates the base level of anxiety and anger was same for the sample of rural and urban children.

As shown in the table 49, in the pre-intervention assessment the mean score of anxiety sub-scale for urban older girls' sample group is 44.33 and for rural older girls' sample group is 48.60, t value is 4.68. In the post-intervention assessment, the mean score of anxiety sub-scale in urban group is 16.67 and in rural group is 15.80, t-value is 4.32* which is statistically significant in the level of 0.5. In the pre-intervention assessment, the mean score of anger sub-scale for urban older girls' sample group is 46.67 and for rural sample mean score is 48.20 t value is 2.95. In the post-intervention assessment, the mean score of anger sub-scale for urban older girls' sample group is 20.17 and in rural group is 17.40, t-value is 6.83* which is statistically significant in the level of 0.5. The t value in the pre-intervention assessment was not statistically significant that indicates the base level of anxiety and anger was same for the sample of rural and urban children.

As shown in table 50, the frequency distribution of anxiety level in pre and post-intervention in control group-1, the total number of the sample was 27. In the pre-intervention assessment among 27 children, 23 (82.1%) were in an extremely elevated level of anxiety and 4 (14.3%) were in moderately elevated level, in the post-intervention

assessment 23 (82.1%) were an extremely elevated level and 4 (14.3%) were in moderately elevated level.

As demonstrated in table 51, in the pre-intervention assessment the mean score of anxiety for boys of younger group is 51.17, SD is 5.63 and in the post-intervention, the mean score is 47.17, SD is 4.56 and the t-value is .77. For the younger group of girls, the mean value is 47.50, SD is 7.21 in pre-intervention assessment, and in post-intervention, the mean value is 40.00, SD is 2.48; t-value is 1.89. For the older group, the mean score is 43.86, SD is 7.44 and the mean value is 44.43, SD is 5.34 for boys in pre and post-intervention consecutively, the t-value is -.13. In the girls' group, the mean score is 49.17, SD is 8.73 and the mean value is 32.50, SD is 3.79 in pre and post-intervention respectively, and the t-value is 4.19. All the t-values are not statistically significant.

As shown in Table 52, the frequency distribution of anger level in pre and post-intervention in control group-1, the total number of the sample was 27. In the pre-intervention assessment among 27 children, 23 (82.1%) were in an extremely elevated level of anger and 4 (14.3%) were in moderately elevated level, in the post-intervention assessment 24 (85.7%) an extremely elevated level and 3 (10.7%) were in moderately elevated level.

As demonstrated in the table 53, in the pre-intervention assessment the mean score of anger for boys of younger group is 52.17, SD is 10.48 and in the post-intervention the mean score is 41.83, SD is 6.87 ; t-value is 2.41, for girls in younger group mean value is 46.50, SD is 5.83 in pre-intervention and in post-intervention the mean value is 42.50, SD is 7.34 ;t-value is 1.94.

For older group, the mean score is 48.71, SD is 12.69 and the mean score is 42.86, SD is 4.55 for boys in pre and post intervention consecutively, t-value is 1.22. In the girls group the mean score is 44.17, SD is 8.16 and the mean score is 44.67, SD is 3.59 in pre and post intervention respectively, t-value is -.15. All the t-values are not statistically significant. This group did not receive any intervention; they came to the hospital for taking treatment of their siblings with NDDs, with their parents. Their parents were not aware about their anxiety or anger but it was alarming that only 50 children were assessed for control group 1. Among the 50 children 33 scored extremely elevated or moderately elevated level of anxiety or anger. It also indicates that a large number of children are not being assessed for their behavioral difficulties.

As shown in table 54, the frequency distribution of anxiety level in pre and post-intervention in control group-2, the sample size was 28. This group received general behavioral modification therapy. In the pre-intervention assessment among 28 children, 23 (82.1%) were in an extremely elevated level of anxiety and 5 (17.9%) were in moderately elevated level, in the post-intervention assessment 4 (14.3%) children were an average level, 16 (17.9%) children were in moderately elevated level and 8 (28.6%) were in extremely elevated level.

As demonstrated in table 55, in the pre-intervention assessment the mean score of anxiety for boys in the younger group is 46.50, the SD value is 5.64 and in the post-intervention, the mean score is 34.62, the SD value is 5.76; the t-value is 5.95, for girls in younger group mean value is 46.40, SD value is 4.24 in pre-intervention and in post-intervention the mean value is 34.00, SD value is 6.78 t-value is 1.94.

For the older group, the mean score is 45.33, the SD value is 6.05 and the mean value is 30.78, the SD value is 3.25 for boys in pre and post-intervention consecutively, t-value is 2.72. In the girls' group, the mean score is 45.17, the SD value is 6.61 and the mean value is 29.17, the SD value is 2.57 in pre and post-intervention assessment respectively, t-value is 4.07* which is statistically significant in the level of 0.5. The t value for the boys' groups (younger and older) and girls' younger group is not statistically significant, which indicates the difference between the mean value in pre and post-intervention assessment is not appropriate for a larger sample of the population.

As shown in table 56, the frequency distribution of anger level in pre and post-intervention in control group-2, the sample size is 28. In the pre-intervention assessment among 28 children, 23 (82.1%) were in an extremely elevated level of anger and 5 (17.9%) were in moderately elevated level, in the post-intervention assessment 7 (25.0%) were an extremely elevated level, 15 (53.6%) were in moderately elevated level and 6 (21.4%) were in mildly elevated level. The frequency indicates that before intervention most of the children were in extremely elevated level whereas after intervention most of them are in moderately elevated level, so they are practicing the general behavior modification techniques to decrease the level of anger, here also 6 children are in mildly elevated level of anger which indicates also the effect of general behavior modification therapy.

As demonstrated in the table 57, in the pre-intervention assessment the mean score of anger for boys of younger group is 50.00, SD is 5.32 and in the post-intervention the mean score is 35.00, SD is 3.65; t-value is 4.55*, for girls in younger group mean

value is 45.40, SD is 6.10 in pre-intervention and in post-intervention the mean value is 30.00, SD is 1.45; t-value is 5.63.

For older group of boys, the mean score is 47.78, SD is 3.39 and the mean value is 28.00, SD is 3.85 in pre and post intervention consecutively, t-value is 5.63. In the girls group the mean score is 45.17, SD is 4.47 and the mean value is 30.17, SD is 2.36 in pre and post intervention assessment respectively, t-value is 2.94*. The t value of the older boy's group and younger girl's group was not significant statistically. In the practical session, it also has been shown that the very young girls are not aware of the task, they did not give the attention properly, they also could not share their feelings properly also they are not aware of the feelings own self and they also liked to play more than boys. In that case parents also think that the behavioral issues will be solve without intervention. In the older group of boy, they aware of their feeling but they cannot accept the others point of view or they cannot make a good rapport or attachment with their parents. They also want to share their own choice or decision but they felt that their decision or action is not welcome to others (family or elder siblings, relatives etc.).

As shown in table 58, the frequency distribution of anxiety level in pre and post-intervention in control group-3, the sample size is 30. This control group gets the intervention by Bangla adapted creative therapy activities intervention. In the pre-intervention assessment among 30 children, 25 (83.3%) were in an extremely elevated level of anxiety and 5 (16.6%) were in moderately elevated level, in the post-intervention assessment 3 (10.00%) were in moderately elevated level, 11 (36.6%) were in mildly elevated level and 16 (53.33%) were in average level. The pre-intervention assessment

shows that the base level was the same as the case group, control group-1, and control group-2.

As demonstrated in table 59, the mean score of anxiety in the pre-intervention assessment for boys in the younger group is 48.00, SD is 7.58 and in the post-intervention, the mean score is 30.33, SD is 5.98; t-value is 5.70* which is statistically significant in the confidence level of 95% so level of significance is 0.5, for girls in younger group mean value is 47.33, SD is 7.63 in pre-intervention and in post-intervention the mean value is 28.33, SD is 6.73; t-value is 7.46 not statistically significant. For the older group, the mean score is 46.00, SD is 5.05 and the mean score is 32.12, SD is 4.33 for boys in pre and post-intervention consecutively, t-value is 3.25* which is statistically significant in the level of significance is 0.5. In the girls' group, the mean score is 46.43, SD is 6.87 and the mean score is 21.57, SD is 3.86 in pre and post intervention assessment respectively, t-value is 9.57** which is statistically significant in the level of significance is 0.1.

As shown in table 60, the frequency distribution of anger level in pre and post-intervention in control group-3, the total number of the sample is 30. In the pre-intervention assessment among 30 children, 22 (73.33%) were in the extremely elevated level of anger and 8 (26.66%) were in moderately elevated level, in post intervention assessment no one in extremely or moderately elevated level. In the post-intervention assessment 19 (63.33%) children were at mildly elevated level and 11 (36.66) children were at average level.

As demonstrated in the table 61, in the pre-intervention assessment the mean score of anger for boys of younger group is 53.83, SD is 10.63 and in the post-

intervention the mean score is 30.17, SD is 6.79; t-value is 5.45** which is statistically significant in the level of 0.1. For the girls in younger group mean value is 45.11, SD is 5.99 in pre-intervention and in post-intervention the mean value is 27.00, SD is 5.64; t-value is 4.94* which is statistically significant in the level of 0.5.

For the older group of boys, the mean score is 48.62, SD is 7.25 and 28.50, SD is 3.38 in pre and post-intervention consecutively, t-value is 7.84. In the girls group the mean score is 44.14, SD is 6.97 and the mean value is 20.57, SD is 2.94 in pre and post-intervention assessment respectively, t-value is 5.21** which is statistically significant in the level of 0.1. The t value for the boys' older group is not statistically significant; the CI is 3.29 to 6.58. During counseling session, researcher found out that in this age level, boys cannot share their decision or choices because of all of the decision of the child cannot be accepted but they think that parents or family does not grant any choices that are the reason, a distance is existent among the relationship between the child and family. The older group of boys shared that they do not share their emotion because they are now grown up if they show their emotion to others they might be counted as weak person. So, the non-significant t value also supports the descriptive feedback. Though their level of anger is reducing but it is not statistically significant.

Tables 62 and 63 demonstrated the mean score of all the groups in the anxiety and anger sub-scale consecutively. The mean score in pre-intervention and post-intervention has been presented in this table. Table 63 demonstrated the mean score of all the groups in the anger sub-scale. The mean score in pre-intervention and post-intervention has been presented in this table. The total sample size was 134, divided in 4 groups randomly.

As shown in table 64, the mean difference between the group. This table shows the t value of boys, the age range from 7 to 10 years old. Here, t values are from pre and post-intervention assessments for the sub-scale anxiety and anger. The value of t is presented between the case group and control group-1, case group and control group-2, case group and control group-3. The t value of case and control group-1 for anxiety sub-scale in pre-intervention assessment is .14 and in post-intervention is 9.90* which is statistically significant at the level of 0.5. The t value of case and control group-2 for anxiety sub-scale in pre-intervention assessment is 1.39 and in post-intervention is 7.64** which is statistically significant at the level of 0.1. The t value of case and control group-3 for anxiety sub-scale in pre-intervention assessment is 1.32 and in post-intervention is 3.16* which is statistically significant at the level of 0.5. The t value in pre-intervention is not statistically significant but in the post-intervention assessment, the t value is statistically significant. The t value of case and control group-1 for anger sub-scale in pre-intervention assessment is -.87 and in post-intervention is 10.63* which is statistically significant at the level of 0.5. The t value of case and control group-2 for anger sub-scale in pre-intervention assessment is .54 and in post-intervention is 8.65* which is statistically significant at the level of 0.5. The t value of case and control group-3 for anger sub-scale in pre-intervention assessment is 1.29 and in post-intervention is 3.44* which is statistically significant at the level of 0.5. The t value in pre-intervention is not statistically significant but in the post-intervention assessment, the t value is statistically significant.

As shown in table 65, the mean difference between the group. This table shows the t value of boys, the age range from 11 to 14 years old. Here, t values are from pre and post-intervention assessments for the sub-scale anxiety and anger. The value of t is presented between the case group and control group-1, case group and control group-2, case group and control group-3. The t value of case and control group-1 for anxiety sub-scale in pre-intervention assessment is 1.54 and in post-intervention is 10.32* which is statistically significant at the level of 0.5. The t value of case and control group-2 for anxiety sub-scale in pre-intervention assessment is .42 and in post-intervention is 3.31* which is statistically significant at the level of 0.5. The t value of case and control group-3 for anxiety sub-scale in pre-intervention assessment is .09 and in post-intervention is 3.75** which is statistically significant at the level of 0.1. The t value in pre-intervention is not statistically significant but in the post-intervention assessment the t value is statistically significant. The t value of case and control group-1 for anger sub-scale in pre-intervention assessment is 1.00 and in post-intervention is 8.40* which is statistically significant at the level of 0.5. The t value of case and control group-2 for anger sub-scale in pre-intervention assessment is .63 and in post-intervention is 4.33* which is statistically significant at the level of 0.5. The t value of the case and control group-3 for anger sub-scale in pre-intervention assessment is .21 and in post-intervention is -3.10** which is statistically significant at the level of 0.1. The t value in pre-intervention is not statistically significant but in the post-intervention assessment, the t value is statistically significant.

As shown in table 66, the mean difference between the group. This table shows the t value of girls, the age range from 7 to 10 years old. Here, t values are from pre and post-intervention assessments for the sub-scale anxiety and anger. The value of t is presented between the case group and control group-1, case group and control group-2, case group and control group-3. The t value of case and control group-1 for anxiety sub-scale in pre-intervention assessment is .48 and in post-intervention is -2.71* which is statistically significant at the level of 0.5. The t value of case and control group-2 for anxiety sub-scale in pre-intervention assessment is -.90 and in post-intervention is 6.18* which is statistically significant at the level of 0.5. The t value of case and control group-3 for anxiety sub-scale in pre-intervention assessment is .66 and in post-intervention is 3.52* which is statistically significant at the level of 0.5. The t value in pre-intervention is not statistically significant but in the post-intervention assessment the t value is statistically significant. The t value of case and control group-1 for anger sub-scale in pre-intervention assessment is .45 and in post-intervention is 5.61* which is statistically significant in the level of 0.5. The t value of the case and control group-2 for anger sub-scale in pre-intervention assessment is 1.73 and in post-intervention is 3.53** which is statistically significant at the level of 0.1. The t value of case and control group-3 for anger sub-scale in pre-intervention assessment is .95 and in post-intervention is 0.56* which is statistically significant at the level of 0.5. The t value in pre-intervention is not statistically significant but in the post-intervention assessment the t value is statistically significant.

As shown in table 67, the mean difference between the group. This table shows the t value of girls, the age range from 11 to 14 years old. Here, t values are from pre and post-intervention assessment for the sub-scale anxiety and anger. The value of t is presented between the case group and control group-1, case group and control group-2, case group and control group-3. The t value of case and control group-1 for anxiety sub-scale in pre-intervention assessment is -.35 and in post-intervention is 7.18* which is statistically significant at the level of 0.5. The t value of case and control group-2 for anxiety sub-scale in pre-intervention assessment is 1.75 and in post-intervention is 3.54* which is statistically significant at the level of 0.5. The t value of case and control group-3 for anxiety sub-scale in pre-intervention assessment is .21 and in post-intervention is 0.87** which is statistically significant at the level of 0.1. The t value in pre-intervention is not statistically significant but in the post-intervention assessment, the t value is statistically significant. The t value of case and control group-1 for anger sub-scale in pre-intervention assessment is .08 and in post-intervention is 3.53* which is statistically significant in the level of 0.5. The t value of case and control group-2 for anger sub-scale in pre-intervention assessment is -.13 and in post-intervention is 4.44** which is statistically significant at the level of 0.1. The t value of case and control group-3 for anger sub-scale in pre-intervention assessment is .39 and in post-intervention is 1.34* which is statistically significant at the level of 0.5. The t value in pre-intervention is not statistically significant but in the post-intervention assessment, the t value is statistically significant.

The t statistics calculated the difference in the mean score between groups. As shown in tables 64, 65, 66, and 67 the t-value in pre-intervention was not statistically

significant which indicates the base level of anxiety and anger was the same for all the four groups. In post-intervention, the t-value was statistically significant in 0.5 and 0.1 levels of confidence (95% and 99% respectively), which that indicates after getting the intervention the level of anxiety and anger was decreasing. For the control group-1, their mean score did not change much because they did not receive any intervention.

As shown in table 68, children articulated their opinion about the activities for intervention. Most of them chose the "yes" option for most of the items. Out of 49 children 41 children (83.68%) enjoyed the activities, 2 (4.08%) did not enjoy the activities and 6 (12.24%) enjoyed the activities "sometimes". For the items easily understand the instruction, followed the steps, and felt good to hear or do the activities almost 43 to 45 children said "yes", they enjoy the activities to act practically. Out of 49 children, 2 to 4 children said they faced difficulties to follow the steps.

Compare the percentage of section 2 to the previous draft in phase 2 credibility questionnaires the percentage shows that, in section 2, 83.68% of children enjoyed the activities whereas, in phase 2, 50% enjoyed the activities totally. 89.80% of children understand the instruction easily in section 2 and 60% of children understand the instruction easily in phase 2. 85.72% of children easily followed the steps in section 2 whereas 50% of children easily followed the steps in phase 2. Their opinion about the psychologist's appearance was 95.92% were satisfied in section 2 but in phase 2, 70% were satisfied totally. 89.80% of children felt good to do the activities in section 2 but in phase, 50% felt good to do and listen to the activities.

As shown in table 69, 1(10%) psychologists gave an opinion by "sometimes" option for item easy to explain, sequence of the activities, appropriateness, and time structure. Most

of them said the activities were easy to follow; the language was understandable for the children. They gave the opinion that the activities were appropriate to decrease the level of anxiety and anger of the children.

These percentages can be compared with the phase 2 credibility of the psychologists. In section 2, 80% chose the totally agree option for easy explain the activities whereas, in phase 2, 60% chose the "totally agree to option" for the item. In section 2, 90% said they "totally agree" that the language was fluent, comfortable, and age-appropriate for the children, and in phase 2, 70% totally agree with the statement. For the statement, words were feasible and harmonious 60% of psychologists totally agreed with the statement in phase 2 whereas 90% of psychologists were totally agreed in section 2. In phase 2, 60% of psychologists totally agreed that the activities sequence was appropriate for the session, activities were socio-economically and culturally appropriate, children's behavioral and mental issues were easily identified and solvable by the activities, activities were structured, and children can do the activities practically in contrast 90% was "totally agreed" to this statement in section 2. For the statement, activities were completed within a time frame 50% of psychologists totally agreed with the statement in phase 2 whereas 90% of psychologists totally agreed in section 2. This comparison shows that activities were more appropriate for the children in section 2 than in phase 2.

As exhibited in table 70, 83% to 95% of parents "totally agree" to the items like task enjoyment, appropriateness of the task, understandability, and level of anxiety, anger was decreasing in the children. Children also liked to do the activities 83% totally "agree" with the item. Out of 49 parents, more than 43 totally agreed to most of the items

which means activities were effective to decrease the level of anxiety and anger of the children.

The comparison between phase 2 and section 2 for the parent's credibility questionnaires shows that the activities are more appropriate for the children in draft-3 which were constructed based on the field test and credibility, feedback in phase 2. The comparison of the percentage is discussed now. In phase 2 out of 18 parents, 10 (55.55%) parents were "totally agree" with the items of enjoyment of the activities, appropriateness of the activities, and understandability and 11 (61.11%) parents gave the opinion that their children's level of anxiety was decreasing and 10 (55.55) parents accounted that the level of anger of the children was decreasing. In section 2, 93.88% of parents totally agreed that children enjoyed the activities, activities were appropriate for the children and their anxiety level was decreased by practicing the activities. For the item children also liked to do the activities, parents' opinion was to "agree" was 61.12%. 55.55% of parents said their children enjoyed the activities "sometimes", out of 18 parents 6 gave the opinion they agree with the item that their children enjoyed the activities whereas, in section 2, 95.92% of parents were totally agreed with the statement. 55.55% of parents think that the activities were appropriate to decrease the anxiety and anger level in contrast 93.88% of parents said they totally agreed that the activities were decreasing the children's level of anxiety.

In phase 2 out of 18 parents, 7 (38.90%) shared that the materials which were used to do the activities were easy to collect and those were economically affordable. 16.66% gave opinion materials were sometimes available but all the materials were not economically affordable. Three parents out of 18 said they faced difficulties to collect the

materials which means 16.66% of parents choose the “sometimes” option whereas 87.86% of parents said the material was very easy to collect from near the shop only 10.20% said sometimes it’s hard to collect the materials. Out of 18 parents, 4 (22.22%) parents did not think that the level of anger was decreasing as much as they want, they choose the option “sometimes”, 5.55% of parents thought the level of anger was not changed whereas, in section 2, 95.92% parents said the level of anger was decreasing as much as they want. So, the percentages show that draft-3 was more effective for the children. Parents also gave their opinion that the selected and applied activities for intervention were effective in decreasing the level of anxiety, and anger, and the language –instruction was more understandable for the children than in phase 2.

Children’s, psychologists, and parents’ feedback also indicates that when children decrease their anxiety level they also calm down their angry feelings. Parents also tell that after practicing the tasks children also improve their self-esteem, and attachment to the family. It is helpful for repairing and reshaping their behavior, the children were establishing new, more productive patterns of relationship not only within the family but also in peer groups and society. It also helps children to be more imaginative. Particularly children improve certain sensory characteristics which are effective in improving mood, sensory integration, and calming the body and mind, especially who have experienced traumatic events which help to develop anxiety and anger. This study shows that child-focused CBT activities will be effective tools for anxiety, and anger in Bangladeshi culture, if we can adapt more tools into Bangla and skill the professional who is working with children then it will be helpful for all of them. These techniques can be applied

widely to children with anxiety, and anger. More editions need for making it culturally appropriate. Therefore, this is the little step for adapting child-focused CBT activities in Bangla, it has lots of shortcomings though professionals can use this intervention on children with anxiety, and anger.

Children can address distorted or upsetting beliefs and attributions through CF-CBT. Children can also learn skills to help them cope with ordinary life stressors. It also helps parents to develop skills that support their children. In this era of globalization, countries, and societies are influenced culturally, religiously, and racially. It is the responsibility of the professionals of each sector to ensure that local contexts are addressed and incorporated along with proper adaptation while engaging any of the systems in their respective fields. From various researches, we know that cultural and social differences influence the process of psychosocial interventions. We also have witnessed the rise of various new dimensions in the delivery of psychosocial interventions.

Limitations and Forthcoming ways of applications

An impending drawback in studying children's anxiety and anger is that both are typically highly interrelated (Chorpita, Moffitt, & Gray, 2005). Therefore, future studies should distinguish between comparatively 'clinically' anxious and clinically 'angry' children and adolescents. The present intervention program did not keep fit parents for helping their children deal with anxiety. The parents can be a great source to help the children with behavior and emotional issues. If professionals can give the proper

training to the parents they can easily take care of the children's behavioral and emotional in the early stage. Some studies found that parents' understanding of anxiety or anger and their responses to their child's anxiety or anger is an important factor in the treatment (Hirshfeld-Becker et al., 2010). Therefore the present intervention program could be extended to train parents along with their anxious or angry children to help the children to cope better and healthier way with the behavioral and emotional distortion.

The present intervention program combined and adapted mainly the child-focused CBT activities. Future research may incorporate other approaches of psychotherapy (e.g. EMDR, play therapy, psychoanalysis, music therapy, dance therapy, etc.) into the intervention program with the aim of enhancing the efficacy of the intervention. This would increase the applicability, usability, feasibility, and efficiency of the intervention program because the same intervention may not work for all the children (World Health Organization, 2012; Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016; Festen et al., 2013; de Haan, Rietveld, Stokhof, & Denys, 2013).

The present research was carried out with developmentally healthy children. It is therefore unknown whether the same intervention program would be effective for children with neurodevelopmental or developmental disorders. This might require some variations of the existing program to suit their special needs. Future research should focus on this matter.

The intervention program can potentially be used in other settings besides hospitals such as in school settings or in a group sessions. The individual session is very time-consuming, so group sessions will be conducted to train the children through child-focused CBT activities.

This intervention program was conducted in a face-to-face session. During the COVID-19 pandemic, the session over the phone or online platform was very necessary for not only parents but also for the children. So, it could be an option to practice the activities over an online platform and find out the effectiveness. Based on the application in the online platform, more modifications can be done.

The present study is not beyond its limitations. Limitations are to select the participant because all parents did not give permission to work with children, conducting intervention need long time 14 weeks which is very time consuming and motivate the children to participate and attend every week that was also difficult to maintain. Researcher and parents also faced political problems for this reason participants could not attend regularly, a big limitation was the assessment instrument has not been standardized in Bangladesh. For all these limitations, only 49 participants were practiced the activities which indicate that more field-testing with a larger number of sample is needed to make it standardized intervention program.

Difficulties faced in implementing the intervention program

The researcher faced some difficulties during the implementation of the intervention program. Children felt difficulty understanding the feeling words and concentrating on the relaxation session. Children also expressed their difficulty in the "Restructuring" session. Further explanations were needed for their understanding. The space or physical environment was not very supportive of the session with the children. Researcher also faced the difficulties to make the tools with available contents, materials.

Recommendations

- Need to apply these intervention programs in different hospital setting in Bangladesh widely (for children and adolescents)
- Mental health professionals can apply this intervention program
- Need to apply in an academic basis in school setting
- These intervention program can be applied in group session of children and adolescents
- Need to conduct session over the phone or online platforms
- Mental health professionals who has specialization on CBT they can apply these intervention program effectively with advance training on CF-CBT
- Need to apply the intervention program for children with trauma or accident to restructure their irrational thoughts
- Need to conduct the sessions on children with special need (NDDs)

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Appendices

1. Assent form
    I. Section 1-
        a) Phase 1 (Regular Random Childrel)
        b) Phase 2 (Children Practice Bangla Adapted CF-CBT Activities)
    II. Section 2-
        a) Case group, Control Group-2, Control Group-3 (Children Practice Bangla Adapted CF-CBT Activities)
        b) Control Group-1 (Does not practice any activities)
2. Socio-demographic information
3. Beck Youth Inventories (Anxiety and anger sub-scales, T-score equivalent to raw score of Beck Youth Inventories)
4. Bangla adapted child focused cognitive behavior activities for intervention
5. Child's pictorial feedbacks in different sessions
6. Bangla credibility questionnaires (parents, children and psychologists)
7. Bangla instruction for the session (parents, children and psychologists)

সম্মতি পত্র (Regular Random Child: Section 1:Phase 1)

১। গবেষণার নাম : "Adaptation of child focused cognitive behavior therapy as an intervention program".

২। গবেষকের নাম : সাদিয়া আফরিন
মনোবিজ্ঞানী (শিক্ষা)
ইপনা, বি.এস.এম.এম.ইউ

এম ফিল গবেষক
ডিপার্টমেন্ট অফ এডুকেশনাল এন্ড কাউন্সেলিং সাইকোলজি
ঢাকা বিশ্ববিদ্যালয়

৩। গবেষণার উদ্দেশ্য : শিশুদের উপযোগী Cognitive Behavior Therapy-র টেকনিকগুলো সেশন অনুযায়ী বাংলায় রূপান্তর করা এবং বাংলাদেশী শিশুদের জন্য ব্যবহার উপযোগী করা।

৪। কার্য-প্রণালী : আপনার অবগতির জন্য জানাচ্ছি যে, শিশুর মানসিক স্বাস্থ্য সম্পর্কে একটি গবেষণা সংগঠিত হচ্ছে , আপনারা যদি আপনাদের শিশুর মানসিক অবস্থা সম্পর্কে জানতে আগ্রহী থাকেন তবে আপনাদের অনুমতির উপর ভিত্তি করে আমরা শিশুকে কিছু মানসিক স্বাস্থ্য ও আচরণ বিষয়ক প্রশ্ন করবো , এখানে প্রশ্নের কোনো ভুল বা শুদ্ধ উত্তর নাই , শিশু যা মনে করবে সে উত্তর দিতে পারে এবং চাইলে আপনারাও তার কথার সাথে কথা যোগ করতে পারেন। এখানে শিশুকে কিছু মানসিক স্বাস্থ বিষয়ক কাজ পড়ে শুনানো হবে এবং কিছু কাজ করতে দেয়া হবে। কাজগুলো শুনে তার কেমন মনে হচ্ছে, শব্দগুলো সে পরিবর্তন করতে চায় কিনা, ধাপগুলো সে বুঝতে পারছে কিনা শিশুর কাছ থেকে এই তথ্যগুলো নেয়া হবে। আমরা ৪ থেকে ৫ সপ্তাহ শিশুর সাথে কাজগুলো করবো। আশা করি পুরো প্রক্রিয়াটি আপনি বুঝতে পেরেছেন যদি আরো কিছু জানার থাকে দয়া করে প্রশ্ন করুন আমরা আন্তরিকতার সাথে উত্তর দেয়ার চেষ্টা করব। আপনার এবং শিশুর মানসিক সাফল্য কামনা করছি এবং গবেষণায় আপনার একান্ত সাহায্য আশা করছি।

৫। সুবিধা ও উপকারীতা : প্রতিনিয়ত আমরা প্রত্যেকে বিভিন্ন মানসিক অবস্থার মধ্যে দিয়ে যাই কখনো তা ভালো লাগার অনুভূতি কখনো তা কষ্টের হয়। শিশুর মানসিক অবস্থা সম্পর্কে আমরা জানতে পারবো এবং আপনারা পরবর্তীতে যদি কোনো মানসিক সাহায্য নিতে আগ্রহী হন তবে উক্ত প্রশ্নমালা আপনাদের সচেতন হতে সাহায্য করবে।

৬। ঝুঁকি : এই গবেষণায় অন্তর্ভুক্তিতে আপনার এবং শিশুর শারীরিক কোনো ঝুঁকি নেই বললেই চলে। । আর মানসিক অবস্থা সম্পর্কে জানলে আমাদের পক্ষে সচেতন হওয়া সহজ হবে, প্রয়োজনে যেকোনো মানসিক ঝুঁকি থেকে নিজেকে সতর্ক করতে এই গবেষণা আমাদের সাহায্য করবে। উক্ত গবেষণায় আপনার অর্থনৈতিক সামাজিক কোনো প্রকার ক্ষতির ঝুঁকি নেই বলে গবেষক হিসাবে আপনাকে নিশ্চয়তা দিচ্ছি।

৭। তথ্যের গোপনীয়তা : কোনো প্রকার বিব্রতকর পরিস্থিতির মুখোমুখি যাতে আপনাকে না হতে হয় সে জন্যে সকল তথ্য সম্পূর্ণ গোপন রাখা হবে এবং আপনার নাম বা পরিচিতি কোথাও রেকর্ড করা হবে না। শুধু মাত্র গবেষণার উদ্দেশ্যে যতটুকু প্রয়োজন সেসব তথ্য-ই রেকর্ড করা হবে।

৮। অংশগ্রহণ : এই গবেষণায় আপনার অন্তর্ভুক্তি সম্পূর্ণ আপনার ইচ্ছার উপর নির্ভরশীল ; গবেষণায় অংশগ্রহণ না করলেও আপনার শিশুর চিকিৎসা সঠিক নিয়মে অব্যাহত থাকবে। শিশুর কিংবা আপনার অংশগ্রহণ এর জন্য কোনো প্রকার বাধ্য বাধকতা নেই। গবেষণা চলাকালে যে কোনো সময় আপনি আপনার নাম প্রত্যাহার করার সুযোগ পাবেন এবং সিদ্ধান্ত নিতে আপনার উপর কোনো প্রকার চাপ প্রয়োগ করা হবে না। গবেষণায় অন্তর্ভুক্তির জন্য কোনো প্রকার আর্থিক সুবিধাপ্রাপ্ত হবেন না।

আমি ..... উক্ত গবেষণার বিষয়ে সম্পূর্ণ অবগত হয়ে এবং গবেষণার গুরুত্ব অনুধাবন করে সজ্ঞানে ইপনা বি.এস.এম.এম.ইউ তে সংগঠিত ড. মেহজাবীন হকের তত্বাবধায়নে পরিচালিত ঢাকা বিশ্ববিদ্যালয়ের ,ডিপার্টমেন্ট অফ এডুকেশনাল এন্ড কাউন্সেলিং এ অধ্যায়নরত সাদিয়া আফরিন কর্তৃক নিয়ন্ত্রনাধীন গবেষণায় অন্তর্ভুক্ত হলাম।

প্রধান গবেষক:	অংশগ্রহণকারী নাম:
স্বাক্ষর:	স্বাক্ষর:
তারিখ:	তারিখ:

সাক্ষী ১।নাম	স্বাক্ষর:	তারিখ:
সাক্ষী ২।নাম	স্বাক্ষর	তারিখ:

সম্মতি পত্র (Field test phase 2, Section 2: Case Group, Control Group 2 & 3)

১। গবেষণার নাম : "Adaptation of child focused cognitive behavior therapy as an intervention program".

২। গবেষকের নাম : সাদিয়া আফরিন
মনোবিজ্ঞানী (শিক্ষা)
ইপনা, বি.এস.এম.এম.ইউ
এম ফিল গবেষক
ডিপার্টমেন্ট অফ এডুকেশনাল এন্ড কাউন্সেলিং সাইকোলজি
ঢাকা বিশ্ববিদ্যালয়

৩। গবেষণার উদ্দেশ্য : শিশুদের উপযোগী Cognitive Behavior Therapy-র টেকনিকগুলো সেশন অনুযায়ী বাংলায় রূপান্তর করা এবং বাংলাদেশী শিশুদের জন্য ব্যবহার উপযোগী করা।

৪। কার্য-প্রণালী : আপনার অবগতির জন্য জানাচ্ছি যে এই গবেষণায় শিশুর/নাম ..... সাথে তার মানসিক সমস্যাগুলো নিয়ে কাজ করা হবে। শিশুর/নাম ..... যাতে তার আচরণগত সমস্যাগুলো খুঁজে বের করতে পারে এবং কার সাথে কেমন আচরণ করা যাবে কিভাবে নিজের কষ্ট বা খারাপ লাগা অন্যদের সাথে শেয়ার করবে , রাগ হলে কিভাবে তা প্রকাশ করতে হবে সেসকল বিষয়ে শিশুর সাথে সেশনে কাজ করা হবে। সেশনে কাজের প্রক্রিয়া হবে : শুরুতে আমরা শিশুর সাথে সাধারণ কিছু আলোচনা করবো তার ভালো লাগা খারাপ লাগাগুলো জন্য তারপর তার মানসিক ও আচরণগত বিষয়গুলো আরো ভালোভাবে জানার জন্য সাইকোলজিক্যাল কিছু প্রশ্নের মাধ্যমে তার উদ্বিগ্নতা এবং রাগের আচরণগুলোকে খুঁজে বের করা হবে। প্রতি সপ্তাহে আমরা এক ঘন্টা ত্রিশ মিনিটের একটা করে সেশন করবো। প্রতিটি সেশনে শিশুকে তার আচরণ , চিন্তা ভাবনা এবং অনুভূতি খুঁজে বের করার জন্য কিছু কাজ শিখিয়ে দেয়া হবে এবং অভিভাবক হিসাবে আপনাদের কাজগুলো সম্পর্কে অবগত করা হবে , আপনারাও বাসায় শিশুকে কাজগুলো করতে সাহায্য করবেন বলে আসা করি। শুরুর এবং শেষ সেশনে শুধু শিশুর মানসিক আচরণগত প্রশ্নমালা পূরণ করা হবে , শিশুর পারিবারিক এবং আর্থসামাজিক অবস্থা সম্পর্কে প্রথম সেশনে আপনাদের কাছ থেকে কিছু তথ্য নেয়া হবে , আশা করি প্রশ্নগুলোর উত্তর দিতে আপনাদের অসুবিধা হবে না যদি কোনো প্রশ্নে আপনারা সমস্যা অনুধাবন করেন অবশ্যই তা আমাদেরকে জানাবে চাইলে উত্তর দেয়া থেকে বিরত -ও থাকতে পারেন। প্রতিটি সেশনে যে সকল কাজগুলো দেয়া হবে সেগুলো সম্পর্কে বা কাজগুলো আরো সহজে গঠনমূলক ভাবে কিভাবে করা যায় সেই সম্পর্কে আপনাদের মূল্যবান মন্তব্য অবশ্যই আপনারা এবং আপনার শিশু আমাদেরকে দিবেন বলে আশা করি। সেশনের শেষে আমরা আপনাদের সাথে কথা বলবো এবং বাসার কাজগুলো সম্পর্কে জানাবো। এভাবে ১৪ সপ্তাহে আমরা সবমিলিয়ে ১৪ টা সেশন করবো এবং আমরা যে লক্ষ্য বা সমস্যা সমাধানের জন্য কাজ শুরু করছি টা

কতটা সফল হলো তাও আপনাদের সাথে কথা বলে এবং শিশুর মানসিক স্বাস্থ্য সম্পর্কিত প্রশ্নপত্র পূরণের মাধ্যমে নির্ণয় করে সেশন শেষ করবো। আশা করি পুরো প্রক্রিয়াটি আপনি বুঝতে পেরেছেন যদি আরো কিছু জানার থাকে দয়া করে প্রশ্ন করুন আমরা আন্তরিকতার সাথে উত্তর দেয়ার চেষ্টা করব। আপনার এবং শিশুর মানসিক সাফল্য কামনা করছি এবং গবেষণায় আপনার একান্ত সাহায্য আশা করছি।

৫। সুবিধা ও উপকারীতা : প্রতিনিয়ত আমরা প্রত্যেকে বিভিন্ন মানসিক অবস্থার মধ্যে দিয়ে যাই কখনো তা ভালো লাগার অনুভূতি কখনো তা কষ্টের হয়। আপনি আপনার শিশুর চিকিৎসার উদ্দেশ্যে ইপনা তে এসেছেন। শিশু/শিশুর নাম বর্তমানে কিছু আচরণগত ও মানসিক সমস্যার মধ্যে দিয়ে যাচ্ছে যেগুলো সে একা সমাধান করতে পারছে না। তার চিন্তার সমস্যা বা মানসিক উদ্বিগ্নতা ,অতিরিক্ত রাগ সে একা কিভাবে নিয়ন্ত্রণ করতে হবে তা বুঝতে পারছে না আবার আপনাদের সাথে তার সমস্যাগুলো নিয়ে কিভাবে আলোচনা করবে তও হয়তো সে বুঝে উঠতে পারছে না। তাই তার আচরণে আপনারা সমস্যাবোধ করছেন এবং শিশুর সঠিক চিকিৎসার জন্যই এখানে নিয়ে এসেছেন। আমরা শিশুর সাথে যে কাজগুলো বিভিন্ন সেশনে করবো তাতে করে শিশু তার মানসিক উদ্বিগ্নতাকে সনাক্ত করতে পারবে এবং কাজগুলোর মাধ্যমে সে শিখতে পারবে যে কিভাবে মানসিক সমস্যাগুলো কে সমাধান করতে হয় এবং সমস্যাগুলো নিয়ে কিভাবে অভিভাবকদের সাথে আলোচনা করতে হয়। একইসাথে সে জানতে পারবে তার রাগ বিরক্তি কিভাবে তৈরী হচ্ছে , কিভাবে এগুলো তার জীবনের গুরুত্বপূর্ণ সম্পর্কগুলোকে নেতিবাচক ভাবে প্রভাবিত করছে এবং সে অন্যদের কাছ থেকে দূরে চলে যাচ্ছে। সে সচেতনভাবে তখন সমস্যাগুলো সমাধানের চেষ্টা করবে বলে আশা করি। এই সেশনগুলোর মাধ্যমে সে তার নেতিবাচক চিন্তাগুলোকে সনাক্ত করতে পারবে , সেগুলো তাকে কিভাবে খারাপ লাগে কিভাবে খারাপ অনুভূতি দূর করে ইতিবাচক ভালো লাগার অনুভূতি তৈরী করা যাই সেটাও সে শিখতে পারবে। আশা করি সেশনগুলো করে সে অনুধাবন করতে পারবে জীবনকে এবং পরিবার –বন্ধু –আত্মীয় –সমাজকে কিভাবে আনন্দের সাথে উপভোগ করা যায় এবং যেকোনো সমস্যাকে পরিবারের সাথে শেয়ার করে দ্রুত সুন্দরভাবে সমাধান করা যায়।

৬। ঝুঁকি : এই গবেষণায় অন্তর্ভুক্তিতে আপনার শারীরিক কোনো ঝুঁকি নেই বললেই চলে। । আর মানসিক অবস্থা সম্পর্কে জানলে আমাদের পক্ষে সচেতন হওয়া সহজ হবে, প্রয়োজনে যেকোনো মানসিক ঝুঁকি থেকে নিজেকে সতর্ক করতে এই গবেষণা আমাদের সাহায্য করবে। উক্ত গবেষণায় আপনার অর্থনৈতিক সামাজিক কোনো প্রকার ক্ষতির ঝুঁকি নেই বলে গবেষক হিসাবে আপনাকে নিশ্চয়তা দিচ্ছি। গবেষণায় অন্তর্ভুক্তির জন্য

কোনো প্রকার আর্থিক সুবিধাপ্রাপ্ত হবেন না।

৭। তথ্যের গোপনীয়তা : কোনো প্রকার বিব্রতকর পরিস্থিতির মুখোমুখি যাতে আপনাকে না হতে হয় সে জন্যে সকল তথ্য সম্পূর্ণ গোপন রাখা হবে এবং আপনার নাম বা পরিচিতি কোথাও রেকর্ড করা হবে না। শুধু মাত্র গবেষণার উদ্দেশ্যে যতটুকু প্রয়োজন সেসব তথ্য-ই রেকর্ড করা হবে।

৮। অংশগ্রহণ : এই গবেষণায় আপনার অন্তর্ভুক্তি সম্পূর্ণ আপনার ইচ্ছার উপর নির্ভরশীল ; গবেষণায় অংশগ্রহণ না করলেও আপনার শিশুর চিকিৎসা সঠিক নিয়মে অব্যাহত থাকবে। শিশুর কিংবা আপনার অংশগ্রহণ এর জন্য কোনো প্রকার বাধ্য বাধকতা নেই। গবেষণা চলাকালে যে কোনো সময় আপনি আপনার নাম প্রত্যাহার করার সুযোগ পাবেন এবং সিদ্ধান্ত নিতে আপনার উপর কোনো প্রকার চাপ প্রয়োগ করা হবে না।

আমি ..... উক্ত গবেষণার বিষয়ে সম্পূর্ণ অবগত হয়ে এবং গবেষণার গুরুত্ব অনুধাবন করে সজ্ঞানে ইপনা বি.এস.এম.এম.ইউ তে সংগঠিত ড. মেহজাবীন হকের তত্বাবধায়নে পরিচালিত ঢাকা বিশ্ববিদ্যালয়ের ,ডিপার্টমেন্ট অফ এডুকেশনাল এন্ড কাউন্সেলিং এ অধ্যায়নরত সাদিয়া আফরিন কর্তৃক নিয়ন্ত্রনাধীন গবেষণায় অন্তর্ভুক্ত হলাম।

প্রধান গবেষক:

স্বাক্ষর:
তারিখ:

অংশগ্রহণকারী নাম:

স্বাক্ষর:
তারিখ:

সাক্ষী ১।নাম স্বাক্ষর: তারিখ:

সাক্ষী ২।নাম স্বাক্ষর তারিখ:

সম্মতি পত্র (Control Group 1)

১। গবেষণার নাম : "Adaptation of child focused cognitive behavior therapy as an intervention program".

২। গবেষকের নাম : সাদিয়া আফরিন
মনোবিজ্ঞানী (শিক্ষা)
ইপনা, বি.এস.এম.এম.ইউ

এম ফিল গবেষক
ডিপার্টমেন্ট অফ এডুকেশনাল এন্ড কাউন্সেলিং সাইকোলজি
ঢাকা বিশ্ববিদ্যালয়

৩। গবেষণার উদ্দেশ্য : শিশুদের উপযোগী Cognitive Behavior Therapy-র টেকনিকগুলো সেশন অনুযায়ী বাংলায় রূপান্তর করা এবং বাংলাদেশী শিশুদের জন্য ব্যবহার উপযোগী করা।

৪। কার্য-প্রণালী : আপনার অবগতির জন্য জানাচ্ছি যে, শিশুর মানসিক স্বাস্থ্য সম্পর্কে একটি গবেষণা সংগঠিত হচ্ছে , আপনারা যদি আপনাদের শিশুর মানসিক অবস্থা সম্পর্কে জানতে আগ্রহী থাকেন তবে আপনাদের অনুমতির উপর ভিত্তি করে আমরা শিশুকে কিছু মানসিক স্বাস্থ্য ও আচরণ বিষয়ক প্রশ্ন করবো , এখানে প্রশ্নের কোনো ভুল বা শুদ্ধ উত্তর নাই , শিশু যা মনে করবে সে উত্তর দিতে পারে এবং চাইলে আপনারাও তার কথার সাথে কথা যোগ করতে পারেন। আমরা ১৪ সপ্তাহ পরে আবারো কিছু প্রশ্নের উত্তর শিশু এবং আপনাদের কাছ থেকে সংগ্রহ করবো। আশা করি পুরো প্রক্রিয়াটি আপনি বুঝতে পেরেছেন যদি আরো কিছু জানার থাকে দয়া করে প্রশ্ন করুন আমরা আন্তরিকতার সাথে উত্তর দেয়ার চেষ্টা করব। আপনার এবং শিশুর মানসিক সাফল্য কামনা করছি এবং গবেষণায় আপনার একান্ত সাহায্য আশা করছি।

৫। সুবিধা ও উপকারীতা : প্রতিনিয়ত আমরা প্রত্যেকে বিভিন্ন মানসিক অবস্থার মধ্যে দিয়ে যাই কখনো তা ভালো লাগার অনুভূতি কখনো তা কষ্টের হয়। শিশুর মানসিক অবস্থা সম্পর্কে আমরা জানতে পারবো এবং আপনারা পরবর্তীতে যদি কোনো মানসিক সাহায্য নিতে আগ্রহী হন তবে উক্ত প্রশ্নমালা আপনাদের সচেতন হতে সাহায্য করবে।

৬। ঝুঁকি : এই গবেষণায় অন্তর্ভুক্তিতে আপনার এবং শিশুর শারীরিক কোনো ঝুঁকি নেই বললেই চলে। । আর মানসিক অবস্থা সম্পর্কে জানলে আমাদের পক্ষে সচেতন হওয়া সহজ হবে, প্রয়োজনে যেকোনো মানসিক ঝুঁকি থেকে নিজেকে সতর্ক করতে এই গবেষণা আমাদের সাহায্য করবে। উক্ত গবেষণায় আপনার অর্থনৈতিক সামাজিক কোনো প্রকার ক্ষতির ঝুঁকি নেই বলে গবেষক হিসাবে আপনাকে নিশ্চয়তা দিচ্ছি।

৭। তথ্যের গোপনীয়তা : কোনো প্রকার বিব্রতকর পরিস্থিতির মুখোমুখি যাতে আপনাকে না হতে হয় সে জন্যে সকল তথ্য সম্পূর্ণ গোপন রাখা হবে এবং আপনার নাম বা পরিচিতি কোথাও রেকর্ড করা হবে না। শুধু মাত্র গবেষণার উদ্দেশ্যে যতটুকু প্রয়োজন সেসব তথ্য-ই রেকর্ড করা হবে।

৮। অংশগ্রহণ : এই গবেষণায় আপনার অন্তর্ভুক্তি সম্পূর্ণ আপনার ইচ্ছার উপর নির্ভরশীল ; গবেষণায় অংশগ্রহণ না করলেও আপনার শিশুর চিকিৎসা সঠিক নিয়মে অব্যাহত থাকবে। শিশুর কিংবা আপনার অংশগ্রহণ এর জন্য কোনো প্রকার বাধ্য বাধকতা নেই। গবেষণা চলাকালে যে কোনো সময় আপনি আপনার নাম প্রত্যাহার করার সুযোগ পাবেন এবং সিদ্ধান্ত নিতে আপনার উপর কোনো প্রকার চাপ প্রয়োগ করা হবে না। গবেষণায় অন্তর্ভুক্তির জন্য কোনো প্রকার আর্থিক সুবিধাপ্রাপ্ত হবেন না।

আমি ..... উক্ত গবেষণার বিষয়ে সম্পূর্ণ অবগত হয়ে এবং গবেষণার গুরুত্ব অনুধাবন করে সজ্ঞানে ইপনা বি.এস.এম.এম.ইউ তে সংগঠিত ড. মেহজাবীন হকের তত্বাবধায়নে পরিচালিত ঢাকা বিশ্ববিদ্যালয়ের ,ডিপার্টমেন্ট অফ এডুকেশনাল এন্ড কাউন্সেলিং এ অধ্যায়নরত সাদিয়া আফরিন কর্তৃক নিয়ন্ত্রনাধীন গবেষণায় অন্তর্ভুক্ত হলাম।

প্রধান গবেষক:

স্বাক্ষর:

তারিখ:

অংশগ্রহণকারী নাম:

স্বাক্ষর:

তারিখ:

সাক্ষী ১।নাম স্বাক্ষর: তারিখ:

সাক্ষী ২।নাম স্বাক্ষর তারিখ:

Data collection sheet

Date:

Child's Name: ……..

Section A : Information of Parents

Sl. No:	Criteria	Description
1.	Child's ID	
2.	Father's and Mother's Age	
3.	Address	: .....
4.	Residential area	1. Urban 2. Rural
5.	Parent's Contact Mobile No:	:
6.	Father's Education	: 1. Illiterate, 2. Primary, 3. Secondary, 4. Higher secondary 5. Graduation & above
7.	Father's Occupation	: 1. Agriculture 2. Business 3. Day labor 4. Service holder 5. Student 6. Housewife 7. Others...
8.	Mother's Education	1. Illiterate, 2. Primary, 3. Secondary 4. Higher secondary 5. Graduation & above
9.	Mother's Occupation	: 1. Agriculture 2. Business 3. Day labor 4. Service holder 5. Student 6. Housewife, 7. Others...
10.	Monthly family income (In Taka)	(1) Below 20,000 (2) Between 20,000-39,000 (3) 40,000-59,000 (4) above 60,000

Section B: Information of children with extremely elevated or moderately elevated anxiety and anger

Sl. No:		
13.	Age	
14.	Date of Birth	
15.	Sex	: 1. Boy 2. Girl
16.	Beck youth inventory score for anxiety	1) Pre-test or pre-intervention 2) Post-test or post-intervention
17.	Beck youth inventory score for anxiety	1) Pre-test or pre-intervention 2) Post-test or post-intervention

Signature: ……

Name of Data Collector: ……

Beck Anxiety Inventory for Youth (BAI-Y)

নিচের তালিকায় মানুষের ক্ষেত্রে ঘটে থাকে এবং যা মানুষ ভাবে বা অনুভব করে এরকম বিবরণ রয়েছে । মনোযোগ সহকারে প্রতিটি বাক্য পড় এবং 'কখনও না', 'মাঝে মাঝে', প্রায়ই অথবা 'সবসময়' এই চারটি বিকল্পের যেটি তোমার (**বিশেষ করে গত ২ সপ্তাহের**) বেলায় সবচেয়ে বেশী প্রযোজ্য বলে মনে কর কেবল এমন ঘরেই "টিক" চিহ্ন দিবে । এখানে কোন সঠিক/ভুল উত্তর নেই.

ক্রমিক নং	বিবরণ	কখনও না	মাঝেমাঝে	প্রায়ই	সবসময়
1.	আমার ভয় লাগে যে স্কুলে আমাকে কেউ কষ্ট দিতে পারে				
2.	আমি ভয়ের স্বপ্ন দেখি ।				
3.	যখন আমি স্কুলে থাকি , আমার ভয় লাগে ।				
4.	ভয়ের বিষয়গুলো আমাকে তাড়া করে বেড়ায় ।				
5.	অন্যরা আমাকে নিয়ে হাসি-তামাশা করতে পারে ভেবে আমি দুশ্চিন্তা করি ।				
6.	আমি কোন ভুল করব ভেবে ভয়ে থাকি ।				
7.	আমি সহজেই ঘাবড়ে যাই ।				
8.	আমি ভয়ে থাকি যে অন্যদের কাছ থেকে কষ্ট পেতে পারি ।				
9.	আমার দুশ্চিন্তা হয় যে পরীক্ষার ফলাফল খারাপ হতে পারে ।				
10.	আমার ভবিষ্যত নিয়ে আমি চিন্তিত ।				
11.	আমার হাত কাপেঁ ।				
12.	আমি ক্ষিপ্ত হতে বা পাগলামি করতে পারি ভেবে দুশ্চিন্তা হয় ।				
13.	অন্যরা আমার উপর ক্ষিপ্ত হতে পারে ভেবে দুশ্চিন্তা হয় ।				
14.	নিজেকে সংযত রাখতে পারব না ভেবে আমি দুশ্চিন্তা করি ।				
15.	আমার খুব দুশ্চিন্তা হয় ।				

16.	আমার ঘুমের সমস্যা হয় ।				
17.	আমার বুক ধড়ফড় করে ।				
18.	আমার অস্থির লাগে ।				
19.	খারাপ কিছু ঘটতে পারে ভেবে আমার ভয় হয় ।				
20.	আমার ভয় হয় যে আমি অসুস্থ হয়ে যেতে পারি ।				

Beck Anger Inventory for Youth (BANI-Y)

নিচের তালিকায় মানুষের ক্ষেত্রে ঘটে থাকে এবং যা মানুষ ভাবে বা অনুভব করে এরকম বিবরণ রয়েছে । মনোযোগ সহকারে প্রতিটি বাক্য পড় এবং 'কখনও না', 'মাঝে মাঝে', প্রায়ই অথবা 'সবসময়' এই চারটি বিকল্পের যেটি তোমার বেলায় সবচেয়ে বেশী প্রযোজ্য বলে মনে কর কেবল এমন ঘরেই "টিক" চিহ্ন দিবে । এখানে কোন সঠিক/ভুলউত্তর নেই।

ক্রমিক নং	বিবরণ	কখনও না	মাঝেমাঝে	প্রায়ই	সবসময়
৬১.	আমার মনে হয় অন্যরা আমাকে ঠকানোর চেষ্টা করে ।				
৬২.	রাগে আমার চিৎকার করতে ইচ্ছা করে ।				
৬৩.	আমার মনে হয় অন্যরা আমার প্রতি অন্যায় আচরণ করে ।				
৬৪.	আমার মনে হয় অন্যরা আমাকে কষ্ট দিতে চেষ্টা করে ।				
৬৫.	আমার মনে হয় আমার জীবন সুন্দর না ।				
৬৬.	অন্যরা আমাকে উত্যক্ত করে ।				
৬৭.	অন্যরা আমাকে পাগল করে তোলে ।				
৬৮.	আমার মনে হয় অন্যরা আমাকে জ্বালাতন করে ।				
৬৯.	অন্যদের উপর আমি ভীষণ রেগে যাই ।				
৭০.	রেগে গেলে আমি রেগেই থাকি ।				
৭১.	রেগে গেলে তা দমন করতে আমার অসুবিধা হয় ।				
৭২.	আমার মনে হয় অন্যরা আমার উপর মাতব্বরি করতে চেষ্টা করে।				
৭৩.	আমার মনে হয় অন্যরা আমাকে হেয় করার চেষ্টা করে ।				
৭৪.	নিজেকে আমার তুচ্ছ মনে হয় ।				
৭৫.	রাগে আমার ফেটে যেতে ইচ্ছা হয় ।				
৭৬.	আমার মনে হয় অন্যরা আমার বিপক্ষে ।				
৭৭.	আমি রেগে যাই ।				

৭৮.	রেগে গেলে শরীরের ভেতর আমার আগুন ধরে যাই ।				
৭৯.	আমি অন্যদের ঘৃণা করে ।				
৮০.	আমি প্রচন্ড রেগে যাই ।				

Table A.1. *T* Score Equivalents for Raw Scores by Sex, Aged 7–10

Raw Score	Female					Male					Raw Score
	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	
0	7	31	34	30	38	13	33	34	31	37	0
1	8	32	35	31	40	14	34	35	33	38	1
2	9	33	36	32	41	15	35	36	34	40	2
3	10	34	37	34	43	16	36	37	35	41	3
4	11	35	38	35	44	16	37	38	36	43	4
5	12	36	39	36	46	17	37	39	37	44	5
6	13	37	40	37	48	18	38	40	38	45	6
7	14	38	41	38	49	19	39	41	39	47	7
8	15	39	42	39	51	20	40	42	40	48	8
9	16	41	43	41	52	21	41	44	41	50	9
10	17	42	44	42	54	22	42	45	42	51	10
11	18	43	45	43	55	23	43	46	43	53	11
12	19	44	46	44	57	24	44	47	44	54	12
13	20	45	47	45	59	24	45	48	45	55	13
14	21	46	48	46	60	25	46	49	46	57	14
15	22	47	49	48	62	26	47	50	47	58	15
16	23	48	50	49	63	27	48	51	48	60	16
17	24	49	52	50	65	28	49	52	49	61	17
18	25	50	53	51	67	29	50	53	50	62	18
19	26	51	54	52	68	30	51	54	51	64	19
20	27	52	55	53	70	31	52	55	52	65	20
21	28	53	56	55	71	31	53	56	53	67	21
22	29	54	57	56	73	32	54	57	54	68	22
23	30	55	58	57	75	33	55	58	55	69	23
24	31	56	59	58	76	34	56	59	56	71	24
25	32	57	60	59	78	35	57	60	57	72	25
26	33	58	61	61	79	36	58	61	58	74	26
27	33	59	62	62	81	37	59	62	59	75	27
28	34	60	63	63	83	38	60	63	60	76	28
29	35	61	64	64	84	39	61	64	61	78	29
30	36	62	65	65	86	39	62	65	62	79	30
31	37	64	66	66	87	40	63	66	63	81	31
32	38	65	67	68	89	41	64	67	64	82	32
33	39	66	68	69	91	42	65	68	65	83	33
34	40	67	69	70	92	43	66	69	66	85	34
35	41	68	70	71	94	44	67	70	68	86	35
36	42	69	71	72	95	45	68	71	69	88	36
37	43	70	72	73	97	46	69	72	70	89	37
38	44	71	74	75	99	47	70	73	71	90	38
39	45	72	75	76	100	47	71	74	72	92	39

Note. **BSCI–Y**=Self-Concept; **BAI–Y**=Anxiety; **BDI–Y**=Depression; **BANI–Y**=Anger; **BDBI–Y**=Disruptive Behavior.

(Continued)

Table A.1. *T* Score Equivalents for Raw Scores by Sex, Aged 7–10 *(Continued)*

Raw Score	Female					Male					Raw Score
	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	
40	46	73	76	77	100	48	72	75	73	93	40
41	47	74	77	78	100	49	73	77	74	95	41
42	48	75	78	79	100	50	74	78	75	96	42
43	49	76	79	80	100	51	75	79	76	97	43
44	50	77	80	82	100	52	76	80	77	99	44
45	51	78	81	83	100	53	77	81	78	100	45
46	52	79	82	84	100	54	78	82	79	100	46
47	53	80	83	85	100	54	79	83	80	100	47
48	54	81	84	86	100	55	80	84	81	100	48
49	55	82	85	87	100	56	81	85	82	100	49
50	56	83	86	89	100	57	82	86	83	100	50
51	57	84	87	90	100	58	83	87	84	100	51
52	58	86	88	91	100	59	84	88	85	100	52
53	59	87	89	92	100	60	85	89	86	100	53
54	60	88	90	93	100	61	86	90	87	100	54
55	61	89	91	94	100	62	87	91	88	100	55
56	62	90	92	96	100	62	88	92	89	100	56
57	63	91	93	97	100	63	89	93	90	100	57
58	64	92	95	98	100	64	90	94	91	100	58
59	65	93	96	99	100	65	91	95	92	100	59
60	66	94	97	100	100	66	92	96	93	100	60

Note. **BSCI–Y**=Self-Concept; **BAI–Y**=Anxiety; **BDI–Y**=Depression; **BANI–Y**=Anger; **BDBI–Y**=Disruptive Behavior.

Table A.2. *T* Score Equivalents for Raw Scores by Sex, Aged 11–14

Raw Score	Female					Male					Raw Score
	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	
0	6	31	34	31	35	4	34	35	32	35	0
1	7	32	35	32	37	5	35	36	33	37	1
2	8	33	36	33	39	6	36	37	34	38	2
3	10	34	37	34	41	7	37	39	35	39	3
4	11	35	39	35	43	8	38	40	36	41	4
5	12	37	40	36	45	10	39	41	37	42	5
6	13	38	41	38	47	11	40	42	38	44	6
7	14	39	42	39	48	12	41	43	39	45	7
8	15	40	44	40	50	13	42	44	40	46	8
9	16	41	45	41	52	14	44	46	41	48	9
10	17	43	46	42	54	15	45	47	42	49	10
11	18	44	47	43	56	16	46	48	44	51	11
12	19	45	49	45	58	17	47	49	45	52	12
13	20	46	50	46	60	18	48	50	46	53	13
14	21	47	51	47	61	20	49	52	47	55	14
15	22	49	52	48	63	21	50	53	48	56	15
16	23	50	54	49	65	22	51	54	49	57	16
17	24	51	55	50	67	23	52	55	50	59	17
18	25	52	56	52	69	24	53	56	51	60	18
19	26	53	57	53	71	25	54	58	52	62	19
20	27	55	59	54	73	26	55	59	53	63	20
21	28	56	60	55	74	27	56	60	54	64	21
22	29	57	61	56	76	28	57	61	55	66	22
23	30	58	62	57	78	30	58	62	56	67	23
24	31	59	64	58	80	31	60	63	57	69	24
25	32	61	65	60	82	32	61	65	59	70	25
26	33	62	66	61	84	33	62	66	60	71	26
27	34	63	67	62	86	34	63	67	61	73	27
28	35	64	69	63	87	35	64	68	62	74	28
29	36	65	70	64	89	36	65	69	63	75	29
30	37	67	71	65	91	37	66	71	64	77	30
31	38	68	72	67	93	38	67	72	65	78	31
32	39	69	73	68	95	39	68	73	66	80	32
33	40	70	75	69	97	41	69	74	67	81	33
34	41	71	76	70	99	42	70	75	68	82	34
35	42	73	77	71	100	43	71	77	69	84	35
36	43	74	78	72	100	44	72	78	70	85	36
37	44	75	80	74	100	45	73	79	71	87	37
38	45	76	81	75	100	46	74	80	72	88	38
39	47	77	82	76	100	47	76	81	74	89	39
40	48	79	83	77	100	48	77	82	75	91	40
41	49	80	85	78	100	49	78	84	76	92	41
42	50	81	86	79	100	51	79	85	77	93	42
43	51	82	87	80	100	52	80	86	78	95	43
44	52	83	88	82	100	53	81	87	79	96	44
45	53	84	90	83	100	54	82	88	80	98	45
46	54	86	91	84	100	55	83	90	81	99	46
47	55	87	92	85	100	56	84	91	82	100	47
48	56	88	93	86	100	57	85	92	83	100	48
49	57	89	95	87	100	58	86	93	84	100	49

Note. **BSCI–Y**=Self-Concept; **BAI–Y**=Anxiety; **BDI–Y**=Depression; **BANI–Y**=Anger; **BDBI–Y**=Disruptive Behavior.

(Continued)

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Table A.2. *T* Score Equivalents for Raw Scores by Sex, Aged 11–14 *(Continued)*

Raw Score	Female					Male					Raw Score
	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	BSCI–Y	BAI–Y	BDI–Y	BANI–Y	BDBI–Y	
50	58	90	96	89	100	59	87	94	85	100	50
51	59	92	97	90	100	61	88	95	86	100	51
52	60	93	98	91	100	62	89	97	88	100	52
53	61	94	100	92	100	63	90	98	89	100	53
54	62	95	100	93	100	64	92	99	90	100	54
55	63	96	100	94	100	65	93	100	91	100	55
56	64	98	100	96	100	66	94	100	92	100	56
57	65	99	100	97	100	67	95	100	93	100	57
58	66	100	100	98	100	68	96	100	94	100	58
59	67	100	100	99	100	69	97	100	95	100	59
60	68	100	100	100	100	70	98	100	96	100	60

Note. **BSCI–Y**=Self-Concept; **BAI–Y**=Anxiety; **BDI–Y**=Depression; **BANI–Y**=Anger; **BDBI–Y**=Disruptive Behavior.

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CBT-টেকনিকগুলোর/ কাজগুলোর ভাষাগত ত্রুটি পরিমাপ করার জন্য ব্যবহারিত যাচাইকরণ প্রশ্নপত্র (অভিভাবকদের জন্য)

কাজগুলো সম্পর্কে আপনাদের মতামত এবং শিশুরা কাজগুলো শুনে সহজে বুঝতে পারছে কিনা ,তারা বাসায় এগুলো সম্পর্কে কি বলছে , বাসায় প্রাকটিস করছে কিনা, ভাষাগুলো বুঝতে পারছে কিনা , তার মানসিক প্রশান্তি বাড়ছে কিনা সেগুলো সম্পর্কে আপনাদের কিছু প্রশ্ন করা হবে। এখানে ভুল বা শুদ্ধ বলে কিছু নাই আপনারা শুধু আপনাদের মতামত জানাবেন ১ থেকে ৫ পয়েন্টের মধ্যে। এখানে ১ মানে খুব কম আর ৫ মানে খুব ভালো। আপনারা নিশ্চিন্তে আপনাদের মতামত প্রকাশ করুন , এখানে আপনাদের কোনো নাম পরিচয় প্রকাশ পাবেনা শুধু মাত্র আমরা যাতে শিশুদের জন্য সুন্দর সহজ আনন্দদায়ক কিছু প্রক্রিয়া লিখিতভাবে প্রস্তুত করতে পারি সেই লক্ষ্যে আমরা আমাদের মতামত প্রকাশ করবো।

ক্রম সংখ্যা	**প্রশ্ন**	**পরিমাপক**				
		খুবই কম	**কম**	**মাঝা মাঝি**	**বেশি**	**খুবই বেশি**
		১	**২**	**৩**	**৪**	**৫**
১	আমার শিশু কাজটি করে মজা পেয়েছে					
২	কাজগুলো শিশুদের বয়স উপযোগী					
৩	কাজের নির্দেশনাগুলো বোঝা সহজ ছিল					
৪	কাজগুলোতে ব্যবহারিত জিনিসগুলো আমাদের সামর্থ্যের মধ্যে ছিল					
৫	আমার শিশু কাজতো করার সময়					

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	আনন্দ পাচ্ছিলো
৬	আমার মনে হয় কাজগুলো করতেও মজা লাগবে

Child focused CBT–টেকনিকগুলোর/ কাজগুলোর ভাষাগত ত্রুটি পরিমাপ করার জন্য ব্যবহারিত যাচাইকরণ প্রশ্নপত্র (Credibility Questionnaire শিশুদের জন্য)

আমি সাদিয়া আফরিন , ঢাকা বিশ্ববিদ্যালয়-এ এম. ফিল. শ্রেণীতে অধ্যায়নরত শিক্ষার্থী , আমি শিশুদের মানসিক হতাশা , বিষণ্ণতা , অস্থিরতা , ভয় , কষ্ট , বিরক্তি দূর করার জন্য কিছু টেকনিক বাংলায় লিখার চেষ্টা করছি যাতে সহজে শিশুরা বুঝতে পারে। তুমি তোমার মূল্যবান সময় এবং মতামত দিয়ে আমাকে সাহায্য করছো তোমাকে অনেক অনেক ধন্যবাদ। সব শেষে তোমাকে উক্ত কাজগুলোর উপর কিছু প্রশ্ন করা হবে তুমি ১ থেকে ৫ এর মধ্যে তোমার মতামত প্রকাশ করতে পারবে , এখানে ভুল শুদ্ধ বলে কিছু নাই তুমি নিশ্চিন্তে তোমার মতামত দিতে পারো। এখানে ১ এর অর্থ হলো খুব কম ,২ মানে কম ৩ মানে মাঝামাঝি ৪ মানে ভালো ৫ মানে খুব ই ভালো। প্রশ্নগুলো হলো :

ক্রম সংখ্যা	**প্রশ্ন**	**পরিমাপক**		
		কম	**মাঝামাঝি**	**বেশি**
		১	**২**	**৩**
১	কাজগুলো করে আমি মজা পেয়েছি			
২	কথাগুলো /নির্দেশনাগুলো সহজ ভাষায় ছিল			
৩	কাজগুলোর ধাপগুলো বুঝতে সহজ ছিল			
৪	কাজগুলো যখন আমাকে বুঝানো হচ্ছিলো তখন আপু /আন্টি (সাইকোলজিস্ট)-র ব্যবহার ভালো ছিল			
৫	কথাগুলো শুনে আমার ভালো লেগেছে			

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৬	আমার মনে হয় কাজগুলো করতেও মজা লাগবে

Child focused CBT-টেকনিকগুলোর/ কাজগুলোর ভাষাগত ত্রুটি পরিমাপ করার জন্য ব্যবহারিত যাচাইকরণ প্রশ্নপত্র (প্রফেশনাল সাইকোলজিস্টদের জন্য যারা অন্তত তিন বছর যাবৎ শিশুদের মানসিক স্বাস্থ্য নিয়ে কাজ করছেন: Credibility questionnaires)

নিচের প্রশ্নের উত্তরগুলোতে কোনো ভুল বা শুদ্ধ উত্তর নেই আপনারা নিশ্চিন্তে ১ থেকে ৫ এর মধ্যে টিক্ চিহ্ন দিতে পারেন।

ক্রম সংখ্যা	প্রশ্ন	পরিমাপক				
		খুবই কম	কম	মাঝামাঝি	বেশি	খুবই বেশি
		১	২	৩	৪	৫
১	থেরাপির কাজগুলো সহজেই শিশুকে বোঝানো গেছে					
২	থেরাপির ভাষা শিশুদের বয়স উপযোগী হয়েছে					
৩	থেরাপির ভাষা সাবলীল এবং স্বাচ্ছন্দ্যময় হয়েছে					
৪	কাগুলোর ধারাবাহিকতা কি আপনার ঠিক মনে হচ্ছে					

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৫	বাসায় কাজগুলো ব্যবহার উপযোগী
৬	আমাদের আর্থসামাজিক পরিস্থিতির উপযুক্ত
৭	শিশুর মানসিক ও আচরণগত সমস্যাগুলো সনাক্তকরণ এবং কাজগুলোর মাধ্যমে সমাধানযোগ্য
৮	কাজগুলো গঠনমূলক
৯	কাজগুলো নির্দিষ্ট সময়ের মধ্যে করা যায়
১০	শিশু নিজে হাতে কলমে কাজগুলো করতে পারে

কাজগুলো সম্পর্কে আপনাদের/আপনার আরো যেকোনো অভিজ্ঞ মতামত বিস্তারিত প্রদান করতে চাইলে পরবর্তী পৃষ্ঠায় সংযোজন করুন

*আপনার/আপনাদের সহযোগিতার জন্য আন্তরিক ধন্যবাদ

CBT-টেকনিকগুলোর/ কাজগুলোর ভাষাগত ত্রুটি পরিমাপ করার জন্য ব্যবহারিত যাচাইকরণ প্রশ্নপত্র (অভিভাবকদের জন্য)

আমি সাদিয়া আফরিন, ঢাকা বিশ্ববিদ্যালয়-এ এম. ফিল. শ্রেণীতে অধ্যায়নরত শিক্ষার্থী বর্তমানে শিক্ষা মনোবিজ্ঞানী হিসাবে ইনস্টিটিউট অফ পেডিয়াট্রিক নিউরোডিসঅর্ডার (ইপনা-তে)এ কর্মরত আছি। আপনারা জানেন যে আমাদের শিশুরা বিভিন্ন সময় বিভিন্ন মানসিক সমস্যার সম্মুখীন হয়। অনেক সময় তারা তাদের মনের কথাগুলো খুলে বলতে পারেনা। অবিভাবক হিসাবে আমরা চেষ্টা করি যে আমাদের শিশুর মানসিক প্রশান্তি যাতে থাকে এবং সে

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যাতে খুশি থাকে। শিশুদের মানসিক বিভিন্ন সমস্যা সমাধানের জন্য পিতামাতা হিসেবে আপনারা প্রতিমুহূর্তে সচেতন হওয়ার চেষ্টা করেন এবং তাদেরকে সময় দিয়ে কথা বলে তাদের আনন্দ দেয়ার চেষ্টা করেন। কখনো কখনো শুধুমাত্র পারিবারিক সাহায্যই শিশুর জন্য যথেষ্ট হয়না, প্রফেশনাল সাহায্যও দরকার হয়। শিশুদের মানসিক প্রশান্তি বৃদ্ধির জন্য প্রচুর ম্যানুয়াল ব্যবহারিত হয় যা প্রফেশনাল সাইকোলজিস্টরা ব্যবহার করি, তবে এসব সকল ম্যানুয়াল-ই ইংলিশ ভাষায় হওয়ায় সবার জন্য ব্যবহার করা কষ্টকর হয়, কাজগুলো সহজে যাতে সবাই সবাইকে বিশেষ করে শিশুকে বুঝাতে পারি সেই লক্ষ্যে আমি প্রতিটি কাজের প্রতিটি ধাপ বাংলায় লিখার প্রচেষ্টা নিয়েছি আমার এম ফিল এর গবেষণার প্রকল্প হিসাবে। কাজগুলো আপনাদের পড়ে শুনানো হবে আপনাদের যদি মনে হয় ভাষা বা স্টেপগুলো শিশুদের উপযোগী হচ্ছে না তবে আপনারা ভাষাগত যেকোনো পরিবর্তনের জন্য আমাদের বলতে পারবেন।

গবেষণা প্রক্রিয়ার স্টেপ ১-এ শিশুদেরকে দেয়া নির্দেশনাগুলো

আমি সাদিয়া আফরিন , ঢাকা বিশ্ববিদ্যালয়-এ এম ফিল শ্রেণীতে অধ্যায়নরত শিক্ষার্থী , আমি শিশুদের মানসিক হতাশা , বিষণ্নতা , অস্থিরতা , ভয় , কষ্ট , বিরক্তি দূর করার জন্য কিছু টেকনিক বাংলায় লিখার চেষ্টা করছি যাতে সহজে শিশুরা বুঝতে পারে। আমি যতটুকু জানি তুমি তোমার জীবনকে আনন্দের সাথে উপভোগ করার চেষ্টা করো। আমরা এখন যেসব টেকনিক আলোচনা করবো তুমি সেগুলো সম্পর্কে তোমার যেকোনো মতামত প্রদান করতে পারো এবং নিশ্চিন্তে আমাকে বলতে পারো। তোমার সকল প্রকার মতামত আমাদের কাজের জন্য খুব-ই গুরুত্বপূর্ণ। তুমি যদি কোনো শব্দ বুঝতে না পারো বা

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তোমার মনে হয় অন্য কোনো শব্দ ব্যবহার করলে কাজটি অন্য সকল শিশুদের জন্য বুঝতে সহজ হবে তুমি তাও আমাকে বল। আমি বলার পর পর ই তুমি আমাকে বিষয়টি সম্পর্কে পুনরায় বলতে পারবে তাতে আমাদের বুঝতে সহজ হবে যে তুমি কি বুঝতে পেরেছো।

তোমাকে অনেক ধন্যবাদ যে তুমি আমার সাথে কাজটি করতে সম্মত হয়েছো।

টেকনিকগুলো শোনার পর এবং শিশু তার মতামত দেয়ার পর অবশ্যই তাকে প্রশংসাসূচক বাক্য বলে এবং ধন্যবাদ দিয়ে সেশন শেষ করা হবে।

Child focused CBT-টেকনিকগুলোর/ কাজগুলোর ভাষাগত ত্রুটি পরিমাপ করার জন্য ব্যবহারিত যাচাইকরণ প্রশ্নপত্র (প্রফেশনাল সাইকোলজিস্টদের জন্য যারা অন্তত তিন বছর যাবৎ শিশুদের মানসিক স্বাস্থ্য নিয়ে কাজ করছেন)

আমি সাদিয়া আফরিন, ঢাকা বিশ্ববিদ্যালয়-এ এম. ফিল. শ্রেণীতে অধ্যায়নরত শিক্ষার্থী , আমি শিশুদের মানসিক হতাশা , বিষণ্নতা , অস্থিরতা , ভয় , কষ্ট , বিরক্তি দূর করার জন্য কিছু টেকনিক বাংলায় লিখার চেষ্টা করছি যাতে সহজে শিশুরা বুঝতে পারে। আমরা প্রফেশনাল সাইকোলজিস্ট হিসাবে শিশুদের সাথে বিভিন্ন থেরাপিউটিক কাজ করছি তাদের মানসিক

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সুস্থতার উদ্দেশ্যে। এসকল কাজগুলো ভিন্ন ভাষায় হওয়াতে আমাদের নিজেদের মতো করে ব্যবহার করতে হয় এতে করে অনেক সময় থেরাপিটির উপকারিতা কম হয়। আমি আমার নিজস্ব অভিজ্ঞতা এবং শিশুদের নিয়ে কাজ করছে এমন অনেক সাইকোলোজিস্ট- এর মতামত নিয়ে দেখেছি যে আমরা যদি এসকল কাজগুলোকে আমাদের নিজেদের ভাষায় শিশুদের বোঝার উপযোগী করে তুলতে পারি তবে তাদের জন্য বোঝা অনেক সহজ হয়ে যাবে । সেই উদ্দেশ্য পূরণের লক্ষ্যে আমি আমার এম. ফিল. এর গবেষণার বিষয়বস্তু হিসেবে শিশুদের উপযোগী টেকনিকগুলো আপনাদের প্রফেশনাল সাহায্য নিয়ে বাংলায় তৈরী করার চেষ্টা করছি। আপনার একান্ত সহযোগিতা এবং মূল্যবান মতামত টেকনিকগুলোকে আরো শিশুবান্ধব সাবলীল করতে আমাকে সাহায্য করবে ।

আপনারা/ আপনি প্রতিটি টেকনিক /কাজগুলো মনোযোগ সহকারে পড়ুন /কাজের শুরুতেই/প্রথমেই প্রতিটি টেকনিক মনোযোগসহকারে পড়ার অনুরোধ রইলো। কাজগুলোর ভাষা , শব্দ , বাক্যের গঠন সম্পর্কে আপনাদের মতামত আমাদের জন্য খুব-ই প্রয়োজনীয় , একই সাথে কাজগুলো কি শিশু বান্ধব কিনা তাও আপনাদের কাছে আমাদের জানার থাকবে সুতরাং আপনারা /আপনি কাজগুলো সম্পর্কে আপনাদের/আপনার মূল্যবান বক্তব্য বিস্তারিত ভাবে লিখে আমাদেরকে দিতে পারেন। আপনাদের/আপনাকে অনেক আন্তরিক ধন্যবাদ আপনি আপনার মূল্যবান সময় দিয়ে আমারকে সাহায্য করেছেন এবং শিশুবান্ধব এই কাজটি করতে নিরলস সাহায্য করছেন। আপনাদের/আপনার প্রতিটি মতামত আমাদের জন্য অত্যন্ত গুরুত্বপূর্ণ।

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আপনারা কাজগুলো শিশুদের সাথে ব্যবহার করছেন বলে আপনাদেরকে অনেক ধন্যবাদ । কাজগুলো ব্যবহার করার সময় আপনারা হয়তো কোনো সমস্যার মুখোমুখি হয়ে থাকতে পারেন অথবা শিশুদের মতামত তাদের প্রতিক্রিয়া ,কাজের আগ্রহ ও দেখেছেন। আপনি /আপনারা সেসব অভিজ্ঞতার ভিত্তিতে যদি আমাদের কিছু প্রশ্নের উত্তর প্রদান করেন আমরা আপনার প্রতি খুব-ই কৃতজ্ঞ হবো। আপনাদের অভিজ্ঞতা এবং মতামতের ভিত্তিতে আমরা পরবর্তী সংশোধন এবং সংযোজন করতে পারবো যাতে করে কাজগুলো আরো বেশি শিশুবান্ধব, সহজবোদ্ধ হয়।