M. Phil Thesis

Impact of parent training on behavior of children with conduct disorder

A Dissertation

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Submitted by

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Declaration

Dedicated to

My Parents

Approval of the Research

Want to substantiate that the study "Impact of parent training on behavior of children with conduct disorder" submitted by Simun Nasa to accomplish the prerequisite for the M. Phil Degree, an authentic research of Clinical Psychology, University of Dhaka. Under my supervision this research was carried out by her. I recommend for approval.

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Abstract

Children's conduct issues are a widespread mental health concern. CD is strongly linked to adult illegal violence, drug misuse, failure of school, adolescent pregnancy and unemployment and so on. This issue is exacerbated in impoverished and working-class nations where mental health treatments for children are severely lacking. Early identification and treatment of Conduct Disorder can help adults avoid negative psychosocial repercussions later in life. In light of this, the current study aims to assist parents by teaching them effective communication with their children and providing intermittent recommendations for parental self-care so that everyone is benefitted. The present study was carried out to see the parent's training impact on behavior of children who are diagnosed with conduct disorder. There were five goals of the study. The first aim was to develop a parent training program which was based on the parental needs whose children are identified with conduct disorder. Secondly investigating in what extent parent training is functional on children's behavior who are diagnosed with conduct disorder. Third objective was to modify children's disruptive behavior. Fourth objective was to assess the changes in distress level of the parents of children who are diagnosed with conduct disordered resulted from the training program. And finally, the fifth objective was to improve parenting practices. Parent training manual was developed through systematic review of available worldwide parent training with evidence, discussion with professionals. Initially a seven sessions manual was developed which was later reduced to five session come-after judge evaluation and pilot study. A total of 16 children with conduct disorder's parents were engaged in this study. The reason behind the participants of choosing to drop out of the study in different phases as they expressed when contacted were mainly due to fixed date and time of the hospitals in which all the training and conduction went on and their inconvenient location to take part in the training

and the educational qualification of the parents as well. One group pre-test/post-test design was selected as a design to see the impact of parent training on behavior of children with conduct disorder. All measures that were used in this study were administered in the pre-test phase and all measures in the post-test phase were re-administered and after this, one- month follow-up was taken from the same groups to see the effectiveness of this training. To see the conditions of dependent variables, appropriate statistical analyses were used to compare pre-test/post-test scores. The severity of conduct disorder in children, fell significantly (Mean Difference = 28.81, $p < 0.001$) after the training, and continued to decline one-month later (Mean Difference = 11.63, $p< 0.001$). This training played an important role on reducing the conduct disorder severity in children. The results showed that the parents reported decreased in stress considerably after the training compared to the baseline assessment (Mean Difference = 7.25, $p< 0.001$) and remained stable (Mean Difference = 1.38, $p> 0.05$) after one month during the follow-up evaluation. Parenting practice among the participants increased significantly following the training (Mean Difference = 27.88, $p < 0.001$) and continued to increase one-month later (Mean Difference = 9.32, $p < 0.05$) compared to baseline evaluation. Main focus of the training module was to teach parents about how to better parenting their children who have conduct disorder. These parenting skills might have contributed enormously in this case. The findings of the study indicated the parent training is effectful on behavior of children with conduct disorder if they can be trained properly.

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Chapter 1

Introduction

The future of tomorrow lies with today's youth. They are at the center of societal growth because they will design the world of tomorrow. How kids prepare themselves for the workforce will determine how things turn out in the future. Growing up to be productive, creative professionals and responsible individuals is a hallmark of children who are healthy, well-fed, and educated. However, troubled children will tax both for the family and the nation. In order for their kids to develop into healthy, productive people who can contribute to society, parents have obligations under the law and in the physical sense.

1.1 What is Conduct Disorder

Conduct disorder is marked by a type of behavioral characteristics that is repeated and persistent and where basic human rights, people or significant age-appropriate cultural standards or rules have been breached or violated (American Psychiatric Association, 2013). During the preschool period, several CD symptoms appear (Keenan & Wakschlag, 2004, 2000). It is counted on that about 3–7% children of preschool match the CD criteria (Egger & Angold, 2006). Moreover, CD diagnosis (Keenan et al., 2011; Kim-Cohen et al., 2005) and CD symptoms (Rolon-Arroyo et al., 2014) are both rather stable from preschool until elementary school and the child's behaviors are seen to be consistent. If the CD symptoms shown early is linked to a worse clinical result regarding health compared to the disorder's beginning in teen age (Lahey et al., 1998; Moffitt et al., 1996). It is difficult to have an overall understanding about the early stages. Children's conduct disorder is a prevalent and intractable problem that causes problems for families, schools, and the larger community. They are highly linked to academic and family adversity, as well as delinquency later in life (Loeber,1990). Adult adjustment prospects are

particularly bleak (Robins, 1978) for those children who are diagnosed with CD may show antisocial behaviors such as hostility, animosity, misconduct, ruinous, impudence, resistance, lying, agitation and disruption at school. To be labeled as having conduct disorders, kids must engage in multiple of these behaviors for at least 6 months and more frequently than other kids their age. A numerous factor-analytic studies validated of these types of clusters (Quay & Werry, 1986) by using the data from a wide range of sources about the children of different age (Achenbach, 1966; Hewitt & Jenkins, 1946; Mattison et al., 1980; Peterson, 1961). Such research has consistently identified a CD cluster of interrelated items that is separate from the anxious-withdrawn cluster.

1.2 Prevalence of CD

CD is believed to affect 2–2.5 percent of people globally, where percent of boys is 3–4 and percent of girls is1–2 (Polanczyk et al., 2015). Despite the fact that these figures indicate that CD is relatively uncommon at any particular moment, longitudinal studies of prevalence rate and case reports of accumulated prevalence have revealed that 10% of people are diagnosed at some stage throughout infancy and adolescence (Copeland et al., 2011). During the late 19th century, there was an increased rate in various psychological disorders- such as antisocial disorder, substance abuse, depressive disorder, etc. among the young population (Gelhorn et al., 2006). Some studies are suggesting that the number of patients with conduct disorder has also increased for the past few decades, whereas others have suggested minimal changes in prevalence over this period (Erskine et al., 2013). CD is most commonly seen in males than females and this prevalence is consistent across geographical regions (Cohen et al., 1993). The beginning of CD is most common in middle childhood or early adolescence. Despite this, the CD is predicted to be present in only about 5% of the world's countries (Lahey et al., 1998).

Children between the ages of 5 and 18 are often the focus of studies measuring the prevalence of CD, even though research suggests that children who are aged below 5 year the onset of CD can be reliably diagnosed (Keenan et al., 2010). Studies conducted on children aged below 5 years have projected either the same or somewhat higher prevalence figures (up to 5%) than the prevalence observed in older individuals, with less evidence of sex differences (Wichstrøm et al., 2011). Prevalence data for conduct disorder in ages 5–17 years was 5.0% (Erskine et al., 2016). The age-related symptoms have changed over the years as reported in research evidence. Aggressive behaviors become less common as people become older, however non-aggressive symptoms, notably status offenses, become more common among patients of conduct disorder (Maughan et al., 2004).

1.3 Causes and Risk Factors of CD

Ample empirical evidence identifies that parent-child relations are an important factor in the development of conduct problems (Latimer et al., 2012). Conduct problems are connected with several parents and family characteristics like raucous, lax, erratic & inconsistent discipline (Gaysina et al., 2013). One of the most frequent observations regarding the risk factors of conduct disorder is “Gender”. It's still unclear why this happens and how much of it is biological and how much is culturally determined. Conduct disorder is associated with a variety of untoward living conditions such as large family size, overcrowding, poor housing and low qualified school settings (Kazdin, 1995). The following factors which are associated with conduct disorder are described below-

1.3.1 Situational Factors

To make better understanding the environmental factors of conduct disorder twin studies have been done. The evidence indicates that due to the environmental influences among which prenatal, prenatal, familial and neighborhood risk factors are line of thinking to have a big role (Ruisch et al., 2018). Smoking (Gaysina et al., 2013) and alcohol intake habit of pregnant mothers (Popova et al., 2016), drug use and extreme stress (Popova et al., 2016) during the pregnancy period found to be a vital cause of CD onset. More evidences have pointed out the role of maternal stress on the development of the prefrontal cortex of a child with conduct disorder (MacKinnon et al., 2018). Perinatal risk factors for CD include obstetric complications (Sandman et al., 2018), parental psychopathology (Lukkari et al., 2012), malnutrition (Liu, 2011), and exposure to heavy metals (Barker et al., 2012). Studies also found a relation between birth difficulties and diagnosis of conduct disorder. The development of the brain gets hampered due to complications during birth which leads to a considerable risk of conduct disorder (Kim et al., 2015). Again, malnutrition can also cause neurocognitive deficits such as neuronal loss, alterations in neurotransmitter function, and neurotoxicity, all of which can raise the risk of CD.

Conduct disorder is a type psychological disorders that is influenced by shared family environment heavily (Johnson et al., 2017). Maladaptive parenting (such as corporal punishment, swearing, threatening etc.) and problematic parent-child conflict can lead to the possibility of CD (Afifi et al., 2011). There is a similar correlation between parental maltreatment and the high risk of CD for males and females (Boden, Fergusson & Horwood, 2010). Epidemiological research has identified additional environmental factors that affect CD, including deviant peers, low socioeconomic position, poverty, and community violence (Wesseldijk et al., 2018).

1.3.2 Heritability

Not only environmental, but studies have also found out important relationship between heritability and conduct disorder onset. Twin studies conducted on 1400-1700 individuals have reported the rate to be between 5% and 74% (Kendler et al., 2013). Furthermore, another multivariate twin study investigated the influence of two distinct genetic components that influence the development of CD. One involves disobeying the law, and the other involves open aggression (Gelhorn et al., 2006). From childhood to puberty, the genetic contribution to CD rises (Fairchild et al., 2009). When it comes to severity, twin research revealed that aggressive conduct has a stronger heredity influence than non-aggressive behavior (Jacobson et al., 2002). Regarding the influence of genetics, CD is not a uniform architecture. As a result, future research is looking more into the interdisciplinary approach while researching on CD.

1.3.3 Brain Mechanisms

Conduct disorder patients have demonstrated a lack of emotional awareness, decision-making, affective empathy, and teaching skills (Goodye et al., 2009; Stevens et al., 2001). (Fanti et al., 2016). Neurocognitive research has shown the influence of brain mechanisms on CD. The researcher also used Functional MRI on their studies to understand more about the brain function of CD patients. The anterior cingulate cortex (ACC), medial prefrontal cortex, and ventral striatum are less activated in young people with CD (Alegria et al., 2016). Conduct disorder has been connected to brain damage in the frontal lobe. One person with behavior disorder may not have proper function in the frontal lobe. Moreover, in terms of emotion processing, the children with CD showed actuation of the Amygdala and striatum cortex (Noordermeer et al., 2016). Past research on CD patients showed low basal cortisol levels (McBurnett et al., 2000) but recent

evidence reported minimal support for the finding (Pajer et al., 2001). There is a link between low resting and slowed heart rate reactions to the stress and CD that psycho-physiological research has consistently showed (Portnoy & Farrington, 2015). Another fascinating possibility has been suggested in several studies: male hormone levels during childhood and adolescence as a predictor of conduct disorder.

1.4 Diagnostic Benchmark of Conduct Disorder

DSM-5 and ICD-11 included conduct disorder in their recent edition. Both of them described the basic characteristics of patients with Conduct Disorder.

The conduct disorder criteria in DSM-5 are essentially unaltered from DSM-IV, although the restricted pro-social specifier is new. Individuals with a more significant pattern of conduct, such as callous-lack of empathy, lack of sorrow or guilt, indifferent about their school regular work, job, or in other essential activities, deficiency influences are eligible for the specifier. Children’s regular patterns of emotional and interpersonal functioning that the specifier represents rather than just the occurrence of bad conduct. People with conduct disorder who exhibit this specifier have little empathy and are unconcerned about other people's feelings, wishes, and well-being.

DSM-5 defined conduct disorder as a pattern of behavior that violates others' basic rights or key age-appropriate societal norms or laws on a regular basis. "International Classification of Diseases" the eleventh edition of the (ICD-11) (World Health Organization, 1988) described conduct disorder as "humdrum and continual patterns of antisocial, violent, or rebellious conduct" in which if such conduct reaches its apex for a person, it should constitute considerable

breaches of age-appropriate societal expectations, making it more serious than regular child mischief or teenage rebelliousness.

Childhood-onset phase and adolescent-onset phase conduct disorder categories has been distinguished by the DSM classification. ICD method, on the other hand, accounts for peer effect on conduct issues by distinguishing between socialized and un-socialized conduct problems. Hyperkinetic conduct disorder and depressive conduct disorder are separate subtypes of conduct disorder in the ICD classification, i.e. conduct disorder with co-morbid ADHD or depression. In the DSM system, however, similar diagnoses would be provided as co-morbid first-axis diagnoses.

1.5 Difference among Oppositional Defiant Disorder, Conduct Disorder and Juvenile Delinquency

Oppositional defiant disorder, a disruptive behavior pattern that is noticeable by anger and irritability, argumentativeness and defiance with regard to command figures that lasts at least for 6 months. When a teen exhibits at least three forms of antisocial behavior in the last 12 months, with at least one behavior exhibited in the previous six months, CD is diagnosed. Aggressive behavior that causes harm to people or animals and put at risk of property loss and destruction, deception and threats, and major violations of norms are all included in the diagnosis (Kimonis & Frick, 2010).

Oppositional defiant disorder may be a precursor to conduct disorder, according to some studies. DSM-IV described that a pattern of behavior that repeatedly and persistently violates others' basic rights or significant age-appropriate social standards is the core element of conduct disorder. In addition, the behavior abnormality must result in clinically substantial impairment in

social, intellectual, or vocational performance. Moffitt et al., colleagues explored adding a childhood-limited subtype, callous–unemotional features, female-specific criteria, and biomarkers in DSM-V diagnosis process for CD. Overall, the existing CD procedure was found to be sufficient.

According to the offender law, theft, burglary, housebreaking, brutality, roughness, and drug usage are all examples of delinquency. As a result, a large number of criminal activities are also CD symptoms. When compared to behavioral criteria, legitimate definitions of delinquency are strenuous to quantify consistently as well as correctly. The key value of legitimate definitions is that, the majority of delinquency researchers have adopted them, which can be used to compare and summarize data from various studies. Official records of judgments as well as self-reported misbehavior, are routinely used to assess delinquency. Official records occasionally contain the worst lawbreaker and crime where self-reports typically contain more of the latter. The tendency of official records to focus on the worst law breaker and the most serious crime or offense but self-reports include a wider range of delinquent behavior.

The DSM-IV divided CD into two types according to the onset: childhood-onset and adolescent-onset. In the beginning of childhood-onset CD, the aspects of ODD which is distinct by temper outbursts and rebellious, impatient, argumentative, and unpleasant conduct usually come before.

Official records of delinquency reveal that the start of delinquency usually occurs between the ages of 13 and 16. The age at which a crime begins varies depending on the sort of crime. Filching and ravaging occur before teen age period (outbreak occurs at 11 years of age), robbery and motor vehicle stealing occurs in teen age (outbreak occurs at 14 to 15 years) and sex offenses and drug using in the later teenage years. According to the Montreal Longitudinal and

Experimental Study average onset is 17 to 19 years. According to the Cambridge Study on Delinquent Development, males who were first convicted at a young age (10 to 13 years) tended to be the most persistent offenders, committing an average of 9 offenses resulting to convictions over the course of a 13-year criminal career. Sweden and Canada have each reported similar finding (Murray & Farrington, 2010).

Conduct disorder is a psychiatric diagnosis that is characterized by a pattern of hostile, resistant or offensive conduct that is repeated and persistent and one of the mass frequent types of mental health condition in children and teen age' period with a prevalence rate of 1.5 percent to 3.4 percent in this age range. Boys are affected three times more than the girls. (Scott, 1998).

Delinquency, on the other hand, is a socio-legal term for children and adolescents who transgress the legislation. The middle adolescent years are when delinquency rates are highest. Each year, about 2% of children and adolescents, aged 10 to 17 come into touch with the juvenile court system. A small fraction of offenders (repeat juvenile delinquents) continue to offend and account for a disproportionately high number of court appearances (Freeman, 1996). Early behavior difficulties are largely considered as the strongest indicators of future repeated delinquency (Sheldrick, 1995).

1.6 Classification of Conduct Disorder

Research has repeatedly shown that some children who are diagnosed with CD start exhibiting minor conduct issues in preschool or in the beginning of elementary school, and that their behavioral issues have the tendency to get worse over the course of childhood and into adolescence (Lahey & Loeber, 1994). Another group shows no signs of conduct disorder during their childhood but starts showing up symptoms when they hit adolescence. They begin showing

delinquent and anti-social behavior at the age of 18. Though there are different patterns of onset, aggressive behaviors are more likely to show in the childhood onset group and adolescent, and antisocial and criminal behaviors are more likely to continue to show from adulthood (Kimonis & Frick, 2010). Moffitt proposed that, childhood-onset group children grow their problematic behavior through a transactional process where vulnerable and a difficult child (e.g., impulsiveness with verbal deficits) endure an inadequate rearing environment (e.g., poor parental relationship, poor school pattern) (Moffitt, 1993).

Many researches have showed the difference between childhood-onset and adulthood-onset. However, emerging research has shown additional reports regarding the onset. A small percentage of youth account for a large proportion of the severity and stability within this group has been revealed by many recent evidence (Kimonis & Frick, 2010). As previously mentioned, the childhood-onset group appears to exhibit a persistent sensitivity that impairs adjustment across several developmental stages. There is evidence, though, that this group can be further divided to define a number of other vulnerabilities. This differentiation is made depending on whether or not a callous and emotionless interpersonal approach is present.

1.7 Consequence of CD

For a variety of causes, CD is a significant mental health issue. It frequently involves animosity, is closely connected to criminal activity, and also connected with a variety of other social, emotional, and intellectual problematic issue, to name a few (Frick, Stickle, Dandreaux, Farrell, & Kimonis, 2005). As for example, CD behavioral issues frequently result in a child being avoided by classmates and being dangled or thrown out from their educational institutions (Frick, 2012). Secondly, conduct problem in childhood phase is a predictor of future issues in

adulthood including different types of mental health issues such as substance abuse, risk of arrest, school dropout, poor marital adjustment, unskilled job performance, and somatic problems such as poor breathing function etc. (Odgers, Caspi, et al., 2007; Odgers, Moffitt, et al., 2008).

The prognosis for conduct disorder depends on the severity and frequency of a child's different patterns of behavioral and emotional issues. Youngster who show very violent, dishonest, or destructive conduct on a regular basis have a terrible prognosis. If additional mental diseases are present, the prognosis is very worse. Getting a timely diagnosis and extensive therapy, on the other hand, can greatly improve a child's prognosis. Once your kid receives therapy for conduct disorder and any other underlying issues, he or she will have a far higher chance of making significant progress and having a brighter future.

The youngsters are likely to suffer long-term issues if they are not treated. They may be unable to adjust to the duties of maturity, resulting in difficulties in relationships and keeping down a career. They're also more likely to engage in substance misuse and have run-ins with the authorities. When children reach maturity, they may acquire a personality condition, such as antisocial personality disorder. For these reason early detection and intervention are so important. Too early youngsters undergo care, the higher their chances of a brighter future.

1.8 Preventive Measures and Treatment

Conduct Disorder is a developmental disorder that deteriorates the social, psychological, and physical aspects of a child and adolescent. Research is also conducted on the preventive measures of conduct disorder. Various models have been established to decrease the negative impact of CD. Recent systematic studies and meta-analyses found that both general and specific

precautionary plan of action for aggression had effect sizes that ranged from zero to small (Hendricks et al., 2018). The measures effective for conduct disorder are given below-

1.8.1 Management

Effective CD management attempts to lessen the primary symptoms, boost moral development and social skills, improve emotion regulation in those who exhibit reactive aggression and emotion deregulation and lessen the symptoms of co-morbid psychiatric and developmental problems. Additionally, it seeks to lessen criminal conduct and enhance educational and employment achievements. (Erskine et al., 2016). The management depends mostly on clinicians and mental health professionals. For the purpose of selecting or identifying the management goals that are suitable for the child's age, primary caregivers and peer groups should consider the developmental models. Behavioral treatments are the most likely of these to produce long-term behavioral change.

1.8.2 Behavioral Interventions

The highest-quality parenting of young to middle-aged children is the focus of the most economical CD therapies. Early interventional parenting training ought to be made accessible to all the parents of CD-affected children (Sampaio, 2018). The behavioral programs might be offered by health and social service providers, physicians, and kindergarten and school teachers who might also inform parents about the availability of these treatments (Dodge et al., 2015).

1.8.3 Psychosocial Intervention

When it comes to treating children with conduct disorder, psychosocial therapies are quite effective. The first line of defense for the treatment of conduct issues in young and middle

childhood (ages 3 to 11) is behavioral parent training, also known as parent management training, which is based on the social learning theory (Michelson et al., 2013). This intervention seems to be most effective while children are young. Examples include the Incredible Years of Positive Parenting Program, and the Management of Parent Training (Forgatch et al., 2017). In late childhood and adolescence, multi-component treatments that integrate family strategies, behavioral strategies and cognitive-behavioral therapy are most effective (Garland et al., 2012). The parenting components of these interventions are based on social learning theory but differ from the interventions used for younger children (for example, age-appropriate consequences for limit-setting might include loss of privileges for adolescents rather than time out for younger children).

1.8.4 Special Education and Detention Facilities

Many children and adolescents with CD are placed in special education, foster care, youth welfare institutions, or the juvenile justice or detention system (Bronsard et al., 2016). Although these are not enough data regarding the effectiveness of these facilities for treating conduct disorder, it is evident from the existing data that outcomes vary according to the intervention method implemented by the educational or detention institutions. Overall, it can be effective in dealing with children with conduct disorder.

1.8.5 Psychopharmacological Interventions

Pharmacological therapy is indicated in some instances, such as in children and adolescents with CD and co-morbid ADHD. Individuals with CD and high levels of reactive aggression and severe emotion deregulation can be given antipsychotics if psychosocial interventions have not led to a meaningful reduction in reactive aggression. The most often

researched and successful drugs in behavior difficulties in ADHD and conduct disorder are CNS stimulants and narcoleptics (Piling et al., 2013).

1.8.6 Parental Role and Family Environment in Management of CD

As previously mentioned, CD is linked to a number of parent-child problems, such as coercive parenting styles, harsh and controlling parenting, lack of child obedience, and increasing resentment against parents. In terms of family environmental variables, Parents whose children and adolescents are diagnosed with conduct disorders usually deal with marital conflict and inter-parental conflict. Parents frequently fail to provide appropriate assistance to these youngsters (Barrett 2007, Hill and Donohue 2007). In addition to these characteristics, Acosta and Rosen (2008) found that family breakup, single-parent families, and even big family sizes put the family setting under a lot of stress and frequently precede the onset of major behavioral problems in some family members. In addition, Jewell and Stark (2003) discovered that families with conduct disorder have lower levels of cohesiveness and higher levels of conflict.

Frick (1993) examined three types of family dysfunction and the effects they had on the development of models that reflected family causal links in conduct disorder. According to this author, socialization processes, marital status, and parental adjustment all come up with the emergence and perseverance of behavioral issues in children. On the other hand, the causal connection is not a simple linear one. It's possible that conduct disorder develops before dysfunctional households, with conduct issues causing the latter. Other variables may also contribute to family dysfunction and conduct disorder, in which case family issues may play a mediating role. These models represent the idea that the parental influences and families on children's conduct problems is more of a correlation than a direct cause. However, when creating and prescribing therapies for children with conduct issues, further study and evaluation of the

parent/involvement of family is required. The kid with conduct disorder has the tendency to expose to a home environment that is often marked by poor parenting, parental substance misuse, rejection, marital conflict, severe and inconsistent discipline and often parental negligence, according to investigators (Patterson, De Barsyshe and Ramsey 1989, Webster-Stratton 1993, Searight, Rottnek and Stacey 2001). In comparison to mothers of children who do not show any signs of conduct disorder, mothers of children with conduct disorder report that their families are less cohesive, less emotionally expressive, more conflictual, less encouraging of independence, less involved in recreational activities, less organized, and more control-oriented (Slee, 1996).

1.9 Behavioral Training for Parents

Since 1970, behavioral training programs for parent have evolved. It began as a type of applied conduct analysis since it relied on learning and conduct principles uncovered via behavioral experimentation. PT programs, on the other hand, were later established using a cognitive behavioral approach, including cognitive treatments into therapeutic procedures (Azar, 1989). Parent training is a method of addressing child behavior problems in which parents are given training about how to change their children's behavior at home by utilizing processes. PT is a therapeutic strategy that teaches mothers, dads, and other parents' tools and tactics for understanding and treating their children's behavior problems.

Parent training can take many forms, including one-on-one, group, classroom, and internet-based, but it always needs some type of direct interaction with parents. This service is usually emphasized as a need for the return of children to their parents' custody and the termination of court dependency proceedings. In the majority of child welfare situations, parents are compelled to participate in interactive education utilizing a range of curricula. Parent education programs are similar to parent training programs.

BPT stands for Behavioral Parent Training, a program that teaches parents how to support their children to behave well. It is conducted with the assistance of a mental health professional who come face to face with parents in person, in groups or by video or the internet. It is critical for the parents to choose a program that meets their family's needs. It's also crucial to pick a program that has been shown to help people overcome behavioral issues. This plan of action cover:

- Setting house rules, and routine
- Giving clear instructions
- Learning how to praise good behavior and avoiding mild, incorrect behavior
- Making a plan and working with children in public places
- Applying points and charts systems with prize and consequences

Considering parents of children up to age 12, Parent Management Training (PMT) teaches parents several methods for controlling behavior. When the parent and child already have more pleasant interactions but the child's conduct is an immediate concern, it is frequently advised. A high-quality Applied Behavior Analysis (ABA) service must include parent management training. For parents, kids, and families parenting education has numerous facilities. This act of assistance can educate parents on how to raise their children with better abilities, deal with difficult habits, and promote their development. All parents of children with Conduct Disorder, ASD (autism spectrum disorder), ADHD- Attention Deficit Hyperactivity Disorder, and other behavioral or communication difficulties are benefitted by parent training that are based on the behavior science and the behavioral analysis. Parent training/education programs can take one of two approaches: behavioral or relationship-based. Parenting strategies are taught in behavioral programs to address the causes of problem behavior, such as ignoring the latter and

applauding cooperative behavior, developing a relationship with the child through child-led play, and establishing consistent limits with 'time out' for violation. Relationship programs are designed to assist parents in better understanding their own emotional world and behavior as well as their child's, as well as to improve communication with their child. These categories are not mutually exclusive and many modern programs incorporate components from both. The term 'program' denotes that the treatment process is firmly structured and its essential elements are well-established document, allowing it to be reliably implemented by a variety of personnel with the required training. The programs are concentrated and short-term (often 8–22 weeks), and they can be delivered in a variety of venues (hospital, community, office, or home), in groups or individually. They include an element of experiential learning and require parents to practice what they learned during the session as homework. Individualized parenting programs, on the other hand, should be distinguished from general one-on-one counseling, which may include some parenting guidance, such as that delivered by health visitors. This isn't to say that such activity isn't important, or that health visitors aren't qualified to provide parent training and education programs.

1.10 Designing a Parent Training Program (TP)

In the past 30 years, Parent Management Training (PMT) consistently has yielded promising results as a treatment for child mental health disorders (Kazdom, 1997). In spite of the fact, more recently its range has expanded to encompass preventative mental health issues for at-risk groups and child internalizing disorders, PMT's primary target population has remained children with disruptive behavior problems (word used to include children and adolescents) (Foote et al., 1998; Kazdin, 1997). PMT is a instructive, educational program-driven treatment package that are given by clinicians with a variety of therapeutic backgrounds. It has even been

researched about self-directed intervention. Consequently, PMT shows assurance as a widely appropriate intervention that could assist in bridging the significant gap between the resources required to manage mental health issues of the children and those available to those children.

1.11 Implementation of a TP

The training is typically given to specific families or group of families by therapists (psychologists or social workers), and it is generally focused on the parents instead of kids, though children can participate if therapist and parents find them fit (Baumann et al., 2014). Different programs range from four to twenty-four weekly sessions in length (Furlong et al., 2013) with a typical training course having 12 core sessions each week (Kazdin et al., 201). PMT has not been frequently used outside of clinical and research settings, and therapists and another provider's training has been restricted (Jones et al., 2013). PMT is not properly utilized and there is a limited training for therapists and other providers and outside of clinical and research settings it has not been widely used (Jones et al., 2013).

Evidence-based programs are methods of improving child outcomes that have been shown to work when researched rigorously and often repeatedly by experimental studies (Allen, 2011; Flay et al., 2005). Examples include parenting programs such as the Incredible Years BASIC program. These work premise that many children develop problem behaviors because parents lack, or inconsistently use, key parenting skills, and that these skills can be improved. Engaging and retaining parents in parenting programs is a challenge. They often live in areas without sufficient evidence-based services and they often lack the transportation needed to access such services. For these families, providing programs that have not been shown to be effective through experimental or quasi-experimental research but include elements that are common to such programs may be necessary. Given that parent participation and retention alone,

however, cannot guarantee positive parent and child outcomes, these programs must have a sound theoretical approach to helping parents acquire the positive parenting knowledge, attitudes, and practices.

1.12 Literature Review of Parent Training of CD Children

Parent training which aims to improve parenting skills in order to change specific family interactions, and multi-systemic therapy (MST), a broad-based intervention that focuses on family and extra-familial aspects like parenting, school and peer relationships (Henggeleret al.,1992). For the treatment of conduct disorder and delinquency, a variety of family and parenting interventions have been suggested (Sheldrick,1995). According to family and parenting interventions, family interactions can cause sustained conduct disorder and delinquent or worsen them and that if family relationships are properly, properly mobilized, they can be a powerful therapeutic agent for reducing undesirable behaviors and preventing relapse (Diamond et al., 1996).Parent training program by professionals can contribute to improvements in parenting practices and in parents' perception of their child's behavior (Webster-Stratton & Hammond, 1997). This can happen in the context of an out-of-home placement, such as Multi-dimensional Intervention Foster Care (Chamberlain & Reid, 1998).

The parenting program technique has been scientifically verified for the prevention and treatment of behavior problems, integrating all elements identified as increasing parent training outcomes, particularly with high-risk children who are typically thought to benefit the least (Mihalic & Irwin, 2003).Parent training programs come into view an successful and potentially cost-effective therapy for these children (Dretzke et al., 2005).The most successful interventions for childhood conduct problems are behavior-based parenting training programs which are conducted to improve parenting skills (Jerrott, 2005). Very little else has been demonstrated to

work. In the volunteer sector, a parenting intervention with randomized controlled trial was used to lessen child behavioral problematic issues and appliances of change were undertaken by Frances, Jennifer, and Ivana (2006).

By emphasizing good parenting, these programs enhance parenting skills, child behavior, and parent–child connection. Furthermore, these types of programs target attendance challenges for socially disadvantaged and difficult-to-engage families (Hutchings et al., 2007). The findings imply that in a community voluntary-sector environment, parenting program that is administered in group settings by expert and well skilled personnel can be beneficial in lowering conduct issues and improving parenting skills. Parental mental health or substance misuse problems or a history of abuse or negligence are particular issues in parent engagement (Utting et al., 2007). Parent trainings are emerging as the most effective ones as medication is largely ineffective for the of conduct disorder (Scott, 2008). Parenting programs are effective in case of the treatment of conduct disorder (Dretzke et al., 2009). In a child safe keeping agency, Marie-Josée, Sylvie and Julie (2010) performed a study on the effectiveness of a parent training program called "Incredible Years." They discovered that, despite the obstacles of implementing an evidence-based parent training program by experts in a child welfare agency, it can help improve parenting practices and parents' perceptions of their children's behavior. One of the main causes of treatment failure concerns difficulties in engaging families. Only about a third of invited families enroll in prevention projects which means they attend at least one program session; of these, 40–60% drops out even when financial incentives, childcare, refreshments and transport are provided (Baker et al., 2011).

When parent training programs are demonstrated in a group setting can be effective for lessening conduct problems and increasing parenting skills (Bloomfield & Kendall, 2012).

Parent management training which was internet based was conducted for eighteen months for children with conduct disorder problems and the relationship of assignments acquiescence to outcome was undertaken by Jens Högströ, Pia Enebrink, Bo Melin, and Ata Ghaderi (2015). The results brace that, internet-based PMT emphasize the need of homework during training of parent compliance. The reduction of IP (ineffective parenting) facilitates a care giving environment that affects children's behavior and developing personality (Elizur, Somech, Amiram & Vinokur, 2016).

1.13 Rationale of the Present Study

Any country's greatest asset is its children. Children with conduct disorders are at a danger for variety reasons. We can tell from the study that these youngsters will never be able to progress in life. They become a burden on both the family and society. These youngsters occasionally engage in antisocial behavior that is both dangerous to themselves and to society. In light of this, the current study aims to assist parents by teaching them effective communication with their children and providing intermittent recommendations for parental self-care so that everyone is benefitted. The goal of the study is to improve awareness of healthy parenting and to lessen children's behavioral issues. As a result, there is a pressing need in Bangladesh to provide parental training for parents of children with conduct disorder. So that parents may have a better concern of the type and scope of conduct disorder, as well as the skills and methods necessary to engage with these children as successful as feasible.

1.14 Research Questions

The questions of this study asked are:

Whether the parent training is effective for lessening the behavioral problem of the children with conduct disorder?

Can parental stress be alleviated by the training and will their parenting practice be improved because of the training program?

1.15 Objectives of the Research

The objectives are as follows:

- To develop a parent training manual according to the need of the parents whose children are diagnosed with conduct disorder.
- To investigate in what extent parent training is effective on behavior of children with conduct disorder.
- To modify disruptive behaviors of the children with conduct disorder.
- To investigate the changes in distress level of the parents whose children are diagnosed with conduct disorder resulted from the training program.
- To improve parenting practices.

Chapter 2

Methodology

This study was conducted following two separate methodology. This study had two phases in method section. The first phase was the development of a manual for parent training and the second phase was to investigate the impact of that training. Procedure of these two sections are described below.

2.1 Steps for Developing Parents Training

Parent training manual was developed by researchers herself by following appropriate procedures. Information was collected from various sources and from existing resources. Steps involved in the training of parents involved review of available worldwide training with evidence, discussion with professionals, writing up the first draft then getting them evaluated by the judges. After that completing the second draft and presenting before the judges for evaluation and finally putting the module for pilot study. All the steps for developing parent training are given below as flow chart:

Figure 2.1

Steps for Developing Parent Training

Systematic review to accumulate core component of available evidence based on worldwide parent training

↓

Discussing the practicing clinical psychologist & psychiatrist

↓

Write up the first draft

↓

Judge evaluation

↓

Second draft

↓

Presenting to the judges for evaluation

↓

Pilot study

Core components are the building block of the training manual development which have their theoretical and historical basis and worldwide use. Every component has its target population which is developed by professionals on the basis of some known theory of learning and development (Albert Bandura, 1977). First component named Adolescent Transition Program, developed by Thomas Dishion and Katharyn Kavanagh, 2000 finds it theoretical basis in social learning theory. The Community education program was developed by Charles E. Cunningham which had its foundation in Family System Theory and scial-cognitive psychology which focuses on positive behavior, family relationship, problem solving among many other things. Other components like Defiant Children, Parent Child training series, parenting wisely, helping your children all have their theoretical foundation in Social Learning theory coined by Albert Bandura. All of them focus on problem solving skill, encouragement, reinforcement, communication, attention, issues of violence and so on. The purpose of the researcher is to accumulate all the core components to develop a more cohesive manual for the parents training to have the largest impact possible for the study. The detailed presentation of all the core components given in table 2. 1.

Table 2. 1

Core Components of Available Evidence

Program title	Developer/author	Target population	Theoretical foundation	Program content
Adolescent Transition Program	Thomas Dishion and Kathryn Kavanagh, 2000	11 to 14	Social learning theory	Stimulation, setting of limit and monitoring, solve the problem, and improvement of family relationship and communication patterns.
The Community Parent Education Program (COPE)	Charles E. Cunningham, Rebecca Bremner and Margaret Secord, 2009.	3 to 12	Family systems theory Social-cognitive psychology Social learning-based parenting programs Group process	Reinforcing positive behavior, balancing family relationship, controlling thoughts which intensify anger, ignoring minor disruptions & protest, improving self-regulation, cognitive strategies, emotionally neutral commands, warning, effective consequence, token economy, problem solving
Defiant Children	Russell A. Barkley, 1997	2 to 12	Social learning theory Behavior modification	Beneficial results, establishment of provocation programs before punishment, pay attention, applying independent play, giving praise is not enough: token system, Time out, prediction of problems, betterment of school performance from home: the daily school behavior report card.
The Incredible Years: Parent and Child Training Series	Carolyn Webster Stratton Bywater, 2012; Webster-Stratton & Reid, 2003)	2 to 12	Social learning theory Cognitive theory	Effective direction, time-out, emphasizing the importance of the family and teacher socialization processes, skills building, irenic discipline techniques, logical and natural outcomes, observation,

				problem solving with children, and family member, parent interpersonal issues, e.g. constructive communication, anger management.
Parenting Wisely	ROBERT E. PUSHAK AND DONALD A. GORDON, 2016	9 to 18	Social learning theory Family systems theory Cognitive behavioral theory	Problem solving skills, communication skills, speaking respectfully, assertive discipline, reinforcement, monitoring, children association of negative peers, solving family problems, single parent issues.
Positive Parent Training Program	Matthew R. Sanders, 2012	birth to age 16	Social learning theory, cognitive and developmental theory and concepts.	Communication, physical affection, attention, ignoring, ground rules setting with children and setting proper direction that is consistent with the ages &making request that is presented with logical outcomes, spending quality time and time out, withdrawal of privileges
Parent-Child Interaction Therapy (PCIT)	Brinkmeyer & Eyberg, 2003; McNeil & Hembree-Kigin, 2010.	children between the ages of 2 and 7	Social learning theory attachment theory	Relationship enhancement phase-praise, reflection, limitations, description, enjoyment, discipline and compliance phase (parent-directed interaction) provide constructive direction, simple instructions to the child,
Helping Your Child	CREA under the project entitled, Instituting Parenting Skills supported by UNODC, 2018	10 and beyond	Social learning theory	Understanding parenting, how will child change, knowing your child's personality, building child self-esteem, children's need and common age-related behavior, communication, settings limits, understanding child's

	misbehavior, positive discipline, monitoring, quality time, making question and hypothesis, encouragement or strokes, reflection and reflexivity, empathy to your child, dealing with coercive circle, alcohol or drug use, short practice on mindfulness.

After writing down the first draft of the manual, for appropriateness of the developed manual was evaluated through feedback from judges. Five professionals participated as judges for this manual evaluation. They gave their valuable feedback and it was revised accordingly. The judge panel includes -three Clinical Psychologists were there as judges who were academicians from University of Dhaka and two professional Psychiatrists evaluated the manual who were from BSMMU and NIMH.

One pilot study was conducted before the final data collection on a group where there were three parents as participants whose children are diagnosed with conduct disorder and their children age range was 9 to 13 years and their parent's educational qualification was S.S.C to H.S. It was conducted at National Institute of Mental Health. The pilot testing was helpful to structure the session time which in turn help in the final study. And the challenge was it took longer time in group therapy sessions. The group conduct was done in the same time and the challenging issue arising from this pilot study shortened the number of sessions. Due to the restricted time of the hospital the number of sessions were reduced to 5 from original 7 set before.

After the pilot testing was over the finalized manual was set upon the basis of the experience. It has five sessions namely-

- Understanding Parenting and Knowing Your Child,
- Learning Parenting Skills -I,
- Learning Parenting Skills-II,
- Learning Parenting Skills-III
- and Parental Self-care.

In the first session parents are welcomed and a formal introduction to child behaviour and understanding of conduct disorder is given. The following three sessions of parenting skills they are informed and taught about important skills like empathy, strokes, problem solving, monitoring, communication etc. Which all are expected to be impactful in changing their view on parenting and hopefully would do a world for their children as well. Finally, to deal with all the stress and negative emotions involved in parenting they learn about their own self-care and some techniques like mindfulness, relaxation, anger and stress management. The total session structure is mentioned in the table bellow

Table 2.2

Contents of the 5 Sessions

Session	Task	Content
1.	Understanding parenting and knowing your child	Getting started Parenting style Understanding child's need and behavior Understanding child misbehavior Psycho education about conduct disorder

2	Learning parenting skills-I	Monitoring Communication Setting limits
3	Learning parenting skills-II	Positive ways of disciplining Empathy Quality time Strokes/encouragement
4	Learning parenting skills-III	Breaking the coercive circle Problem solving Improving the school performance
5	Self-care (parental)	Mindfulness Relaxation Anger management Stress management

In the second phase, sample as well as equipment used, research design's descriptions included here which was used to explore this parent training manual's impact. Next step is to put out the study procedure in chronological sequence and ethical considerations. A brief

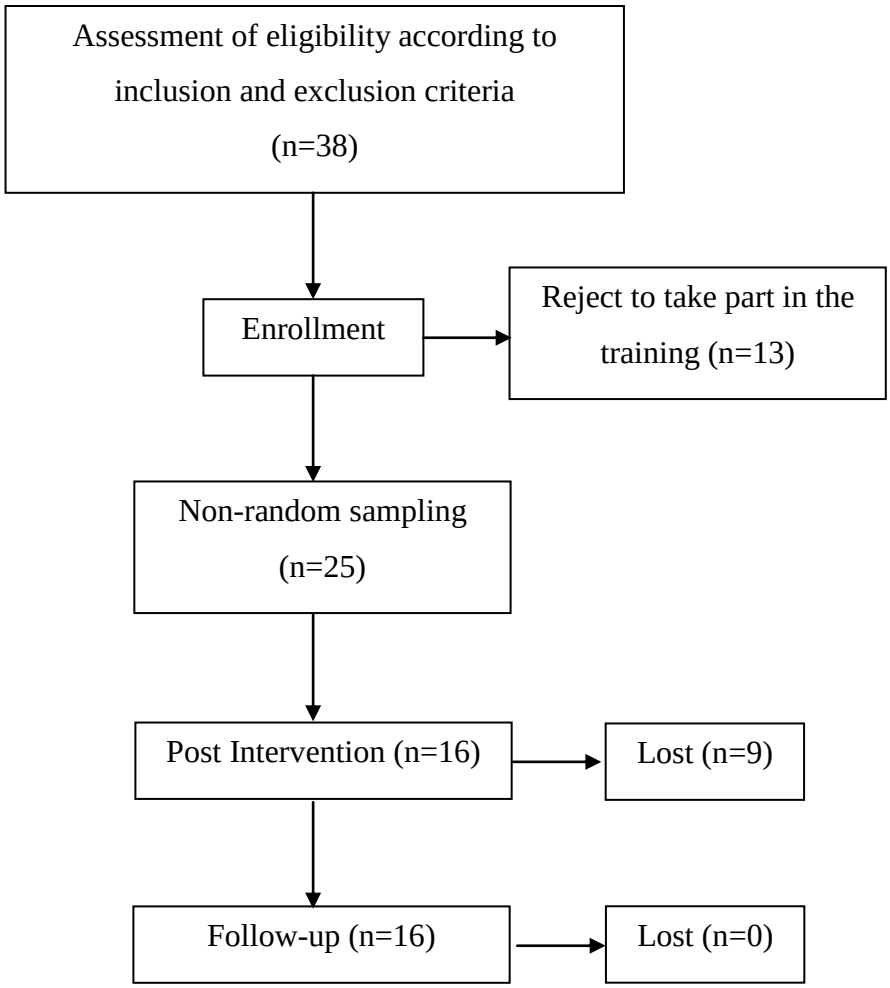
explanation of data analysis concludes this chapter. In the result section, the concept of data analysis is covered in greater depth.

2.2 Participants

A purposive sampling technique was used for this research. With this technique, samples were chosen by their availability and some sampling criteria. 16 participants whose children were diagnosed with conduct disorder were arranged for this study filtered by some inclusion criteria, which are as follows I) Parents who take care to their children since childhood and who had no formal training on conduct disorder II) Age range of their children was 4 to 16 years. In the case of the first criterion, it was also considered whether they are the direct and primary caregivers of the children with conduct disorder. Participants were selected from different hospitals of Dhaka city where they came for treatment of their children. In the case of children with some other psychotic disorders other than conduct disorder, the participants were excluded from the sample. Figure 2.1 describes the whole participant scenario:

Figure 2.2

Participant Flow of the Study



The participants were selected from Bangabandhu Sheikh Mujib Medical University (BSMMU), National Institute of Mental Health (NIMH) and Dhaka Shishu Hospital. After assessing all the inclusion criteria on eligibility 38 parents of children who is diagnosed with conduct disorder were selected and enrolled for the study. 13 of them opted out of the study in the first phase so 25 participants were left for the Baseline assessment. 16 participated in the post intervention phase losing 9 participants. All of them participated in the follow up phase of the study. The reason behind the participants of choosing to drop out of the study in different phases

as they expressed when contacted, were mainly due to fixed date, time and their inconvenient location to take part in the study.

2.3 Characteristics of the participants

A total of 16 children with conduct disorder's parents engaged in this study. These 16 children and their parent's demographic information are given in the table no. 2.3 and table no. 2.4 respectively. Table no.2.3 showed that, 75.00 % of the children were male and 25.00 % were female. 62.50% of the participants belong to the age ranges of 6-11 years on the other hand,37.50% of the participants belong to the age ranges of 12-16 years. Half (n = 8) of the children were the first child in terms of birth order and maximum of them (43.75%) were student of the primary level. One fourth (n = 4) of the children used to feel well most of the time while 62.5% (n = 10) of them used to feel well sometimes.

Table 2.3

Demographical Distribution of the Children

	N	*%*
Age		
6-11 years	10	62.50%
12-16 years	6	37.50%
Sex		
Male	12	75.00%
Female	4	25.00%
Birth Order		
First	8	50.00%
Second	5	31.25%
Third	2	12.50%
Fourth or more	1	6.25%

Educational Qualification		
Illiterate	1	6.25%
Literate	4	25.00%
Primary	7	43.75%
Secondary	4	25.00%
Monthly Family Income		
20000 or less	6	37.50%
20001 to 40000	4	25.00%
40001 to 60000	3	18.75%
60001 or more	3	18.75%
Wellness of the Children		
Most of the time feels well	4	25.00%
Sometimes feels well	10	62.50%
Often feels ill	2	12.50%

Half (n = 8) of the fathers were in their 40s and most of the mothers were evenly distributed between 30s and 40s with 7 in each group. Higher portion of the parents, 7 fathers (43.75%) and 8 mothers (50%) had an educational level of below SSC.

Table 2.4

Demographical Distribution of the Parents

	N	*%*
Father's age		
30 - 40 Years	3	18.75%

40 - 50 Years	8	50.00%
50 - 60 Years	5	31.25%
Father's educational qualification		
Below SSC	7	43.75%
SSC – HSC	4	25.00%
Honors – Masters	5	31.25%
Mother's age		
20 - 30 Years	7	43.75%
30 - 40 Years	7	43.75%
40 - 50 Years	2	12.50%
Mother's educational qualification		
Below SSC	8	50.00%
SSC – HSC	3	18.75%
Honors – Masters	5	31.25%

2.4 Measures

Three psychometric tools as well as a standard demographic questionnaire were used in this research:

2.4.1 Demographic Questionnaire

2.4.2 The Bengali Version of The Child Behavior Checklist (CBCL)

2.4.3The Bengali Version of Perceived Stress Scales (PSS)

2.4.4 The Bengali Version of Parenting Practices Scales (PPS)

2.4.1 Demographic Information

A demographic questionnaire was used for collecting information that includes: age of the children, age of the both parents, educational qualification of children and their parents, sexual identity of the children, birth order of the children, income ratio of the parents or family and wellness of the children.

2.4.2 The Bengali Version of The Child Behavior Checklist (CBCL)

The CBCL is a checklist that is often given to adults who react based on their observations and judgments about their child's behavior and difficulties. Caregivers were requested to give rating on how truthful different assertions about their child's behavior were in the last six months. Parents or caregivers who have frequent contact with the kid might use this tool to offer information on the child's issues.

This scale was originally developed by Achenbach & Edelbrock in 1983. It is primarily used to detect behavioral and emotional problems in children including anxiety, depression, aggression, delinquency, etc. It is used in a number of settings including schools, hospitals, mental health facilities, private practices, and research. The CBCL consists of 113 questionnaires. Three-point Likert scale was used to score about the behavior. The items are in the form of how true various statements are. They are answered by giving tick mark, from 0 = Not True, 1 = Sometimes true and 2 = Often true. The score range of this scale is 0 - 190. It is self -administered and meant to be completed by parents. From CBCL six subscales we get the information or data about emotional problem, somatic problems, anxiety, hyperactivity, oppositional defiance, and conduct problems. Original scale has reported high validity and

reliability. As it has been revised many times no steady coefficient alpha was found. But the range has always been from 0.76 to 0.91 which is considered as a good reliability (Cortina, 1993). The Bengali version of this scale was developed in 1993 (Begum, 1993), which has been reported to be qualified as a psychometric tool with high reliability and validity.

In addition, the parents fill out three social competence measures, which measure the child's participation in school, social connections, and non-academic activities. The scores of each kid are then compared to gender and age-appropriate norms (4-5, 6-11, and 12-16 years). There are eight scales in this questionnaire. Externalizing behavior issues (e.g., items from the delinquency and aggressiveness scales) and Internalizing behavior problems (e.g., items from the withdrawn, Somatic Complaints, and Anxious/ Depressed scales) are represented on these scales. The CBCL behavior issue scale contains wide and narrow band groupings for people of all ages and genders. The behavior problem scales for each sex and age that are assessed on the Child Behavior Profile describe a picture of a child's behavioral problem. This profile may be used to determine a child's place among different broad (externalizing and internalizing) and narrow (delinquent, aggressive) groupings. The amount of CBCL subscales are measured by age and gender of the children. Somatic complaints, withdrawal, hyperactivity, aggression, and delinquency are factors or subscales that are common to both sexes in the age groups of 6-11 and 12-16.

2.4.3 The Bengali Version of Perceived Stress Scale (PSS)

In 1983 Cohen and his associates outlined to assess to which in one’s life situation are estimated as stressful. The Bangla translated version of PSS-10 was used for the present study. No published data on the reliability and validity were found for the Bangla version of the PSS-10. The Bangla version is available at Sheldon Cohen's Laboratory for the study of stress

(Mozumder, 2017). The 10-item five-point Likert-type scale measures the degree to which an individual appraises his or her life as stressful. The scale combined both positive (4, 5, 7, 8) and negative items (1, 2, 3, 6, 9, 10). In case of negatively stated items, 0 signifies ‘never’, 1 ‘almost never’, 2 ‘sometimes’, 3 ‘fairly often’, and 4 ‘very often’ while the reverse can be seen in case of positive items.

2.4.4 The Bengali Version of Parenting Practice Scale (PPS)

This scale was originally developed by Strayhorn & Widman (1988). To measure four parenting practices namely positive parenting, functional discipline, discipline avoidance, and nature of parental engagements of their child's life. The caregivers were requested to take part in the study the scale contains 34 multiple-choice items. There are seven possible responses for each question which shows how parents’ reaction varies in response to the different activities done by their child. For example, it may range from Giving the child a long lecture to keeping it short and precise. The reliability of the Bengali version of the scale was determined by, i.e., administering both the versions to a target sample within a two weeks interval. The correlation coefficient e.g., Pearson r was found to be r = 0.70. The original English version scale was found to have a six-month test-retest reliability of r = 0.70 and an internal consistency coefficient alpha of 0.79. The Bengali version of the scale was adapted in 2003. (Begum, Rahman & Ahmed, 2003). This tool was used for assessing the participant’s overall skill of parenting.

2.5 Design

The overall technique which is used to explore the many elements of the study in a cohesive and rational manner is known as a research design. As a result, a study design serves as a roadmap for data collection, measurement, and analysis. Design for this study was one group

pretest-posttest design of research to see the impact of parent training on behaviour of children with conduct disorder. Participants' data were taken by using all of the above-mentioned psychometric tools. Parents were given verbal and written instructions properly before filling up the data sheet. Then the 5 session long parenting training was delivered which includes

1. Understanding parenting and knowing the child
2. Learning parenting skills and
3. Parental self-care

The full module and structure of the training is in the appendix section 1 and 2. Participants' responses using the same three psychometric tools were taken immediately after the training ended. Then after one month their responses were recorded again for a third time as a follow up. The data collection procedure of this study is given in table 3.

Table 2.5

Data Collection Procedure

Pre-test	**Treatment**	**Post-test**
CBCL, PSS, PPS	Understanding parenting and knowing the child Learning parenting skills and Self-care	CBCL, PSS, PPS

2.6 Procedure

At first, an official approval for space, assistance and cooperation was obtained from different hospitals like BSMMU, NIMH, and Dhaka Shishu Hospital. The psychiatrists were requested to refer to the parents whose children are diagnosed with conduct disorder as reported by the inclusion and exclusion benchmark of the sample. Through a declaration and agreement letter parents were requested to take part in the study. Child Behavior Checklists were administered about each child and parents filled up the CBCL. The Bengali Version of Parenting Practices Scale and The Bengali Version of Perceived Stress Scale was also administered to know the participant's parenting skills and to measure the one's life stressful conditions respectively. Along with written instruction within the questionnaire parents were instructed verbally to make sure that they understood the task.

After assessing the child behavior problem, parental stress and parenting skills then the parent training program was administered in group settings for five weeks and then, to see the impact of this parent training all measures were re-administered after completing the training and after this, one- month follow-up was taken from the same groups to see the impact of parent training on behavior of children with conduct disorder.

2.7 Intervention Procedure

Intervention was run primarily with the parents in a group who applied several treatment procedures at home. Each session was of three hours durations and the training was in five sessions. For the first session main task was understanding parenting and knowing your child, for the second, third and fourth session it included learning parenting skill and finally in the fifth session the main task was parental self- care. Parent training was followed by pre-treatment

evaluation. To understand, define and monitor problematic behaviors in new advanced ways parents were skilled by using different techniques. Parents were introduced to different parenting skills to alter interaction's pattern with their child, to promote pro-social behavior monitoring, communication, setting limits, positive ways of disciplining, empathy, quality time, encouragement, breaking the coercive circle, problem solving, improving the school performance which were used for practice and the behavior-change plan of actions were implemented at home. At the last session, parents were trained with mindfulness, relaxation, anger management and stress management programs. The whole training module is attached in the appendix section.

2.8 Data entry and analysis

Data preparation and analysis were performed using SPSS Statistics. For the statistical analysis of this study, a descriptive analysis of the scores obtained from the three measures- Child Behavior Checklist (CBCL), Perceived Stress Scale (PSS), and Parenting Practice Scale (PPS) in three phases- pre-training phase, post-training phase and after one-month follow-up phase was used. The analysis of mean difference technique was applied to check if there had been any significant changes in results over the period. ANOVA and Post-hoc tests were administered to exhibit the mean differences that occurred over the period.

2.9 Ethical Consideration

Ethical guidelines were strictly maintained during conducting the research. It was necessary to take verbal and written informed consent before conducting the interview. Participants were ensured about the confidentiality that was maintained. They were allowed to

reject participating in the study. All participants were informed about the purpose, process, duration and their role in the training section.

Chapter 3

Results

In this section the analysis of the result obtained from the investigations were presented.

3.1 Major Analysis

In order to see the impact of parent training on behavior of children with conduct disorder a descriptive analysis of the scores obtained from the three measures- Child Behavior Checklist (CBCL), Perceived Stress Scale (PSS), and Parenting Practice Scale (PPS) in three phases- pre-training phase, post-training phase and one-month follow-up phase was used. ANOVA was used to see whether the differences were significant among the three different phases of the study and Post-hoc tests were administered to exhibit the impact not only the post-training phase but also the follow-up phase.

Table 3.1 reveals the descriptive analysis of the scores obtained from the three measures- Child Behavior Checklist (CBCL), Perceived Stress Scale (PSS), and Parenting Practice Scale (PPS) in three phases- pre-training phase, post-training phase, and a one-month follow-up phase. It can be seen the mean score of CBCL and PSS has decreased after the training and in the follow up. On the other hand, mean score of the PPS has increased.

Table 3.1

Summary of the Descriptive Data in Three Phases

	Pre-training		Post-training		Follow-up	
Measures	*M*	*SD*	*M*	*SD*	*M*	*SD*
CBCL	81.63	14.41	52.81	10.72	41.19	13.23
PSS	34.44	4.20	27.19	4.02	25.81	4.5
PPS	87.75	16.18	115.63	14.12	124.94	15.84

To find out whether the mean scores of CBCL, PSS, and PPS differed significantly among the three phases, ran a repeated measure ANOVA. The assumption of sphericity for repeated measure is indicated by Mauchly's Test of Sphericity. ANOVA had been violated in each of the three measures- for CBCL $\chi^2(2) = 6.519$, $p < .05$; for PSS $\chi^2 (2) = 6.071$, $p < .048$; for PPS $\chi^2 (2) = 10.871$, $p < .05$; and therefore, a Greenhouse-Geiser correction was used.

Table 3.2

Repeated Measure ANOVA in Three Phases

	F	*Significance*	*Partial* η^2
CBCL	75.63 (1.46, 21.86)	.000	.83
PSS	44.65 (1.48, 22.19)	.000	.75
PPS	73.75 (1.30, 19.48)	.000	.83

As it is shown in Table 3.2, CBCL (F (1.46, 21.86) = 75.63, $p < 0.001$), PSS (F (1.48, 22.19) = 44.65, $p < 0.001$), and PPS (F (1.30, 19.48) = 73.75, $p < 0.001$)- all differed significantly among the three different phases of the study. That means the training had a positive impact on

all of the tree measures. But now the question is whether the training impacted not only the post-training phase but also the follow-up phase. To answer the question, results of a post hoc analysis with a Bonferroni adjustment can be taken into account (see Table 3.3 and Figure 3.1).

Table 3.3

Post Hoc Analysis for the Three Measures among All the Phases

Measures	*Phases (I)*	*Phases (J)*	*Mean Differences (I-J)*	*Sig.*	*95% Confidence Interval for Difference*	
					Lower Bound	*Upper Bound*
CBCL	Pre-training	Post-training	28.81*	.000	18.53	39.09
		Follow-up	40.44*	.000	29.89	50.99
	Post-training	Follow-up	11.63*	.000	5.92	17.32
PSS	Pre-training	Post-training	7.25*	.000	4.35	10.15
		Follow-up	8.63*	.000	5.53	11.73
	Post-training	Follow-up	1.38	.138	-.33	3.08
PPS	Pre-training	Post-training	-27.88*	.000	-36.54	-19.21
		Follow-up	-37.19*	.000	-48.14	-26.24
	Post-training	Follow-up	-9.32**	.001	-14.42	-4.20

* The mean difference is significant at the .001 level

** The mean difference is significant at the .005 level

Post hoc analysis revealed that severity of children's conduct disorder (mean score in CBCL) dropped significantly from pre-training to post-training phase (28.81 (95% CI, 18.53 to 39.09), $p < .001$), from pre-training to follow-up phase (40.44 (95% CI, 29.89 to 50.99), $p < .001$), and from post-training to follow-up phase (11.63 (95% CI, 5.92 to 17.32), $p < .001$).

In terms of perceived stress, a significant drop was found from pre-training to post-training phase (7.25 (95% CI, 4.35 to 10.15), $p < .001$), from pre-training to follow-up phase (8.63 (95% CI, 5.53 to 11.73), $p < .001$), but not from post-training to follow-up phase.

Finally, parenting practice improved significantly from pre-training to post training phase (-27.88 (95% CI, -36.54 to -19.21), $p < .001$), from pre-training to follow-up phase (-37.19 (95% CI, -48.14 to -26.24), $p < .001$), and from post-training to follow-up phase (-9.32 (95% CI, -14.42 to -4.20), $p < .005$)

Figure 3.1

Trend line of mean score of CBCL, PSS and PPS

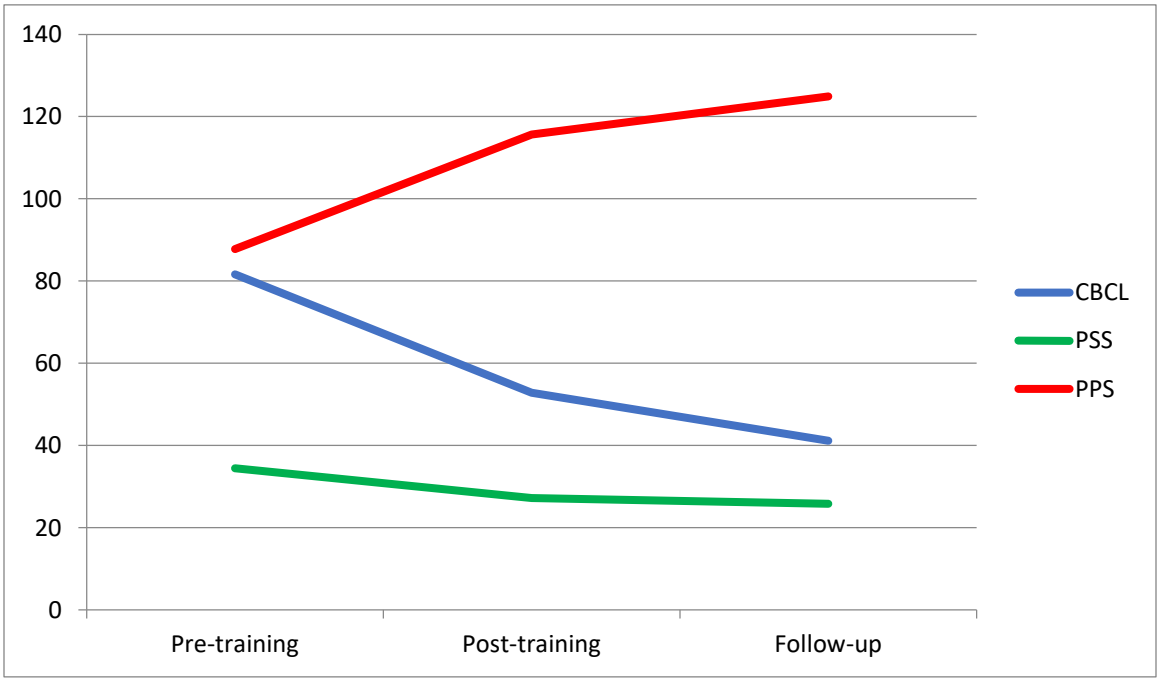


Figure-3.1 shows that the trend of PPS score (red line) was going up from baseline to post-training after training period but the slope was not as high when moving towards the follow up phase. Similarly, as result suggested, CBCL (blue line) score also decreased drastically while moving towards the finishing of the parent training but more modest decrease was seen for the follow up stage. Parenting Stress (PSS), shown in green line, also decreased rather slowly moving from baseline to follow-up stage.

Chapter 4

Discussion

A type of behavior that is repeated and persistent and where basic human rights, people or significant age-appropriate cultural standards or rules have been breached or violated is called Conduct Disorder (American Psychiatric Association, 2013).This study is intended to design a training program and implement it on the parents whose children are diagnosed with conduct disorder, to make better the children's behavior, lessen their level of stress and enhance parents' parenting skill. Children's conduct issues are a widespread mental health concern, impacting 5–8% of the population (Scott, 2008). CD is strongly linked to adult offender sadism, misuse of drug, failure of school, adolescent pregnancy and joblessness and so on (Fergusson et al., 2005). This issue is exacerbated in developing and under developed nations, where mental health treatments for children are severely lacking (Belfar, 2008). In Bangladesh, Conduct Disorder's prevalence rate in children aged 5 to 10 years was 2.9 percent and 5.9 percent, respectively and the prevalence in slum regions was substantially greater than rural and urban areas (Mullick, 2005). In a community poll, however, a countrywide survey indicated a 1.0 percent prevalence of this disease (Rabbani et al., 2009). Early identification and treatment of Conduct Disorder can help adults avoid negative psychosocial repercussions later in life. Conduct symptoms were shown to be the most reliable predictor of severe and persistent anti-social behavior in later life (Pardinin & Fite, 2010). When intervention is given in early school time it has been seen to remarkably improve in the child behavioral issues in a middle-income nation (Baker-Henningham et al., 2012). In this light of view the first aims of this research was to develop a parent training manual according to the need of the parents whose children were diagnosed with conduct disorder. Secondly to investigate in what extent parent training was effective on

behavior of children with conduct disorder. Third objective was to lessen the problematic behaviors of the children who were diagnosed with conduct disorder. Fourth objective was to assess the changes in distress level of those parents resulted from the training program. And finally, the fifth objective was to improve parenting practices. Keeping these objectives in mind a training module was developed. This training module is prepared for the conduct disordered children's parent. The age range of the children was 4 to 16. In order to develop a successful intervention training program, it involved multiple steps such as systematic review to accumulate core components of available evidence based worldwide parent training, discussing with practicing clinical psychologist and psychiatrist, writing up first draft, judge evaluation, writing up second draft, presenting to the judge again for evaluation and giving for pilot study and when it was complete and satisfactory then moving on with the real training procedure of the parents.

The core component of this training selected from the available evidence-based parent training and the local parent training booklet which are made for the conduct disordered children's parent. This module has been covered in five weeks long parent training program and consist of two section. First section contains the content of treatment or treatment guideline and second section contains the description of applied treatment techniques. Every component has its target population which is developed by professionals on the basis of some known theory of learning and development. First component named Adolescent Transition Program. The Community education program was developed by Charles E. Cunningham has its foundation in Family System Theory and social-cognitive psychology which focuses on positive behavior, family relationship, problem solving among many other things. Other components like Defiant Children, Parent Child Training Series, Parenting Wisely, Helping Your Children are also there.

All of them focus on problem solving skill, encouragement, reinforcement, communication, attention, issues of violence and so on.

The number of parents initially selected to participate in the training program was 38 but 15 denied to do so due to various personal and other issues. So, 25 participants attended the training program and data was collected from them maintaining standardized procedure. Unfortunately, 9 were lost so a total number of 16 participants provided data during post training and follow up phase of the study. The participants who were engaged in the study consist of parents having children who were diagnosed with conduct disorder as previously mentioned. 62.5% of the children were between 6-12 years of age and rest of them were between 12-16 years of age. 75% were male children and 25% were female. Half of the children were first born in the study. The family income were largely less than 40000 BDT and wellness of the children were mostly moderate in response which was termed by “sometimes they feel well”.

Data was collected from the parents who have one or more children with conduct disorder at home which consist of standardized measurement of Child Behavior Check List (CBCL), Parenting Practice Scale (PPS) and Parenting Stress Scale (PSS) respectively in three time periods. Before they receive training, after the training and a further follow up stage after a month, all measures were administered. The intervention program was created with the goal of reducing perceived stress and increasing parental practice in parents of children who were diagnosed with conduct disorder, additionally lessening the severity of their children's conduct disorder. Before and after the intervention program, the participants and their children were evaluated in all three domains of perceived stress, parental practice and conduct disorder severity. A follow-up estimation was escorted one month after the training program ended. Standard data collection procedure was maintained, participants were given proper verbal and

written instructions and finally ethical consideration was followed while collection of the data. Data was analyzed using SPSS.

The results showed that, the severity of conduct disorder in children whose parents were recruited for the training, fell significantly (Mean Difference = 28.81, $p < 0.001$) after the training, and continued to decline one month later (Mean Difference = 11.63, $p< 0.001$). The training program taught the parents how to act with a child with conduct disorder and as conduct disorder severity can be fueled by parent's behavior, this training played an important role on reducing the conduct disorder severity in children (Lytton H., 1990).

On the other hand, in perceived stress, we found a significant drop ($p < 0.001$) in parent's perceived stress after the training (M = 27.19, SD = 4.020,) and in follow up assessment phase (M = 25.81, SD = 4.535) compared to the baseline assessment (M = 34.44, SD = 4.195), but the follow up assessment phase did not differ remarkably from the post-training assessment phase (p = 0.634).The parents' stress levels may be reduced as a result of the intervention program, which includes instruction on getting to know their children better, intense parenting skills and parental self-care.

Parenting practice among the participants increased significantly following the training (Mean Difference = 27.88, $p < 0.001$) and continued to increase one month later (Mean Difference = 9.32, $p < 0.05$) compared to baseline evaluation. The training module was focused on teaching parents about how to better their children's behavior who are diagnosed with conduct disorder. These parenting skills might have contributed here heavily.

We can definitely see improvement in all three areas of our interest. Measure of CBCL showed to be lowered prior to training and it was indeed effective as shown in the follow up

scores. So, there was improvement in multiple facets of child behavior one after the other have its own influence on the parenting practice and on the stress of their parents (Yeo & Teo, 2013).Similar training programs were found to be effective like Behavioral Parenting Training (BPT) programs are effective in reducing negative parenting practices and improving outcomes for this population which means it effectively improves behavior of ADHD children (Louise C. O'Keefe, Comprehensive Child and adolescent learning, Taylor and Francis Online). The positive parenting program can also be utilized as a therapeutic and preventive approach to lessen behavioral problems in kids as well as parental stress and depression in relation to kids. In order to betterment of children's behavior, positive parent training is an effective tool (Somaye T. et al., 2020).

On PSS, the training program has an effect but it was not consistent as we can see from the follow up scores. The training did have a significant impact but it did not continue to be impactful in the same way. Indeed parental training programs have a remarkable aftermath on these stressful conditions of parent when applied in practical life settings (Hans O. Löfgrenet al. , 2017) A group of researchers inquired into the behavioral parent training impact on parenting stress and sense of competence. Results show that group parent training program bring a remarkable change in parent and child behavior and relationships. (Pisterman et al., 1992)

This result can also be attributable to the relatively lower sample size, losing of the participant in the post training and follow up phase and other socio-economic factors like COVID-19, economic stress, increased stress due to it and lack of exposure to more programs like this. It could be due to also to the factors like location of the participants, strict timing of the hospitals in which all the training and conduction went on and the educational status of the parents as well. Only about a third of invited families enroll in prevention projects which means

they attend at least one program session; of these, 40–60% drops out even when financial incentives, childcare, refreshments and transport are provided (Baker et al., 2011).

Previous studies indicated that parent training programs increased parental competency among alluded parents. Parent training program that is put in an application in the general population may also intensify perceived parental gratification, suggested that parent training programs can be a foremost preventative plan of action to increase parental feelings of satisfaction in the wider population (Lofgren et al., 2017). With a greater number of participant parents with increasing number of training sessions potentially via online to make it more accessible to wider group of population as well as to make it more accessible for the trainers, researcher and the participants, also the result of the study would have been more generalizable and more socio-economic variables could be factored in. To make the training more impactful it can be made accessible to more parents of different cast, areas and ethnicity so that our result can be more generalizable. With limited time and resources these finding can also open new doors for further generalizable findings to discover like how gender role affects the parenting stress, difference of the training program for urban and rural parents, how it is impactful on different ethnicities like Rohingya population in different areas of Cox's Bazar, Bhashanchar and the indigenous people of Chittagong Hill Tracts and so on.

The prevalence of Conduct and other form of behavioral disorder has been on the rise (Keenan et al., 2011). In both urban and rural area, we are developing as a nation, joint family have been broken down, parents have become more productive, gender role has shifted, education system has been improvising more and more due to the needs of the future. It is an opportunity now to carry further importance to this issue and develop and implement more parenting practice training module like this for specific needs of the children, children with other

physical or mental disorders, children with special needs for the better overall mental health of the parents and ultimately for the children as well.

Implication of the Research

The present study represents a parent training manual for conduct disorder children's parents, for future study, this research will serve as a foundation. The study will help parents to skill them how to understand their children behaviour and to communicate more effectively with those children and to provideintermittent recommendations for parental self-care so that everyone is benefitted. The study will attempt to increase knowledge about positive parenting and reduce children's behaviour problems. Through parent training, parents can understand the nature and extent of children behaviour and learn the skills and ways to interact with these children as effectively as possible. The study will create awareness concerning the mental health service needed among these populations and will enlighten a new horizon in the treatment of the individual for conduct disorder. The study will minimize the rate of antisocial behavior.

Limitations

The result of this study must be viewed with caution because, this research was conducted with a small sample size, in addition, the issue of other events like the environment of those children and direct involvement of both parents which was most essential could not be managed for all cases.

Conclusion

In closing, the present study represents that the parent training manual is a convenient and auspicious guideline of the better treatment for conduct disorder. The present study is a glimpse of hope in the face of inadequate research of these areas of mental health issues.

Additionally, data of children behavior, parental stress and parenting practices showed that the intervention of this parent training manual was effective in decreasing children's behavioral problem and parental stress and in increasing in effective parenting practice. As this study was demonstrated with a small sample size, further research should be conducted with a large sample for its long-term effectiveness. So, the developed parent training manual will become an effective tool for the management of conduct disorder.

Chapter 5

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Appendix 1

Session Plan

Session-1

Understanding Parenting and Knowing Your Child

Objectives

Get to know one another

Find out what we want to learn in the training

Understand what the training is about

To know what is their parenting style and how can it affect their children.

Understanding children's needs and behaviors change in each stage of development

To meet the needs of children differently, depending on their developmental stage

The reasons why children misbehave

To educate about the conduct disorder

Materials

A piece of paper and a pencil

Pictures of parenting style

Time

3 hours

Procedure

Presentation and Group discussion

Activity 1: Getting started (35 minutes)

- Get to know one another

- Find out what we want to learn in the training
- Understand what the training is about
- Develop the rules to be followed in the training

Activity 1.1: Opening of the training

Steps

1. Welcome participants

2. Introduce yourself/myself by sharing:

Name

Where I/we work

What I/we do

Activity 1.2: Getting to know one another

Steps

1. Ask participants to share:

Their names

Where they come from

How many children they have or care for

Their "baby" name or nickname

Activity 1.3: "What do we want to learn?"

Steps

1. Ask participants to share their expectation they want to learn during the training.

Activity 1.4: "What the training is about"

Steps

1. Share these messages about the training with participants:

Raising a child is wonderful, but it is also difficult. Our children need and deserve the best possible care

All of us can learn to become better parents or caregivers

To enable parents, learn to modify the behavior of children with conduct disorder and to reduce parent distress.

To enhance parenting skills for helping them to modify their children's behavior.

2. Provide this other information about the training:

Number of sessions

Duration of each session

Place where the sessions will be held

Activity 1.5: Group Rules/Agreements

Steps

1. Explain that people work better in groups when they have rules.

2. Ask participants to identify the rules the group should follow.

The list should be included: Participation in all training sessions (mandatory), be on time, participate in training session actively, ask when you don't understand, be honest when sharing about your life, but also only provide as much information as you feel comfortable to share, respect other people's ideas and opinions, keep other people's information private

3. Write the list of rules on a piece of paper. Use this list to remind participants about the rules during each session.

Activity 2: Participant will concern and learn about parenting style and how can it affect their children (40 minutes)

- Description of parenting style with pictures (at the end of the manual under session 1 materials)
- Ask participants to share what their parenting style is and why.
- Discussion of the case studies.
- Group discussion about how does parenting style affect children.
- Ask the group to identify the best parenting style, based on what they have learned.
- Thank the groups for their work and then share the information about impact of parenting style

Remember

- Caregivers' parenting styles can affect their children's feelings, development and behaviors.
- Authoritative/ Firm-but-fair is the best parenting style for raising children.
- Authoritative/ Firm-but-fair caregivers provide affection and support, but also rules for their children.

Assignment

Ask yourself these questions:

- What is my parenting style? Remember that your parenting style might be a little of this and a little of that, sometimes you might firm but at other times in different.
- Is my parenting style helping or harming my children?
- What do I need to change?
- What small steps can I take to begin to change?

Activity 3: As children's needs and behaviors change in each stage of development, here participant will learn how to meet the needs of children differently, depending on their developmental stage. (40 minutes)

- Explain that as children grow, they develop in four different ways:

  • Physically

  • Intellectually

  • Socially

  • Emotionally

- Describe these areas, one at a time, showing the pictures (at the end of the manual under session 1 materials)
- Explain that, as children grow, they go through different stages of development.
- Ask participants if they know what these stages are. (Allow some responses.)
- Pointing at each child in picture, explain that these stages are:

  Infant (0–1 year)

  Toddler (2–3 years)

  Early childhood (4–5 years)

  Middle childhood (6–12 years)

  Late childhood/Adolescence (13–17 years)

- Ask some participants to share the stage of development their children are in.
- Participants will now do the following work in small groups

  Group Work

  • Each group will draw a child in a different stage of development.

  • In the drawing they will show the needs and behaviors of the child.

• Ask each group to discuss how parents and caregivers should respond to these needs.

- Describing the children's common need and age-related behavior.

Remember

Children's needs change as they grow older, as do their behaviors. Children express their needs through their behaviors. (If they are exhibiting a negative or bad behavior, try to find out why they are doing this.) Parents and caregivers must try to understand their children's needs as they grow older, so that they can respond well to those needs.

Activity 4: Understanding child misbehavior. Here participant will learn why children misbehave. (20 minutes)

- Ask and explain what is misbehavior.
- Share with the participants some possible reasons for misbehavior.

Activity 5: Educate the participant about conduct disorder. (30 minutes)

Activity 6: End-of-session summary. (7 minutes)

Activity 7: Eliciting feedback. (8 minutes)

Session: 2

Learning Parenting Skill-I

Objectives
To know about the empathy
How to listen to their children well
How to talk in a positive way to their children
What setting limits for children means
Why setting limits is important
How to set proper limits for their children

Materials

A piece of paper and a pencil, pictures

Time

3 hours

Procedure

Presentation, role-playing, group discussion and group work

Activity 1: Welcome participants and checking mood. (5 minutes)

Activity 2: Bridge from previous session. (5 minutes)

Activity 3: Setting the agenda (10 minutes)

-Checking assignment. Ask two or three participants to share

-Monitoring

-Communication

-Setting limits

-Setting new assignment

-Summary and feedback

Activity 4: Discussion of issues on the agenda:

Monitoring your child (30 minutes)

- Describing what does monitoring mean, why we monitor and the area of monitoring.
- Allow some responses. (Note that monitoring does not mean having to observe the children directly at all times.)
- Group work how do you monitor your children? How does this change, based on their age or what they are doing?

- Process of monitoring will be conducted and give as assignment

Communication (60 minutes)

Describe what is communication and explore each of the communication skills with pictures (Large versions of the pictures are at the end of the Manual, under "Session 2 Materials".), listening to my child, talking with my child, talking with I-statement

A. Listening to my child

- Listen
- Keep eye contact
- Let your child speak
- Show interest in what the child is saying
- Ask participants if they have any questions.
- Now demonstrating these listening skills through role-play.
- Ask participants what they think about these listening skills. Do they seem easy or hard to practice? Why or why not?
- Close this activity by sharing the following messages

communication makes it possible to have a good relationship with your children. The most important part of good communication is good listening, which includes paying attention, expressing appreciation that the child has spoken and making sure you understand what the child has said.

B. Talking with my child

- Make sure your child is listening
- Keep eye contact with your child
- Talk with your child, not at your child

- Speak kindly
- Keep your statements simple
- Match your tone of voice to your message
- Say do instead of don't
- Communication acceptance
- Answer any questions participants may have.
- Now demonstrate these talking skills through a role-play
- End these activities by sharing the following massage

Talking with your child means that both of you are talking turns listening and talking. Listening and speaking in a respectful way builds understanding and cooperation. Good communication helps prevent some problems from occurring, and helps resolve other problems when they arise.

C. Talking with I-statements

Four parts of an effective I-statement are-

1. A statement of how the child's unacceptable behavior makes you feel;
2. A non-blameful description of the child's behavior;
3. An explanation regarding the tangible effect of that behavior on you;
4. The required positive behavior/ change henceforth.

Setting limits for your child (45 minutes)

- Ask participants what limits are.
- Explain and share the following advice on how to set effective limits for children-

  Limits are rules

  Limits your limits

Limits should be clear

Limits should be consistent

Limits should be stated positively

Set limits- and also consequences

Limits may involve children's input

Be firm in enforcing the limits or rules

- Respond to any question's participants may have.
- Participants will now practice setting limits in small groups
- Explaining the examples and guidance of setting limits according to their stage of development.

Activity 5: End-of-session summary. (15 minutes)

Activity 6: Eliciting feedback. (10 minutes)

Session -03

Learning Parenting Skill-II

Objectives
To know about the positive ways to discipline children
The importance of monitoring children.
How we can monitor children
What does Good Quality Time mean and how does it benefit your child
What are some of the ways to spend Good Quality Time with your children
To know about the stroke/encouragement and its methods

Materials

A piece of paper and a pencil, pictures

Time

3 hours

Procedure

Presentation, role-playing, group discussion and group work.

Activity 1: Welcome participants and checking mood. (5 minutes)

Activity 2: Bridge from previous session. (5 minutes)

Activity 3: Setting the agenda (10 minutes)

-Checking assignment. Ask two or three participants to share

-Positive ways of disciplining

-Empathy

-Quality time

-Strokes/encouragement

-Setting new assignment

-Summary and feedback

Activity 4: Discussion of issues on the agenda:

- **Positive ways to discipline children** (45 minutes)
  - Briefly ask for some volunteers to share how they currently discipline their children.
  - If participants mention punishments that hurt children physically or emotionally, inform them about the differences between discipline and punishment.
  - Defining positive discipline and sharing with participants the positive discipline methods below.

Instructions

First describe the discipline method using the information below. Then ask for volunteers to role play the discipline method (one minute each). Ask for feedback from the other participants and make corrections, if needed.

- Praising the good
- Showing the good behavior
- Withholding privileges
- Grounding
- Time out
- Consequences

Remember

Corporal (physical) punishment is not effective in disciplining children. Corporal punishment damages a child's self-esteem, may cause your child to rebel and resent (disrespect) you, and can breed more violence in the future. Positive discipline methods are an effective alternative to corporal punishment and should be used instead.

Assignment

Participants will put into practice one of the new discipline methods learned.

Empathy to your child-active/empathetic listening (30 minutes)

Spending good quality time with your children (30 minutes)

- Describing what does quality time mean, how does good quality time will be benefited for your child and some of the ways to spend good quality time with your children with pictures.

- Conducting group work with the copies of the 8 pictures which is attached under session 3 materials.

Strokes/encouragement (40 minutes)

- Educating about four types of stroke
- Describing the methods of giving strokes

Activity 5: End-of-session summary. (10 minutes)

Activity 6: Eliciting feedback. (5 minutes)

Session -04

Learning Parenting Skill-III

Objectives
To educating about the parent child coercive circle and describing how to break the cycle
To know about the problem-solving techniques
How to improve the school performance
Review of the all previous sessions

Materials

A piece of paper and a pencil

Time

3 hours

Procedure

Presentation, role-playing, group discussion and group work

Activity 1: Welcome participants and checking mood. (5 minutes)

Activity 2: Bridge from previous session. (5 minutes)

Activity 3: Setting the agenda (10 minutes)

-Checking assignment. Ask two or three participants to share

-Breaking the coercive circle

-Problem solving

-Improving the school performance

-Review of the previous sessions

-Setting new assignment

-summary and feedback

Activity 4: Discussion of issues on the agenda:

Breaking the coercive circle (30 minutes)

- Educating about the parent child coercive circle
- Describing about how to break the cycle and the emotional preparation of the parent to break the cycle.

Problem solving (45 minutes)

- Describing about how they can solve the problems and the objectives of problem-solving techniques.
- Conducting group work to practice these ways of problem solving and giving as a home work.

Improving the school performance (45 minutes)

- To improve the school performance specific target behaviors and academic goals will be set jointly by the teachers, child and parents and a points system will be agreed.
- Ways of supporting child's education

Review of the previous session (25 minutes)

Activity 5: End-of-session summary. (10 minutes)

Activity 6: Eliciting feedback. (5 minutes)

Session -05

Self-Care (parental)

Objectives
To know and practice mindful training and how it can apply in parenting
To practice of PMR and breathing relaxation
To educate about anger and to know the techniques of anger management
To educate about stress and its coping

Materials

A piece of paper and a pencil

Time

3 hours

Procedure

Presentation, role-playing, group discussion and group work

Activity 1: Welcome participants and checking mood. (5 minutes)

Activity 2: Bridge from previous session. (5minutes)

Activity 3: Setting the agenda. (10 minutes)

-Checking assignment. Ask two or three participants to share

-Mindfulness

- PMR and breathing relaxation

-Anger management

-Stress management

-summary and feedback

Activity 4: Discussion of issues on the agenda:

Mindful parenting (40 minutes)

- Describing what mindful parenting mean, why it is important and some of the ways of mindfulness.
- A short practice on mindfulness will be conducted in group work.

Relaxation (30 minutes)

- Progressive muscular and breathing relaxation

Anger management (35 minutes)

- Educating about anger with myths.
- Identifying the events that trigger anger
- Cues to anger: four cue categories
- Anger control plans
- Cognitive restructuring

Stress management (35 minutes)

- Defining stress and identifying the sources of your stressors.
- Coping with stress

Activity 5: End-of-session summary and reviewing what was learned in the training. (15 minutes)

Activity 6: Eliciting feedback. (5 minutes)

Appendix 2

Applied Treatment Techniques and Their Description with Evidence

The treatment techniques that will be applied can be describe under the following headings-

1. Knowing your child/ understanding parenting and child behavior
2. Parenting skills
3. Self-care (parental)

1. Knowing your child / understanding parenting and child behavior

Generally, parent training or child upbringing is the process of promoting and supporting the physical, emotional, social, and intellectual development of a child from infancy to adulthood. Parenting thus refers to the aspects of raising a child aside from the biological relationship. Parenting is a lifelong commitment.

Parenting style

There are many researches which discover strong connections between parenting styles and the impact of these styles have on their children. According to Diana Baumrind (1960) parenting styles can be classified under four major types, they are as follows:

1. **Authoritarian parenting (strict/ harsh)**

   Specific characteristics are:

- Strict rules established by parents
- Failure to follow such rules usually result in punishment
- Parents fail to explain the reasoning behind the rules. If asked, they say “because I said so!”
- Parents have high demand but not responsive to their children

2. **Authoritative parenting (responsible/caring)**

Specific characteristics are:

- Parents establish rules and guidelines like authoritarian parents but they provide explanations for the rules and demand
- Parents are responsive to their children and willing to listen to the questions

  These parents are more nurturing, forgiving, encouraging rather than punishing.
- Are more sensitive to their children's needs

3. Lenient parenting

- Have few rules or standard of behavior
- Rarely discipline their children because they have relatively low expectation of maturity and self-control.
- When they are rules, they are often very inconsistent
- Parents are usually very nurturing and loving towards their children. Seem more like a friend than a caregiver
- May use bribery such as toys, gifts and food as a means to get a child to behave.

4. Uninvolved parenting (neglectful/careless)

- In this type parents have few dictate, low receptiveness, little communication
- Parents don't seem to notice or care what's happening within their family and with their children
- Are not sensitive in case of their children's needs.

Impact of parenting style

Parenting style	Children behavior
Authoritarian	Reserved, less affectionate, uncommunicative, not creative, maintain strict rules, compliant without questioning, sad, always see things as biased, feels insecurity
Authoritative	Social, self-reliant, self-controlled, successful at school, confident, creative, likeable, feels secure, take risk and independent
Permissive	Impulsive, immature, low self-control, moody, dependent, unable to make decision, unmotivated at school, more likely to experience problems with authority.
Uninvolved	Indifferent, rejecting behavior, rebellious, no self-control, unsuccessful at school

(Described by Pact Ethiopia, 2014)

Explanation of the four different ways of development

Physical development

Refers to changes in children's: body (size, shape, maturity), physical ability (strength, coordination, balance, coordination).

Intellectual development

Refers to changes in children's ability to: think for themselves, reason, organize their ideas, memorize and remember things, use language, solve problems.

Social development

Refers to changes in children's ability to: relate to other children (play, share toys, etc.), relate to adults, participate in groups.

Emotional development

Refers to changes in children's ability to: understand different emotions and what causes them, manage their emotions (not letting their emotions take control of them inappropriately), express emotions according to specific situations. (Described by Pact Ethiopia, 2014)

Children's need and common age-related behaviors

It will be used the information in the table below to understand the children need and common age-related behavior according to their age

Stages/Age	**Children's need**	**Common behaviors-responses**
Infant (0–1 year)	Food, sleep, cleaning, Comfort, safety and protection. Strong bond and attachment with parent/caregiver Stimulation and attention	Caries to have his or her needs satisfied **0–6 months**: Will smile, babble and cry to attract the caregiver's attention. Caregiver should provide care, cuddling, caressing and protection. **6–12 months**: Will cling to the parent/caregiver, especially when feeling insecure or frightened. Will protest the caregiver's departure. Follows the caregiver when able.
Toddler (1–3 years)	Same as above, but also… • Becomes more curious; wants to explore and become more independent • Wants to learn how to do new things (e.g. dress and undress) and wants	Becomes more independent and continues to explore his or her surroundings. Starts talking Should be given small choices (between two acceptable options and the opportunity to try new things. Does not like to lose or take turns, but sharing

	to make own decisions • Seeks praise, approval	can be taught. May express feelings in dramatic ways. Can begin to learn how to manage emotions.
Early Childhood (3–5 years)	Same as above, but also… • Learns through actions; play. Develops relationships with other children. • Has questions; seeks answers.	Finds difficult to separate fantasy from reality. Express feelings in dramatic ways May talk a lot and ask many questions. Does not like to lose, share or take turns, but losing and taking turns can be taught.
Middle Childhood (6–12 years	Same as above, but also… • Interested in learning; school. • Wants more independence, trust • Wants to spend time with other children (play is important and can teach important social values)	Very active. Often can't sit for more than 15-20 minutes. Wants to be more independent; seeks more responsibility and trust Can be very self-conscious and sensitive. May feel hurt easily and have mood swings. May answer back to adults to show that they "know". Is better able mange anger and tolerate frustration.
Late Childhood/ Adolescence (13–17 years	Same as above • Wants even more independence, trust • Seeks acceptance from peers for self-esteem. • Focused on forming her or his own identity; • Eager to learn about sexuality; maybe also about alcohol and drugs • May worry about the Future	Prefers more interaction with peers than parents. Becomes interested in sexual relationships. May engage in risky behaviors. Frequent mood swings and rebellious attitude. Wants to make own choices and decisions. Should be taught that all decisions have consequences. May becomes challenging, rebellious and aggressive. May seek guidance and role models outside of the family.

(Described by Pact Ethiopia, 2014)

Understanding children's misbehavior

Misbehavior is something a child does that is against the limits or rules, and those results in harm or inconvenience to others. Children misbehave because of many reasons. Sometimes the caregiver is responsible for that. Caregivers need to understand the reasons for the misbehavior before disciplining their children. Possible reasons for misbehavior are given bellow:

1. Children want their needs met

As adults we find ways to get our needs met. For example,

• If we are thirsty, we go and get a glass of water.

• If we feel lonely, we go to a friend's house.

• If we have problems, we find someone to talk with, who may be able to help.

• Children are immature; they are not always capable of appropriately expressing their needs.

• When children feel ill, hungry, sleepy, lonely or bored, they sometimes misbehave to get their needs

2. Children don't understand limits

• Some limits may go beyond the child's age and ability to understand.

• Sometimes different limits are set for children by different parents or caregivers and the children get confused.

3. Children want to test limits

• Children like to test their caregivers. This is part of their normal development.

• They want to see if limits are real and if caregivers will enforce them.

4. Children want independence and feel in control

As children grow, they need more independence and control. If they don't get it, they rebel with bad behaviors.

5. Children have been rewarded for their misbehavior

Sometimes caregivers reward bad behavior without knowing it. For example, when a child whines and the caregiver gives the child what she or he wants in order to keep the child quiet, then the caregiver is rewarding the misbehavior.

6. Children copy bad behaviors

Children copy what their caregivers do. If they hear you yelling or cursing, they may do the same. (The same may be true if a caregiver drinks too much alcohol, is violent, etc.) (Described by Pact Ethiopia, 2014)

Psycho education

In psycho education it is necessary to convey the idea that aggressive, destructive or defiant behavior is not a reflection of an intrinsic negative characteristics of the child is central to psychoeducation in case of conduct disorder. Through psychoeducation the parents will be helped to view the child as good child with bad habits that are triggered by certain stimuli, reinforced by certain consequences and keep in extensive by patterns of interaction within the family and social situation and therefore family and network members must be contracted in the treatment process (Carr, 1999). Conduct disorder encompasses heterogeneous and multifaceted problems. According to DSM-5, the diagnosis is reached if child shows at leastthree of the 15 symptoms within the past 12 months, with at least one symptom evident within the past 6 months. The symptoms are bullying others, initiating fights, using a weapon, being physically cruel to others or to animals, stealing while confronting a victim, destroying property, breaking into others' property, stealing items of nontrivial value, staying out late, running away, lying,

deliberate fire setting and truancy. This type of children showslow performance in school, poor interpersonal relations deficits and distortions in their cognitive and attributional processes, and cognitive problem-solving skills (Kazdin, 1995*b*).

Patterson's (1982) explained about the coercive cycle of interaction will be included in psychoeducation. In almost every household parent and child get into oral fights where parents ask the child to do or not to do something and the child refuses-the parents shouts and the child counter backs and so on (it will be described in the next section, in page.37)

Monitoring your child

Psychologist call monitoring when parents know where their children are and what they are doing at the same time adolescents knows the parents knows. Monitoring children and adolescent can make a risk-free for a range of bad experience such as drug, alcohol, tobacco use, sexual behavior, pregnancy, delinquency and violence. Monitoring should be inquisitive but not interfering and, in this process, it is important to respect child's personal privacy as you establish trust and immediacy. (U.S. Department of Education, 2005)

We monitor children for their safety or protection, and to promote their well-being-that is to help them and give them a better future. Monitoring children is knowing:

• What they are doing.

• Where they are going.

• With whom they are spending their time.

• How they are feeling (if they are sick, well, sad, happy, worried., etc.)

• How well they are doing in school and in other activities where the parent or guardian is not present.

Caregivers need to monitor their children's relationships:

• With their friends.

• With any adult with whom they are in contact (for example, teachers, coaches, neighbors) to ensure their children's safety.

Also, monitoring children is about asking:

• Where is my child?

• What is my child doing?

• Who is my child with?

• What do I know about the person(s) my child is with?

• When will my child be returning home?

• How is my child feeling these days?

• How well is my child doing in school and in other activities? Is he or she facing any problems where I might be able to help?

And

• Caregivers need to start monitoring their children when they are small.

• The earlier you begin monitoring your child, the easier this will be to do so as your child gets older.

• The way that caregivers monitor their children depends on their age.

Finally

• All children need monitoring, but some need more than others.

• Young children and children with disabilities are usually more defenseless (meaning, they need more protection, more monitoring) than other children.

• All children need monitoring when they are with people, especially adults, whom you don't know.

• All children need monitoring because it shows them that you care about them, even if they are someplace else (for example, in school or playing sports).

Monitoring your children does not mean being with them every minute. Monitoring a child combines: Asking questions, paying attention to your children's behaviors, setting limits, and helping your children make positive choices when you are not with them, if you are concerned or worried about what you see or hear, take action to protect and support your child. (Described by Pact Ethiopia, 2014)

Emphasize that if participant see or learn something during their monitoring that concerns them (that is, which worries you), do they best to change or improve the situation for their child. Do not wait if their child's safety is at risk! With an older child, they may discuss their concern first and try to come up with a solution together.

Process of monitoring will be conducted by using diaries or chart to identify antecedent and consequences of specific target behavior (Carr,1999). Participants will be trained to make a number of hypothesis (probable explanations behind a behavior) to understand the behavior. During assessment a three-column chart may be used to identify antecedents and consequences of specific target behaviors during a specific time interval. It is important to write no more than three positive behavior and no more than three negative behavior. After that participants will make a list of those behavior and will set reward chart, tally chart, smiling faces, star according to their age. (Three-column chart for monitoring is at the appendix 1)

Communication

Communication is the sharing of information between people. It includes listening and talking, as well as non-verbal communication such as gestures and facial expression but there is no recipe exists for successful communication. In communication process it is necessary to have some content which are given bellow:

Listen. Listen means to avoid interruption and it means to pay close attention in a quiet place with no distractions.

Making opportunities to talk. It is necessary to make yourself available for communication. Sometimes young adolescent resist "scheduled" talks. Some of them like to talk when they first get home from school. Others may like to talk at the dinner table or at bedtime. Many of the best conversation grow out of shared activities.

Avoid over-reacting. Responding too strongly can lead to yelling and screaming and it can shut down conversation. For this it is necessary to control anxiety and emotions out of the conversation then kids will open up. Kids will open up if they look at you as somebody who is not going to spread their secrets or get extremely upset if they confess something to you. When kid's openness gets punished rather than rewarded, they make themselves vulnerable.

Communicate with kindness and respect. When child pushes your buttons, it's best to respond calmly. If you display respect and self-control in talks with your child may be reflected in her conversations with others. Child also give attentiveness to the sound of your voice and they can differentiate between a peaceful voice and an irate tone. Kindness goes with respect. It also requires not talking down to child.

Talk about things that are important to your young teen. Different youngsters like to talk about different things. Some of things they talk about may not seem important to their parents.

Parents should show respect about child's feelings and opinions. Some topics that generally interest young adolescents which are given bellow:

-School. If you ask child, "What did you do in school today?" she or he most likely answer "Nothing". Here the task is to look at the child's assignment book or reading notices sent home by school. With this information you can know the other activities in classroom which is can be started with a conversation.

-Hobbies and interests. If your child loves sports or music, talk about his favorites team and singer and watch the event with him. When you notice that the music, he is listening to is inappropriate it is important to tell your child and explain why.

-Emotions. They are worry about different things like their friend, being popular, sexuality, being overweight or scrawny, tomorrow's math test, grade, getting into college, being abandon and future of the world. Parents will help to figure out the size and importance of the problem helps his or her decide how to address it.

-Family. Child likes to talk about and be involved in plans for the whole family, such as vacations, curfews or allowances. Being a part of conversations about such topics can contribute to tour child's feelings of belonging and security.

-Sensitive subject. If parents avoid talking with your child about sensitive subject, he may turn to the friends or media for information. This will increase the chances that what he hears will be out of line with your values or that the information will be wrong –or both.

-The future. As young adolescent's cognitive ability develops, they begin to think more about the future and its responsibilities.

Though ours is a media-rich world, young children are exposed to television, music, movies, video and computer games and other form of media. After watching a movie with your child, you may ask her whether she liked it and what part she liked best.

A. Listening to my child

Listen

• Pay attention to what your child is saying.

• Stop what you are doing to listen.

• If you are busy, tell your child: “I’m busy now, can we talk later?”

• Then, find the time to listen your child.

Keep eye contact

• Eye contact improves communication.

• Reduce the physical distance between you and your child.

• Bend down or sit on the floor to be eye-to-eye with your child

Let your child speak

• Don’t interrupt your child.

• Praise him/her when your child finishes

Show interest in what the child is saying

• Show your child that his/her ideas are important to you.

• Say: “Really?’, “Tell me more”, “Say that again”, “That’s interesting”.

B.Talking with my child

Make sure your child is listening

• Call your child’s name.

• Make eye contact before you start speaking.

• Reduce the physical distance between you and your child.

• Get to the same level as your child.

Keep eye contact with your child

• Reduce the physical distance between you and your child.

• Make eye contact.

• Get onto the same level as your child.

Talk with your child, not at your child

• Talking with your child is a two-sided conversation.

• You and your child should both talk and both listen. You may take turns.

• By contrast, talking at your child is not a conversation. In those situations, only you speak, for example, “Go fetch some water” or “You have to milk the goat.”

Speak kindly

• Use words that communicate love and respect.

• Avoid using unkind words that ridicule, shame or label your child.

• If there is something you feel that you need to criticize, focus your criticism on the thing you are unhappy about – but do not criticize the person. For example, say, “You are a very clever person, but this thing you did was a mistake.”

Keep your statements simple

• Ask your child to do only one thing at a time.

• Young children can’t follow too many instructions.

Match your tone of voice to your message

• Speak firmly when you are making a request.

• When you are not firm your child thinks your request is not important.

• Be specific and explain why you are making the request.

• Avoid being threatening. Do not shout.

Say do instead of don't

• Tell your child what to do, rather than what not to do.

• Example: "Close the door softly" instead of "Don't slam the door."

Communication acceptance

• Avoid lecturing your child.

• Express thanks, that your child is sharing with you.

• Use expressions such as "I understand", "I know how you feel."

• Children who feel accepted are more likely to communicate with their parents and caregivers.

(Described by Pact Ethiopia, 2014)

C. Talking with 'I'-statement

Parents should be aware of the fact most commands and put downs contain strong evaluations of another person. If you could only explain to your child how his/her unacceptable behavior make you feel, it would be what is referred to as I-statement. For example, I can't watch television, when there is so much noise here. I –statement contain an explanation of how the parents feels about their child's annoying behavior. It refers only to the child's unacceptable behavior, thus making the difference between child and unacceptable behavior. You-statement is a judgement of child's self-worth, whereas I-statements refer to the parent's feelings.

Four parts of an effective I-statement are-

1.A statement of how the child's unacceptable behavior makes you feel;

2.A non-blameful description of the child's behavior;

3.An explanation regarding the tangible effect of that behavior on you;

4.The required positive behavior/ change henceforth.

The format of an I-statement, then, is:

“I feel….1…when you…2…because….3…. I would like it if….4.”

I-statement can bring out some startling results. It surprises children in a positive way to learn how their parents feel. It motives children to repeat the adapted behavior in order to please their parents and avoid their discomfort. It is also good and recommendable to praise the child afterwards with a positive I-statement for the change in behavior. (CREA,20108)

Setting limits for your child

Parents should know:

Limits are rules

• Limits tell children what they can and cannot do.

• A limit refers to the establishment of a maximum, beyond which a person cannot go or do. For example, “You can play with your friends, but you must be back for dinner.” Or “You may have a sweet, but only one.”

• Applying these limits or rules to children’s behavior involves directing the children towards the desired behaviorin a positive and caring way. At the same time, you make it clear what is not allowed or what should not be done.

• Limits or rules should be applied consistently.

Limits your limits

• Having too many limits or rules is being too strict.

• Too many limits prevent children from learning on their own.

• Set limits only about things that are really important.

Limits should be clear

• Limits should be easy to understand for children.

• Children should understand the "why" behind the limit.

• Children who understand their limits are more likely to obey them.

Limits should be consistent

• Limits should not change from day-to-day. This confuses children.

• When there is more than one caregiver in the home, they should agree on the limits to avoid giving children mixed messages.

Limits should be stated positively

• Tell your child what to do instead of what not to do.

• This is much clearer for the child, and helps them do what you want. For example: you should say,

"Play on the floor" instead of, "Don't play on the sofa." And "Please be quiet," instead of "Don't be so loud."

Set limits- and also consequences

• Think of the consequences for not obeying the limits.

• Sometimes, this may be discussed with the child. For example, "You must finish your homework first. If you are not finished, then you cannot go out to play with your friends."

Consequences should be:

• Fair

• According to the "size" of the child's misbehavior

• Appropriate for the child's age and understanding

• Should not involve corporal (physical) punishment

Limits may involve children's input

• Children often have good ideas and opinions about limits.

• When children participate in the setting of limits, they are more likely to obey them. This becomes truer as they get older.

• You do not have to agree on the limits with your child. Your decision is still the most important and should set the rule.

Be firm in enforcing the limits or rules

• Letting children have their own way all the times is not good for them

• You can be kind but firm at the same time

• Being firm creates a strong foundation in your relationship with your child.

• Every time a limit is not obeyed, carry through with the consequences

• Consistent application of consequences lets the child know that you mean what you say

Children need limits as much as they need food and shelter for their wellbeing. Limits protect children. They help them behave well and keep out of trouble. Limits make children feel safe and secure. When you set limits, your children learn that you care about them. Limits help children develop into responsible and dependable adults.

Explaining the examples and guidance of setting limits according to their stage of development.

Stage of development	Setting limits-example and guidance
Infant (0–23 months)	• If during breast-feeding the infant tries to bite the breast, stop feeding for one minute. • If the infant seems irritated or cries a lot, always make sure she/he is clean, not hungry and not ill. If there is no problem, you can leave the infant safely on the bed alone for a short while (especially at 6 months plus)– but take care that the child can't fall of the bed by accident.

	• If older infant clings too much or engages in bad behavior, try to distract the child with something else of interest.
Toddler (2–3 years)	• Teach the child how to use the utility (toilet, bed-pan) by praising the child joyfully when she/he does well. Do not express anger when this is not accomplished. • The child should learn how to wash hands before meals and after toileting, get dressed (some clothes), use words to express desires. Praise the child when doing well.
Early childhood (3–6)	As above, but also… • The child should know how to keep their play materials in a safe place so that they can't be broken or get lost. • The child should learn that she/he cannot use things belonging to other people without asking permission. • Small chores around the house can be expected of the child.
Middle childhood (7–11)	As above, but also… • The child should maintain her/his personal hygiene. • Child should assist in house-hold activities, but leave time for schoolwork and play. • Child should attend school regularly and do school assignments as well as possible (may ask for help.)
Late childhood (Adolescence) (12–17)	As above, but also… • Child should return home when expected (early enough for safety, adequate sleep, good school performance.) • Child should introduce his/her friends to the family. • Child should take greater responsibility in the family and in school. • Child should respect elders, even if not agreeing with them.

(Described by Pact Ethiopia, 2014)

Positive Discipline

Positive discipline focuses on the positive or good expressions of behavior. It is based on the idea that there are no bad children, just good and bad behaviors. One way to reinforce the good behaviors while decreasing the bad behaviors is by actively helping children learn how to handle difficult situations well, and also complementing them when they succeed. When a child misbehaves or makes a mistake (which happens to all children at least sometimes), you should try to remain calm, friendly and respectful. This helps children listen to what you say and want to copy your behavior. Methods of positive discipline are

Praising the good

• Celebrate the good behavior

• Ignore the bad behavior

• Can be used with children of all ages

Showing the good behavior

• Stop the bad behavior and show the good behavior.

• Can be used with children of all ages, except adolescents.

Withholding privileges

• A privilege is something that is valued by the child, such as playing with friends.

• Children should learn that privileges need to be earned.

• This method is most effective with adolescents.

Grounding

• Not allowing the child to communicate with others or leave the house for some hours or days.

• This method is effective with school age children and adolescents (ages 7–17)

Time out

• Sending your child to a corner of the room (face to the wall) with no toys or other distractions.

• Ignoring the child until he/she is calm and quiet.

• The time of "time-outs" is one minute per year of life of the child. Should not last longer than 5 minutes

• Should be used with young children only (e.g. 2–5 years old).

Consequences

• The child suffers the consequences of his or her own bad behavior.

• This method can be used for all ages, but for younger children the consequences should be relatively minor. As the child grows older or if the same misbehavior is repeated again, the consequences should increase gradually in severity. Older children may be consulted as to what an "appropriate consequence" might be.

Corporal (physical) punishment is not effective in disciplining children. Corporal punishment damages a child's self-esteem, may cause your child to rebel and resent (disrespect) you, and can breed more violence in the future. Positive discipline methods are an effective alternative to corporal punishment and should be used instead. (Described by Pact Ethiopia, 2014)

Empathy to your child

Empathy means listening without judgement and connecting on an emotional level. In empathetic listening, be sure your conversations take place at a time and in a setting where your complete attention is available. When your child speaks, listen and then repeat your child major points and focus on what you perceive to be your child's feelings about a situation. In this way you can avoid misunderstandings and help your child identity and manage his or her emotions.

Toward the end of the conversation, ask your child if there is anything else, he or she would like to talk. By reminding your child of the conversation, you show that you are listening- and that you care. (Described by LifeCare,Inc. 2011)

Spending good quality time with children

Quality time strengthen parent child relationship. Quality time with children is, doing things together that parent and children enjoy. It does not make a lot of time. The idea is to enjoy some activity with child, without interruptions. It is necessary to spend quality time with all of your children together, but it is a good to have some quality time alone with each child on a regular basis.

Good quality time helps to build positive relationships, improve communication, strengthen mutual respect, make everyone involved feel good. (CREA, 2018

Breaking the coercive circle

Coercion theory (Patterson, 1982) describes a mutual reinforcement process during which parent unintentionally reward children's problem behaviors, which one after the other elicits caregiver negativity, and so on, until the interaction is discontinued when one of the participants "wins."

There is a common pathway for all of these coercive interactions, which usually start in one of two ways:

A. Parents gives a directive that is ignored by the child.

B. Child makes a demand that parent reject.

Each scenario leads to one person attacking the other. The party feeling attacked tries to escape the punishment by counter-attacking, which punishes the attacker. These counter-attack goes on for a while, until one party reaches a level of punishments. These cycle ends in

reinforcing the attacker, who is more likely to engage in the same behavior next time. If the entire sequence ends with both persons making up and apologizing, the entire system is more likely to occur again.

To break the coercive cycle in case of parent direct child, parent stop talking, leaves, removes a reinforce, or removes child from reinforcement. When child begin to comply, parents behave positively, speaks positively, or provides some other reinforcements (behavior shaping). In case of parent respond to child, once child stop arguing, parents make counter offer to child's request, staying engaged with child as long as child stays calm.

It is necessary for the parents to stay focused on the behavior goal, anticipate the child reaction to their behavior, calm yourself down, take a deep breath before encounter, keep voice low, measured when talking, take time in responding to child's comments, rehearse what intended to say ahead of time (CREA, 2017).

Strokes/encouragement

Strokes are the recognition, attention or responsiveness that one person gives another. Eric Berne called unit of attention 'strokes. Here four types of strokes are described: positive and negative, conditional and unconditional.

- Positive strokes are anything which make one feel good when one gets them e.g. a compliment, a smile, a hug, flowers, praise, a pat on the back etc.
- Negative strokes are which make you feel bad when you get them e.g. a frown, being left out or ignored, a slap, a punch, an insult, a scowl.

Conditional stroke is received for something you did rather than for who you are. Suppose your son has just completed his homework spending a considerable length of time you

say ‘Great job.’ You have just given him a stroke but it was in exchange for something he did; it was conditional and it is related to his role.

Unconditional stroke is if you tell your girl that ‘you are a nice girl’, an unconditional stroke has given for who she is instead of in exchange for what she did. Most people place a higher value on, and have a greater need for, unconditional strokes. It is related one’s identity. Methods of giving strokes are verbal strokes (e.g. laugh at their jokes, call them by their name, look to agree, warm and generous tone in voice etc.), touch strokes are physically given (e.g. a hug, congratulate, praise, applause, a handshake, a touch on the forearm, and a high five are all touch strokes), written strokes as for example, receiving a congratulatory note from a friend or an associate and time strokes are given when you take time to listen to your child and show an interest in understanding his/her situation. (describe by CREA, 2018)

Problem solving

In problem solving process, participants will be helped to define problems concisely to concrete term and avoid long-winded. They will be helped to subdivide big problems into a number of smaller problems and tackle these one at a time. Tackling problems involves brainstorming options; exploring the pros and cons of these; agreeing on a join action plan; implementing the plan; reviewing the progress; and revising the original plan if progress is unsatisfactory. (Carr, 1999)

Parents will be trained to understand that games and stories can be used to help children begin to learn problem-solving skills, to appreciate the developmental nature of children’s ability to problem solve, to strengthening a child’s beginning empathy skills or ability to understand a problem from another person’s point of view, to recognize why aggressive and shy children need to learn these skills, to learn how to help children think about the emotional and behavioral

consequences to proposed solutions, to understand the importance of validating children's feelings and to learn to model problem solving for children. (Carolyn, 2011)

Improving the school performance

Poor academic performance is associated with the children of conduct disorder(Akpan, Ojinnaka,and Ekanem 2010). To improve the school performance specific target behaviors and academic goals will be set jointly by the teachers, child and parents and a points system is agreed. Points may be used to buy items from a reinforcement menu at home or to achieve specific privileges in school. For older children and teenagers, a daily report card system that is in appendix 2.

Ways of supporting child's education are:

Promoting reading skills, it includes building children's self-esteem and self-confidence in their learning ability and fostering children's through interactive dialogue, praise and open-ended questions, dealing with children's discouragement through helping children avoid a sense of failure and criticism trap when they can't do something and motivating them through approval and cheering, promoting good learning practice and routines, showing interest in school. (Carolyn, 2011)

Progressive Muscular Relaxation training

Pevels and Jhonson (1986) found that relaxation increase the accessibility of positive memory in the brain. Breathing relaxation and Progressive Muscular Relaxation training will be practiced in session for reducing level of anxiety. After that the participants will practice it regularly at home.

In Progressive Muscular Relaxation exercise, the body will be divided into a series of musclepart and each body will be tensed and then relaxed. By altering tension and relaxation

participant will teach to differentiate between these two states and become aware of the parts of the body. First, the researcher model how the different group of muscles should be tensed and relaxed. Participants will do the various tension- release exercises at the same time, with the researcher. Tension will be normally maintained for about five seconds with the subsequent relaxation of a muscle group lasting 10-15 seconds. Participants will be asked to rate the degree of relaxation obtained using a 0 -100 scale (Hawton, K. Salkovskis, P.M., Kirk, J. & Clark, D.M. 1989).

In imagery relaxation participants will be asked about a place in their experience that they will find very comfortable and peaceful. Researcher will help the participants to describe the setting in sufficient details that the therapist could guide them through the images after the muscle tensing and relaxing have been completed (Masters, J. C., Burish, T.G. Hollon, S.D. & Rimm, D.C. 1987)

Breathing relaxation

The participant will be instructed to breathe in through the nose, watching the lower abdominal area arise, and to breathe out through the mouth. After establish a comfortable breathing pattern, participant will be asked to close the eyes while excelling

Mindfulness

Mindfulness is one kind of meditation that involves being present in the moment, focusing on the reality and accepting it for what it is. It focuses on what is happening in our bodies, our emotions, our minds, and in the world. Through mindfulness practice we can avoid harming ourselves and others (Hanh, N.T. 2017). Mindful parenting offers a way of approaching parenting in high stressful situations. Mindfulness help parents to learn being purposefully aware of their own experience of parenting and teach parents to nourish their children in an optimal

manner so that their children, and they themselves can realize their full potential. (Sujata Sethi and Harshit Sharma, 2018).

Duncan et al (2009) describe these in a simple manner as follows:

1. Acting with awareness: This is the opposite of dissociation/absent mindedness.

2. Observing: It is the intentional focusing of attention on stimuli.

3. Describing: It means describing experiences with words.

4. Non-reactivity to inner experience: This involves decentering from mental events and allowing thoughts to be “just thoughts” or affect to be “just feelings” instead of over identifying with them.

5. Non-judging of inner experience: This involves self-regulation of reactivity to mental events, including social information processing.

Bogels and Restifo (2014) described mindful parenting as a way of approaching parents in high stress times. Mindfulness is a form of meditation that involves being present in the moment, focusing on the reality and accepting it for what it is.

Participant will do short practice on mindfulness. Here researcher will teach them the S-T-O-P techniques. Participants will use this technique to balance throughout the day whenever in any angry, stressful interaction. Here

S= Stop

T= Take breath

O=Observe your thoughts and feelings

P=Pause. Proceed mindfully. The pause makes the difference and we learn to respond rather than react.

Mindfulness can help almost any relationship and it can be changed by the way we interact with our child and others around us.

Anger management

Aggression is demented with anger by some people. Aggression is behavior that causes suffering or injury to another person or damages to property. On the other hand, a set of perception and judgments that motivate aggressive behaviors refers to aggression.

Participant will be educated about the myth of anger such as anger is inherited, anger automatically leads to aggression which come after anger that is automatically leads it, one must be violent to receive what he/she want, anger ventilation is always advantageous. Participant will be trained about identifying the events that trigger anger and four cues (e.g. physical, emotional, behavioral and cognitive) to anger. After that they make a plan to control anger through time out, exercise, cognitive restructuring such as A-B-C-D model, thought stopping and assertiveness (Shopshire, M.S., Reilly, P.M., Durazzo, T.C. & Campbell, T.A., 2012).

Stress control

There are three ways to conceptualize the stress (Baum, 1990; Coyne & Holroyd, 1982; Hobfoll, 1989). The first way is to describe stress as a stimulus that one recognizes as frightening or unfavorable that produce feelings of tension, are called stressors. The second way is describing stress as a response that focus on people's reaction to stressors and finally, the third is describing stress as a procedure that includes stressors and strains (psychological response to a stressors).

Methods of coping with stress are

In managing stress first, identifying the source of stress then knowing which type of stresses are toxic then plan to control stress. In managing stress problem solving (D'zurilla, 1990)

mindfulness (Grossman, Niemann, Schmidt, Macan, 2004) time management (Shahani, Dipboye, 1990), PMR and breathing (sarfino,) are the effective techniques.

Time management

Time management means organizing one's time. It consists of three elements (Lakein, 1973)

1. Setting goal: Goals should be reasonable and obtainable. These goals should be divided in long term goals and short-term goals.
2. Setting priorities: it will be necessary to make a list early each morning or late in the preceding day. Each list must be written on a paper.
3. Setting a schedule: it will be necessary to allocate estimated time to each item in the list.

Others method of reducing stress such as problem solving, mindfulness, PMR and breathing relaxation were described in previous section.

Appendix 3

Session Materials (Picture)

Session 1 materials

 strict/harsh	 responsible/caring
 Liberal parenting	 Casual parenting (neglectful/careless)

Session 2 materials

 Listen	 Keep eye contact
 Let your child speak	 Show interest in what the child is saying

 Make sure your child is listening	 Keep eye contact with your children
 Talk with your children, not at your children	 Speak kindly
 Keep your statement simple	 Match your tone of voice to your message

Session 3 materials

Spending good quality time with your children








Appendix4

Behavioral Observation

আচরণ পর্যবেক্ষণ

তারিখ এবং সময়	আচরণের পূর্ববর্তী ঘটনা	আচরণ	আচরণের পরবর্তী ঘটনা

Appendix 5

Weekly Reward Chart

সাপ্তাহিক পুরস্কারের চার্ট

কাজ	শনিবার	রবিবার	সোমবার	মঙ্গলবার	বুধবার	বৃহস্পতিবার	শুক্রবার
১.							
২.							
৩.							
৪.							
৫.							
৬.							
৭.							
দৈনিক স্টার সংখ্যা							

সাপ্তাহিক লক্ষ্যঃ.....

সাপ্তাহিক পুরস্কারঃ.....

নির্দেশনাঃ

আপনার শিশুকে সাথে নিয়ে শিশুটির জন্য ছোট ছোট এবং সম্ভম্পর লক্ষ্য নির্ধারণ কর"ন। "কাজ" লেখা কলামে সেই লক্ষ্য গুলো সিরিয়াল অনুসারে লিখুন অথবা শিশুটিকে লিখতে বলুন। সপ্তাহ শেষে এই কাজগুলো সঠিক করতে পারলে তাকে কি পুরষ্কার দেয়া হবে তা দুজনে একসাথে নির্ধারণ কর"ন। পুরসপ্তাহ জুড়ে ঐ লক্ষ্যগুলোকে খেয়াল কর"ন এবং লক্ষ্য পুরন হলেই তাকে স্টারটি রং করতে বলুন। এমনিভাবে সারাদিন কয়টি স্টার হল তা রাতে দুজনে একসাথে পর্যালোচনা কর"ন। শিশুকে তার সপ্তাহ শেষে পুরষ্কারের কথা মনে করিয়ে দিন

এবং তাকে উৎসাহ দিন তার লক্ষ্য স্টার আদায় করার জন্য। এমনিভাবে সাতদিন পার হবারপর দুজনে একসাথে বসে দেখুন কততা স্টার হল। যদি সে তার লক্ষ্য স্টার আদায় করতে পারে তবে তাকে অবশ্যই পূর্ব পূর্বনির্ধারিত পুরষ্কার দিতে হবে এবং যদি সে লক্ষ্য স্টার আদায় করতে না পারে তবে তাকে উৎসাহ দিন পরবর্তী সপ্তাহে লক্ষ্য পুরনের জন্য।

বি.দ্র. কোন কিছুর জন্যই তাকে দোষারোপ করবেন না। পুরষ্কার না পেলেও বিদ্রুপ করবেন না। লক্ষ্য স্টার অর্জন করতে না পারলে পুরষ্কার প্রদান করবেন না এবং লক্ষ্য স্টার অর্জন করলে যত দ্রুত সম্ভব পুরষ্কার প্রদান করবেন। লক্ষ্য নির্ধারণে শিশুর মতামতের গুরুত্ত দিন।

Appendix 6

Daily Report Card of School

বিদ্যালয়ের দৈনিক কাজের বিবরণ

নামঃ

তারিখঃ

তার আজকের কাজের দক্ষতার জন্য, দয়া করে নিচের তালিকার ক্ষেত্রগুলো ৫-পয়েন্ট স্কেল ব্যবহার করে শিশুটির বিদ্যালয়ের কাজের অবস্থা নির্দেশ কর"ন।

১ **খুবই খারাপ**	২ **খারাপ**	৩ **মোটামুটি**	৪ **ঋাল**	৫ **বেশি ভাল**

	শ্রেণী ১	**শ্রেণী ২**	**শ্রেণী ৩**	**শ্রেণী ৪**	**শ্রেণী ৫**	**শ্রেণী ৬**	**শ্রেণী ৭**	**শ্রেণী ৮**
মনোযোগ দেয়া								
শ্রেণীর কাজ শেষ করা								
নিয়ম-কানুন মেনে চলা								
অন্যান্য								

Appendix 7

Summary of Session Outline

প্রশিক্ষণের উদ্দেশ্য

পিতামাতাকে তাদের সন্ড়ানের

- আচরণ সম্পর্কে সচেতন করা
- আচরণগুলো পরিবর্তনের কৌশল শেখানো
- পিতামাতাদের প্যারেন্টিং দক্ষতা বাড়ানো এবং তাদের নিজস্ব মানসিক চাপগুলো মোকাবেলা করতে সক্ষম করে তোলা

দলীয় নিয়মনীতি

- সবগুলো প্রশিক্ষণে অংশগ্রহণ করা
- যথাসময়ে উপস্থিত থাকা
- অন্যদের ধারণা ও মতামতের প্রতি শ্রদ্ধাশীল থাকা
- অন্যদের কথা বলার সুযোগ দেয়া
- কোন তথ্য শেয়ার করার জন্য কেউ বাধ্য নয়

বয়সঅনুযায়ি শিশুদের চাহিদা ও আচরণ

সাধারণ চাহিদা- খাদ্য, নিরাপত্তা, আরাম, মনোযোগ পাওয়া, বাবামায়ের সাথে ভাল সম্পর্ক, কৌতুহল, নতুন কিছু আবিষ্কার, স্বাধীনতা, নতুন কিছু শিখা, প্রশংসা, অনুমোদন, নিজের সিদ্ধান্ড় নিজে নেয়া।

	চাহিদা	আচরণ
৩-৫ বছর	কাজের মাধ্যমে শেখাযেমনখেলা। অন্য শিশুদের সাথেসম্পর্ক তৈরি করা, প্রশ্ন থাকা এবং উত্তর খোজা	বাস্ড়বের সাথে কল্পনার পার্থক্য খুজতে অসুবিধা হওয়া, অনুভূতিগুলো নাটকীয়ভাবে প্রকাশ করা, অনেক কথা বলে ও অনেক প্রশ্ন করে, হেরে যাওয়া, শেয়ার করা এবং অন্যকে সুযোগ দেয়া পছন্দ করে না তবে কিভাবে অন্যকে সুযোগ দেয়া যায় তা এই বয়সে শেখানো যায়
৬-১২ বছর	স্কুলে শেখার বিষয়ে আগ্রহ , স্বাধিনতা, বিশ্বাস, অন্য শিশুদের সাথে থাকতে চাওয়া, (খেলাধুলা করা	খুব অ্যাক্টিভ থাকে, নিজের ব্যাপারে অনেক সচেতন এবং সংবেদনশীল থাকে, একটুতেই কষ্ট পায়, মনের অবস্থার দ্রুত পরিবর্তন হয়, বড়দের কথার উত্তর দেয় এটা দেখাতে যে তারাও জানে। রাগ এবং হতাশা

	গুর"ত্বপূর্ণ কারন এর মাধ্যমে তারা সামাজিক মূল্যবোধগুলো শিখে)	নিয়ন্ত্রন করতে জানে।
১৩-১৭ বছর	অধিক স্বাধিনতা এবং বিশ্বাস চায়,সঙ্গীদের কাছ থেকেগ্রহণযোগ্যতা চায়, নিজস্বপরিচিতি তৈরি, যৌন এবং মাদকের বিষয় আগ্রহ, ভবিষৎ নিয়ে উদ্বিগ্নতা	পিতামাতার চেয়ে বন্ধুদের সাথে বেশি মিশতে চায়, ঝুঁকিপূর্ণ কাজে লিপ্ত হয়, বারবার মুডের পরিবর্তন এবং প্রতিদ্বন্দ্বী মনোভাব, নিজের সিদ্ধান্ড় নিজে নিতে চায়, পরিবারের বাইরে পথপ্রদর্শক খুজে।

কেন শিশুরা খারাপ আচরণ করে

১। যখন তারা অসুস্থ, ঘুম, একাকীত্ব অথবা বিরক্ত অনুভব করে অর্থাৎ তাদের চাহিদা পুরনের জন্য।

২। তারা তাদের সীমা সম্পর্কে না জানলে। এই সীমা বা নিয়মগুলো তাদের বয়স ও বোঝার ক্ষমতা

অনুযায়ী হতে হবে।

৩ ।অনেক সময় শিশুরা যদি স্বাধীনতা চায় আর তা যদি না পায় তবে তারা তা খারাপ আচরণ এর

মাধ্যমে প্রকাশ করে।

৪। অনেক সময় বড়রা না জেনে খারাপ আচরণকে পুরস্কৃত করে

৫। শিশুরা খারাপ আচরনকে অনুকরন করে।

মনে রাখতে হবে

শিশুর খারাপ আচরণ গুলো তার অভ্যন্ড়রীণ কোন বৈশিষ্ট্য নয়। শিশুটি ভাল কিন্তু তার

আচরণটি খারাপ এভাবে ভাবতে হবে। শিশু যখন কোন আচরণ করে, সে কি কারনে তা করল তা খেয়াল করতে হবে এবং এর

ফলাফল আমরা কি দিচ্ছি তাও খেয়াল রাখব।

শিশুটির সাথে কিভাবে কথা বলব ও শুনবো

- মনোযোগদিব
- যে কাজটা করছি তা বন্ধ করে ওর কথা শুনবো
- যদি ব্যস্ড় থাকি তবে বলব আমি এখন ব্যস্ড় আছি আমরা কি পরে কথা বলতে পারি? তারপর একটা সময় নির্ধারণ করব।
- তার দিকে তাকিয়ে কথা বলব।

- কথা বলার সময় শিশুটিকে বাধা দিব না এবং কথা শেষ করার পর তাকে প্রশংসা করব
- আর তাকে জিজ্ঞাস করব সে আরও কিছু বলতে চায় কিনা ।শিশুটির সঙ্গে যখন কথা বলব তখন তার নাম ধরে ডাকব, তার সাথে দূরত্ব কম রেখে কথা বলব।
- সহজ করে কথা বলব। একটি সময় শুধু একটি কাজ বা নির্দেশনা দিব।
- তাকে ভয় অথবা চিৎকার দিয়ে কথা বলব না নরম স্বরে কথা বলব।
- শিশুটিকে ইতিবাচকভাবে নির্দেশনা দিব। জেমন-মেঝেতে খেল (বলব) সোফায় খেলনা (বলব না)
- যখন শিশুটি কিছু শেয়ার করবে তখন তাকে ধন্যবাদ দেয়া ।কথপকথনের সময় কিছু উক্তি ব্যবহার করা যেমন "আমি বুঝতে পেরেছি", "আমি জানি তুমি কি অনুভব করছ"। শিশুরা যখন মনে করে যে বাবা-মা এবং পরিবারে তার গ্রহণযোগ্যতা আছে তখন তারা পরিবার ও মাবাবার সাথে ভাল যোগাযোগ রাখে।

নিয়ম শিখানো

নিয়মগুলো হবে সীমিত, পরিষ্কার, সমঞ্জস্যপূর্ণ, ইতিবাচক, একটা ফলাফল থাকবে, নিয়ম তৈরিতে শিশুটিকে রাখতে হবে এবং নিয়ম প্রয়গের ক্ষেত্রে নিজেকে দৃড়হতে হবে।

বয়সঅনুযায়ী নিয়মকানুন

৩-৬ বছর	খেলনা গুছিয়ে রাখা কোন কিছু নিতে হলে অনুমতি নেয়া ছোটখাটো বাড়ীরকাজ
৭-১১ বছর	স্বাস্থ্যর দিকে মনোযোগ দেয়া বাড়ীর কাজ নিয়মিত বিদ্যালয় উপস্থিতি বিদ্যালয়ের কাজ করা তবে সাহায্য চাইতে পারে
কিশোর বয়স	উপরের গুলো করবে...পাশাপাশি প্রত্যাশিত সময় বাড়ি ফেরা (নিরাপত্তার জন্য তারাতারি) পর্যাপ্ত ঘুম, খওয়া পরিবারের সাথে বন্ধুদের পরিচয় করিয়ে দেয়া বিদ্যালয় ও পরিবারের দায়িত্ব নেয়া মতের অমিল হলেও বড়দের সম্মান করা

নিয়ম শিখানোর পদ্ধতি

- ভাল আচরণের প্রশংসা করা খারাপ আচরণ গুলো পাত্তা না দেয়া
- নিজে ভাল আচরণ করা যাতে শিশুরা দেখে শিখতে পারে
- শিশুটি যদি খারাপ আচরণ করে তবে সে যে সুবিধাগুলো পেত সেগুলো তাকে না দেয়া

- যতক্ষণ শিশুটি শান্ড় না হয় ততক্ষণ তাকে পাত্তা না দেয়া।
- শিশুটি ভাল আচরণ করার সাথে সাথে তাকে ক্ষমা করে প্রশংসা করা।

শারীরিক শাস্ড়ি দিয়ে সিশুকে নিয়ম শিখানো যায় না বরং এতে তার নিজের সম্পর্কে নিু ধারণা তৈরি হয় পাশাপাশি সে অনেকবেশী বিদ্রোহী হয়ে উঠে।

- শিশুটির সঙ্গে যখন কথা বলব তার অনুভুতিগুলো বোঝার চেষ্টা করব অর্থাৎ তার জায়গা থেকে তার বিষয়গুলো বুঝা।
- একটা নির্দিষত সময় শুধু শিশুটির সঙ্গে কাটানো
- শশুটিকে কারো সাথে তুলনা না করা
- ওকে খারাপভাবে লেবেল না করা যেমন-তুমি খারাপ, তুমি কিছু পার না।
- শিশুর সাথে যদি তার পিতামাতা ও অন্যান্য অভিভাবকদের ইতিবাচক সম্পর্ক থাকে তবে সেটা তাকে ভালভাবে বিকাশের পথকে সুগম করে তুলবে।

Appendix 8

Ethical Approval

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা-১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th floor)
Dhaka 1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-8615583, E-mail: clinpsy@du.ac.bd

Certificate of Ethical Approval

Project Number : **MP181002**

Project Title : **Impact of Parent Training on Behavior of Children with Conduct Disorder**

Investigators : **Simun Nesa** and **Kamal Uddin Ahmed Chowdhury**

Approval Period : **09 January 2019** to **08 January 2021**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.

. . . . . .

Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

Appendix 9

Data Collection Permission Letter

Government of the People's Republic of Bangladesh
Office of the Director-cum-Professor
National Institute of Mental Health & Hospital
Sher-e-Bangla Nagar, Dhaka-1207

Memo No.NIMH/2019/ 551 Date : 18/3/19

To

Kamal Uddin Ahmed Chowdhury
Associate Professor
Dept. Clinical Psychology
University of Dhaka

Subject: Permission to collect research data.

Thank you for your letter. The Research Proposal **"Impact of Parent Training on Behavior of Children with Conduct Disorder"** has been reviewed and approved by the ethical committee of this institute.

I am happy to permit your student **Simun Nasa** to collect data for her study from this institute.

13/3/2019

(Prof. Dr. Md. Abdul Mohit)
Director-cum-Professor (C.C)
National Institute of Mental Health
Sher-e-Banga Nagar, Dhaka

Memo No. NIMH/2019/ Dated :

Copy forwarded for information and necessary action to :-

1. Simun Nasa, M.Phil (Part-2), Dept. of Clinical Psychology, University of Dhaka.
2. Office Copy.

(Prof. Dr. Md. Abdul Mohit)
Director-cum-Professor (C.C)
National Institute of Mental Health
Sher-e-Banga Nagar, Dhaka

Student/N/370

বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়

Bangabandhu Sheikh Mujib Medical University
শাহবাগ, ঢাকা, বাংলাদেশ।

নং- বিএসএমএমইউ/২০১৯/৬৬২৮ তারিখ ঃ ১২-০৬-২০১৯ ইং

Simun Nasa
M. Phil (Part-2)
ক্লিনিক্যাল সাইকোলজি বিভাগ
ঢাকা বিশ্ববিদ্যালয়, ঢাকা।

বিষয় ঃ তথ্য সংগ্রহের অনুমতি প্রদান প্রসঙ্গে।

উপরোক্ত বিষয়ে আপনার ১১-০৪-২০১৯ ইং তারিখের আবেদনের প্রেক্ষিতে কর্তৃপক্ষের অনুমোদনক্রমে "Impact of Parent Training on Behavior of Children with Conduct Disorder" শীর্ষক গবেষণা কাজের জন্য এই বিশ্ববিদ্যালয়ের মনোরোগ বিদ্যা বিভাগের প্রচলিত নিয়ম অনুসরণ পূর্বক রোগীদের নিকট থেকে তথ্য সংগ্রহের অনুমতি প্রদান করা হ'ল।

আদেশক্রমে

(ডা. ফেরদৌস আলম)
উপ-রেজিস্ট্রার (শিক্ষা)

নং- বিএসএমএমইউ/২০১৯/৬৬২৮/১(৯) তারিখ ঃ ১২-০৬-২০১৯ ইং

অনুলিপি সদয় অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য প্রেরণ করা হ'ল ঃ

১। ডীন, মেডিসিন অনুষদ, বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়, ঢাকা।
২। চেয়ারম্যান, মনোরোগ বিদ্যা বিভাগ, বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়, ঢাকা।
৩। পরীক্ষা নিয়ন্ত্রক/পরিচালক (পরিদর্শন)/পরিচালক (হাসপাতাল)/পরিচালক (অর্থ ও হিসাব)/গ্রন্থগারিক, বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়, ঢাকা।
৪। অতিরিক্ত রেজিস্ট্রারদ্বয়, বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়, ঢাকা।
৫। কামাল উদ্দিন আহমেদ চৌধুরী, সহযোগী অধ্যাপক, ক্লিনিক্যাল সাইকোলজি,বিভাগ, ঢাকা বিশ্ববিদ্যালয়, ঢাকা।
৬। একান্ত সচিব, মাননীয় ভাইস চ্যান্সেলর/ প্রো-ভাইস চ্যান্সেলরগণ/কোষাধ্যক্ষ, বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়, ঢাকা।
৭। সহকারী পরিচালক (শিক্ষা), বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়, ঢাকা।
৮। রেজিস্ট্রার মহোদয়ের ব্যক্তিগত কর্মকর্তা, বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়, ঢাকা।
৯। অফিস কপি।

(ডা. ফেরদৌস আলম)
উপ-রেজিস্ট্রার (শিক্ষা)

Dhaka Shishu (Children) Hospital
Sher-e-Bangla Nagar, Dhaka-1207, Bangladesh
Tel : (PABX) 9104211- 9104220, 9117512, 58152805
Fax : 880-2-9128308, E-mail : dhakashishu2010@gmail.com
website : www.dhakashishuhospital.org.bd

ঢাকা শিশু হাসপাতাল
শেরে বাংলা নগর, ঢাকা-১২০৭, বাংলাদেশ
ফোন ঃ (পিএবিএক্স) ৯১০৪২১১-৯১০৪২২০, ৯১১৭৫১২
৫৮১৫২৮০৫, ফ্যাক্স ঃ ৮৮০-২-৯১২৮৩০৮

নং প্রশাসন/১৭৫৯ /২০১৯/ ঢাশিহাঃ

তারিখঃ ০৩.১০.২০১৯ইং

দপ্তরাদেশ

Simun Nasa, Student M.Phil (Part-2) Department of Clinical Psychology, University of Dhaka কর্তৃক "Impact of Parent Training on Behavior of Children with Conduct Disorder" এর গবেষণার অনুমতি চাহিয়া আবেদনের প্রেক্ষিতে তাহার মূল গবেষণা পত্রে ঢাকা শিশু হাসপাতালকে স্বীকৃতি প্রদান করার শর্তে এবং হাসপাতাল এর Ethical Committee ছাড়পত্র প্রদান করায় তাহাকে ০১/১০/২০১৯ হতে ৩১/০৩/২০২০ পর্যন্ত উক্ত গবেষণার অনুমতি প্রদান করা হইল।

তাহাকে অত্র হাসপাতালের ডাঃ সায়লা ইমাম (কান্তা), সহকারী অধ্যাপক, পেডিয়েট্রিক নিউরোসাইন্স বিভাগ এর সহিত সমন্বয়ের মাধ্যমে এবং হিসাব বিভাগে ফি বাবদ ১,০০০/- (এক হাজার) টাকা প্রদান সাপেক্ষে গবেষণার কাজ শুরু করিতে হইবে।

অধ্যাপক (ডাঃ) সৈয়দ সফি আহমেদ
পরিচালক
ঢাকা শিশু হাসপাতাল

নং প্রশাসন/১৭৫৯ /২০১৯/ ঢাশিহাঃ

তারিখঃ ০৩.১০.২০১৯ইং

অবগতি ও প্রয়োজনীয় ব্যাবস্থা গ্রহনের জন্য অনুলিপিঃ

১। সদস্য- সচিব, ইথিক্যাল রিভিউ কমিটি, ঢাশিহা।
২। উপ-পরিচালক (হাসপাতাল), ঢাশিহা।
৩। উপ-পরিচালক (অর্থ), ঢাশিহা।
৪। ডাঃ সায়লা ইমাম (কান্তা), সহকারী অধ্যাপক, পেডিয়েট্রিক নিউরোসাইন্স বিভাগ, ঢাশিহা।
৫। প্রশাসনিক কর্মকর্তা, ঢাশিহা।
৬। Simun Nasa, Student M.Phil (Part-2) Department of Clinical Psychology, University of Dhaka
৭। পরিচালক মহোদয়ের একান্ত সচিব, ঢাশিহা।
৮। কোষাধ্যক্ষ, ঢাশিহা।
৯। দপ্তর কপি।

প্রশাসনিক কর্মকর্তা

Appendix 10

Consent Form

গবেষণায় অংশগ্রহনে সম্মতিপত্র

সম্মানিত অংশগ্রহণকারী,

আমি ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগে একজন এম.ফিল গবেষক। পাঠ্যক্রমের অংশ হিসাবে আমি একটি গবেষনা করছি। আমার গবেষণার শিরোনাম "Impact of parent training on behavior of children with conduct disorder"। এ উদ্দেশ্যে আপনার শিশুর আচরেণর উন্নতির জন্য গবেষণার অংশ হিসাবে আমি আপনাকে মনোবৈজ্ঞানিক সেবা প্রদান করতে আগ্রহী। সেবাটি আপনার শিশুর মানসিক সুস্থতায় সহায়ক হবে। এই গবেষনায় অংশগ্রহনের মাধ্যমে আপনি বাংলাদেশের একটি যথার্থ ও নির্ভরযোগ্য চিকিৎসা সেবার কার্যকারিতা প্রতিষ্ঠা করার ক্ষেত্রে অবদান রাখতে পারবেন।

আপনার দেওয়া তথ্য গুলো শুধুমাত্র গবেষণার কাজে ব্যবহার করা হবে এবং ব্যক্তিগত সকল তথ্য সম্পূর্নভাবে গোপন রাখা হবে। তবে গবেষণায় অংশগ্রহন করা বা না করা একান্তই আপনার ইচ্ছার উপর নির্ভরশীল। আপনি ইচ্ছুক হলে আমি সেবা প্রদানের কাজটি শুর্ করতে পারি। এক্ষেত্রে যদি অন্যান্য চিকিৎসা সেবার প্রয়োজন হয় (সাইকিয়াট্রিক অথবা, সাইকিয়াট্রিক মূল্যায়ন) তাহলে আপনাকে যথাযথ সেবার জন্য রেফার করা হবে। এজন্য নিম্নে আপনার স্বাক্ষর অথবা মৌখিক অনুমতি প্রয়োজন।

আপনার সহযোগিতার জন্য ধন্যবাদ।

অনুমতি প্রদান করা হয়েছে / হয়নি

স্বাক্ষর (গবেষক)

স্বাক্ষর (গবেষণায় অংশগ্রহণকারী)

সায়মুন নেছা
এম. ফিল গবেষক
চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

Appendix 11

Study Questionnaires

Demographic Information

(জীবন বৃত্তান্ড় তালিকা)

এখানে যে প্রশ্নমালাগুলো রয়েছে তা অনুগ্রহ করে প্রতিটি উক্তি মনোযোগ সহকারে পর"ন এবং যথাস্থানে আপনার উত্তর ব্যাক্ত কর"ন।

অনুগ্রহ করে প্রথমে কয়েকটি তথ্য প্রদান কর"ন

আপনারসন্ড়ানের

নামঃ

বয়সঃ

লিঙ্গঃ ছেলে/মেয়ে

জন্মক্রমঃ

পড়াশুনাঃ

ধর্মঃ

পারিবারিক মাসিক আয়ঃ

বাসার ঠিকানাঃ

সুস্থতাঃ ক) বেশীরভাগ সময় সুস্থ থাকে খ) মাঝে মাঝে অসুস্থ থাকে গ) প্রায়ই অসুস্থ থাকে

শিশুটির অভিভাবক (মা অথবা বাবা অথবা উভয়ই অথবা যিনি সন্ড়ানের সঙ্গে বসবাস করেন)ঃ

অভিভাবকের পেশাঃ বাবার পেশাঃ মায়ের পেশাঃ

অভিভাবকের বয়সঃ বাবার বয়সঃ মায়ের বয়সঃ

অভিভাবকের শিক্ষাগত যোগ্যতাঃ

বাবার শিক্ষাগত যোগ্যতাঃ মায়ের শিক্ষাগত যোগ্যতাঃ

অভিভাবকের সাথে শিশুটির সম্পর্কঃ

তথ্য দাতার নামঃ

ছেলেমেয়ের আচরণ নিরীক্ষণ তালিকা পিতামাতার বিবরণী ফরম
The Bengali version of Child Behavior Checklist (CBCL)
৪ থেকে ১৬ বৎসর বয়স্ক ছেলেমেয়েদের আচরণ নিরীক্ষণ তালিকাঃ

নিচে কতগুলি উক্তির তালিকা আছে যা দিয়ে ছেলেমেয়েদের বর্ণনা করা যায়। যে উক্তি আপনার সন্তানের ক্ষেত্রে এখন থেকে গত ৬ মাসের মধ্যে প্রযোজ্য তা নির্দেশ করুন। লক্ষ্য করুন, বিবৃতির ডান পাশে তিন ধরনের উত্তর দেয়া আছে। সঠিক উত্তরটি টিক চিহ্ন দিয়ে নির্দেশ করুন। দয়া করে আপনার সাধ্যমত সবগুলি উক্তির উত্তর দিন। যদিও কিছু উক্তি আপনার সন্তানের ক্ষেত্রে প্রযোজ্য নাও হতে পারে।

নম্বর	উক্তি সমূহ	০=সত্যি নয় (যতদূর আপনি জাননে)	১=কছিুটা অথবা কখনও কখনও সত্যি	২=খুবই সত্যি অথবা প্রায়ই সত্যি
১	বয়সের তুলনায় ছোটদের মত ভাব করে			
২	এলার্জি (বর্ণনা করুন)			
৩	অনেক তর্ক করে			
৪	হাঁপানি			
৫	বিপরীত লিঙ্গের ন্যায় আচরণ করে			
৬	নির্দিষ্ট স্থান ছাড়া পায়খানা করে			
৭	বড়াই অথবা অহংকার করে			
৮	মনোনিবেশ করতে পারে না, বেশিক্ষণ মনোযোগ দিতে পারে না			
৯	কোন কোন চিন্তা মন থেকে দূর করতে পারে না (বদ্ধ সংস্কার বাতিক) (বর্ণনা করুন)			
১০	শান্ত হয়ে বসতে পারে না অস্থরি অথবা র্কম চঞ্চল			
১১	বড়দের কাছ ঘেঁষে থাকে অথবা অতিরিক্ত নির্ভরশীল			
১২	নিঃসঙ্গতা সম্পর্কে অভিযোগ করে			

নম্বর	উক্তি সমূহ	০=সত্যি নয় (যতদূর আপনি জাননে)	১=কছিুটা অথবা কখনও কখনও সত্যি	২=খুবই সত্যি অথবা প্রায়ই সত্যি
১৩	বিভ্রান্ত অথবা মনে হয় অস্পষ্টতার মধ্যে আছে			
১৪	অনেক কান্নাকাটি করে			
১৫	জীবজন্তুর প্রতি নির্দয়			
১৬	অন্যরে প্রতি নির্দয়, তর্জন গর্জন অথবা হীন ব্যবহার করে			
১৭	দিবা স্বপ্ন দেখে অথবা নিজের চিন্তায় মগ্ন থাকে			
১৮	ইচ্ছাকৃতভাবে নিজের ক্ষতি করে অথবা আত্মহত্যার চেষ্টা করে			
১৯	অধিক মনোযোগ দাবি করে			
২০	নিজের জিনিসপত্র বিনষ্ট করে			
২১	নিজের পরিবারের অথবা অন্যান্য ছেলেমেয়েদেরজিনিসপত্র বিনষ্ট করে			
২২	বাড়ীতে অবাধ্য			
২৩	বিদ্যালয়ে অবাধ্য			
২৪	ঠিকমতো খায় না			
২৫	অন্য ছেলেমেয়েদের সংগে মিলেমিশে থাকতে পারে না			
২৬	অসদ্ববহার করার পর নিজেকে অপরাধী মনে করে না			
২৭	সহজেই ঈর্ষাপরায়ণ			
২৮	খাদ্য নয় এমন জিনিস খায় অথবা পান করে (বর্ণনা করুন)			
২৯	বিদ্যালয় ব্যতীত কোন কোন জীবজন্তু , পরিস্থিতি অথবা জায়গাকে ভয় পায় (বর্ণনা করুন)			

নম্বর	উক্তি সমূহ	০=সত্যি নয় (যতদূর আপনি জাননে)	১=কছিুটা অথবা কখনও কখনও সত্যি	২=খুবই সত্যি অথবা প্রায়ই সত্যি
৩০	বিদ্যালয় যেতে ভয় পায়			
৩১	খারাপ কছিু করতে অথবা চিন্তা করতে পারে বলে সে ভয় পায়			
৩২	নিজেকে নিখুত হতে হবে বলে মনে করে			
৩৩	কেউ তাকে ভালবাসে না বলে মনে করে অথবা অভিযোগ করে			
৩৪	অন্যরা তাকে হামলা করবে বলে মনে করে			
৩৫	নিজেকেঅপদার্থ অথবা নিকৃষ্টতর বলে মনে করে			
৩৬	প্রায়ই ব্যথা পায়, দুর্ঘটনা প্রবণ			
৩৭	প্রায়ই মারামারিতে লিপ্ত থাকে			
৩৮	অনেকে তাকে খেপায়			
৩৯	যে সমস্ত ছেলেমেয়ে সমস্যায় লিপ্ত থাকে সে তাদরে সংগে থাকে			
৪০	নানা জিনিস শোনে যদিও সেগুলি সেখানে নেই (বর্ণনা করুন)			
৪১	আবেগবশত অথবা চিন্তা না করে কাজ করে			
৪২	একা থাকতে পছন্দ করে			
৪৩	মিথ্যা কথা বলে অথবা প্রতারনা করে			
৪৪	আঙ্গুলের নখ কামরায়			
৪৫	ভীত সন্ত্রস্ত, সহজইে উত্তেজিত অথবা উদ্বিগ্ন			
৪৬	চলাফেরায় ভীত সন্ত্রস্ততা অথবা কাপুনি (বর্ণনা করুন)			

নম্বর	উক্তি সমূহ	০=সত্যি নয় (যতদূর আপনি জাননে)	১=কছিুটা অথবা কখনও কখনও সত্যি	২=খুবই সত্যি অথবা প্রায়ই সত্যি
৪৭	দুঃস্বপ্ন দেখে			
৪৮	অন্য ছেলেমেয়েরা তাকে পছন্দ করে না			
৪৯	কোষ্ঠকাঠিন্য, সহজে পায়খানা হয় না			
৫০	অতিরিক্ত ভীত অথবা উদ্বিগ্ন			
৫১	মাথা ঘোরা অনুভব করে			
৫২	অতিরিক্ত অপরাধী ভাবে			
৫৩	অতিরিক্ত আহার করে			
৫৪	অতিরিক্ত ক্লান্তি বোধ করে			
৫৫	অতিরিক্ত ওজন থাকতে পারে না			
৫৬	ডাক্তারি কারন ছারা শারীরিক সমস্যা			
	ক) ব্যথা অথবা বেদনা			
	খ) মাথা ব্যথা			
	গ) বমি বমি ভাব			
	ঘ) চোখের সমস্যা (বর্ণনা করুন)			
	ঙ) ফুসকুড়ি অথবা অন্য কোন চর্ম সমস্যা			
	চ) পাকস্থলীতে ব্যথা অথবা খিচুনি			
	ছ) বমি করা, উদগীরণ করা			
	জ) অন্য কোন লক্ষণ (বর্ণনা করুন)			
৫৭	অন্য লোকদরেও আক্রমণ করে			
৫৮	নাক চর্ম অথবা kwi‡jঅন্য কোন অংশ চুলকায় ..... (বর্ণনা করুন)			
৫৯	জনসম্মুখেনিজের যৌনাংগ নিয়ে খেলা করে			
৬০	নিজের যৌনাংগ নিয়ে অতিরিক্ত খেলা করে			

নম্বর	উক্তি সমূহ	০=সত্যি নয় (যতদূর আপনি জাননে)	১=কছিুটা অথবা কখনও কখনও সত্যি	২=খুবই সত্যি অথবা প্রায়ই সত্যি
৬১	বিদ্যালয়ের কাজ নিম্নমানের			
৬২	অনিপুনভাবে কাজ করে অথবা অগোছালো			
৬৩	তার চেয়ে বয়সে বড় মেয়েদের সংগে খেলতে পছন্দ করে			
৬৪	তার চেয়ে বয়সে ছোট মেয়েদের সংগে খেলতে পছন্দ করে			
৬৫	কথা বলতে চায় না			
৬৬	কোন কাজ বার বার পুনরাবৃত্তি করে বাধ্যবাধকতা বাতিক (বর্ণনা করুন)			
৬৭	বাড়ী থেকে পালিয়ে যায়			
৬৮	খুব চেচামেচি করে			
৬৯	গোপনীয় ভাবে সবকিছু নিজের মধ্যে রাখে			
৭০	কোন জনিসি না থাকা সত্বেও তাদেখে(বর্ণনা করুন)			
৭১	আত্মসচেতন অথবা সহজেই বিব্রতবোধ করে			
৭২	আগুন লাগিয়ে দেয়			
৭৩	যৌন সমস্যাবলী (বর্ণনা করুন)			
৭৪	বড়াই অথবা ভাঁড়ামি করে			
৭৫	লাজুক অথবা ভীতু			
৭৬	বেশিরভাগছেলেমেয়েরচেয়ে কম ঘুমায়			
৭৭	দিন এবং / অথবা রাত্রে বেশিরভাগ ঘুমায় (বর্ণনা করুন)			

নম্বর	উক্তি সমূহ	০=সত্যি নয় (যতদূর আপনি জাননে)	১=কছিুটা অথবা কখনও কখনও সত্যি	২=খুবই সত্যি অথবা প্রায়ই সত্যি
৭৮	পায়খানা দিয়ে লেপন অথবা খেলা করে			
৭৯	কথা বলার সমস্যা (বর্ণনা করুন)			
৮০	ভাবলেশহীন ভাবে তাকিয়ে(বর্ণনা করুন			
৮১	বাড়িতে চুরি করে			
৮২	বাড়ীর বাইরে চুরি করে			
৮৩	যে সমস্ত জনিসি তার প্রয়োজন নইেসেগুলি জমা করে (র্বণনা করুন)			
৮৪	অদ্ভুত আচরন করে (বর্ণনা করুন)			
৮৫	অদ্ভুত ধারনা করে (বর্ণনা করুন)			
৮৬	একগুঁয়ে জেদি অথবা রগচটা			
৮৭	ভাব অথবা অনুভূতির হঠাৎ পরিবর্তন			
৮৮	খুব বেশি অভিমান করে			
৮৯	সন্দেহ পরায়ণ			
৯০	অশ্লীল অথবা নোংরা ভাষা ব্যবহার করে			
৯১	নিজেকে হত্যা করার কথা বলে			
৯২	ঘুমরে মধ্যে কথা বলে অথবা হাটে(বর্ণনা করুন)			

নম্বর	উক্তি সমূহ	০=সত্যি নয় (যতদূর আপনি জাননে)	১=কছিুটা অথবা কখনও কখনও সত্যি	২=খুবই সত্যি অথবা প্রায়ই সত্যি
৯৩	অতিরিক্ত কথা বলে			
৯৪	অতিরিক্তখেপায়			
৯৫	বদ মেজাজ অথবা গরম মেজাজ			
৯৬	যৌন বিষয় নিয়ে খুব বেশি চিন্তা করে			
৯৭	বুড়ো আংগুল চোষে			
৯৯	পরিষ্কার পরিচ্ছন্নতা নিয়ে বেশি উদ্বিগ্ন			
১০০	ঘুমের অসুবিধা (বর্ণনা করুন)			
১০১	বিদ্যালয়থেকে পালায়, বিদ্যালয় ফাঁকিদেয়			

১০২	কম সক্রিয়,শিথিল অথবা চলাফেরা উদ্যমের অভাব			
১০৩	অসুখী, দুঃখিত অথবা মন মরা			
১০৪	অস্বাভাবিকচিৎকার করে			
১০৫	মদ অথবা মাদক দ্রব্যসেবন করে (বর্ণনা করুন)			
১০৬	ধ্বংসাত্মক কাজ করে			
১০৭	দিনের বেলা প্রস্রাব করে নিজেকে ভিজায়			
১০৮	বিছানায় প্রস্রাব করে			
১০৯	ঘ্যান ঘ্যান করে			
১১০	বিপরিত লিঙ্গের ন্যায় হতে চায়			
১১১	নিজেকে গুটিয়ে রাখে অন্যের সংগে জরাতে চায় না			
১১২	উদ্বিগ্ন থাকে			
১১৩	উপরে তালিকা করা হয় নাই এমন কোন সমস্যা যদি আপনার সন্তানের /প্রতিষ্ঠানের শিশুটির থাকে তাহলে দয়া করে লিখুন			
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সবগুলি উক্তির উত্তর দিয়েছেন কিনা দয়াকরে দেখে নিন।

উপরের টেবিলের কোন কছিু সম্মন্ধে আপনি উদ্বিগ্ন বোধ করলে তার নিচে দাগ দিন ।

বাংলা সংস্করনঃ রোকেয়া বেগম

শিশু প্রতিপালন চর্চামানক

The Parenting Practices Scale (Strayhorn & Weildman, 1988)

নীচের প্রশ্নগুলো আপনার শিশু কি করে এবং আপনি আপনার শিশুর প্রতি কিভাবে প্রতিক্রিয়া করেন সে সম্পর্কীত। দয়া করে প্রত্যেকটি প্রশ্নের একটি মাত্র উত্তর বৃত্তাকার করুন।

0= কখনই না, 1= সপ্তাহে একবারের ও কম, 2= সপ্তাহে একবার, 3= প্রায় সপ্তাহে ৩/৪ বার, 4= দিনে প্রায় ১ বার, 5= দিনে কয়েক বার, 6= দিনে অনেকবার।

ক্রমিক	বিবৃতি সমূহ	0	১	২	৩	৪	৫	৬
১	আপনার শিশু কতবার এমন কিছু করে যা আপনার জন্য আনন্দময় ও উপভোগ্য?							
২	আপনার শিশু কতবার এমন কিছু করে যা সাধারণতঃ আপনাকে বিরক্ত করে এবং আপনার জন্য সংবেদনশীল?							
৩	আপনি আপনার শিশুকে কতবার উপলব্ধি করেন?							
৪	আপনি আপনার শিশুকে কতবার শারিরীকভাবে শাস্তিদেন?							
৫	আপনি আপনার শিশুকে কতবার প্রশংসা করেন? যেমন "তুমি কত ভাল কাজ করছ।" অথবা "ধন্যবাদ" অথবা "ভাল করেছ।"?							
৬	আপনি আপনার শিশুকে আপনার অভিজ্ঞতার কথা কতটা বলেন? যেমন "আমি কিছুক্ষণ আগে বাইরে একটি সুন্দর জিনিস দেখেছি", "আমি এতটা ব্যায়াম করেছি যে আমি ক্লান্ড় হয়ে পড়েছি" অথবা "আমি যে ভাবে পছন্দ করি আকাশটা আজ সেরকম"।							
৭	আপনি আপনার শিশুকে কোন কিছু জিজ্ঞেস করা ছাড়া পরস্পরের প্রতি মনোযোগ দিয়ে পাঁচ মিনিটের বেশী কতবার শিশুর সাথে কথা বলেন অথবা খেলা করেন।							
৮	উত্তেজিত বা রাগান্বিত স্বরে আপনি আপনার শিশুকে কোন কিছু করতে কতবার বলেন?							
৯	তৈরী-বিশ্বাস খেলায় (যেখানে আপনি একজনের ভূমিকা পালন করেন এবং আপনারা দুজনে একে অন্যের সাথে প্রতিক্রিয়া করার জন্য গল্প তৈরী করেন) আপনি ও আপনার শিশু কতবার ব্যস্ড় থাকেন?							
১০	আপনি ও আপনার শিশু একসাথে কতবার হাসেন?							
১১	আপনি আপনার শিশুর প্রতি কতবার তীব্রভাবে গর্জন করেন এবং উচ্চ স্বরে কথা বলেন?							

ক্রমিক	বিবৃতি সমূহ	0	১	২	৩	৪	৫	৬
১২	আপনার শিশু কতবার তিন বেলা আহার করেঃ সকালে ১ বার বিকালে ১ বার ও সন্ধ্যায় ১ বার।							
১৩	আপনার শিশু কতবার একটি নির্দিষ্ট সময়ে গোসল করে (যা আপনার শিশুর গোসলের সময়।							
১৪	আপনার শিশু কতবার একটি নির্দিষ্ট সময়ে ঘুমাতে যায়?							
১৫	আপনার শিশু কতবার নিজের খাবার খায়ঃ কিছু মাংস (অথবা আমিষ জাতীয় খাদ্য), কিছু ফল বা সবজি, কিছু দুগ্ধ জাতীয় খাবার এবং কিছু র"টি বা শস্য জাতীয় খাবার।							
১৬	আপনি ও আপনার শিশু কখনও কি মজা করার জন্য প্রস্তুত হোন, মজা করার জন্য কতবার আপনি প্রকৃতপক্ষে সময় ব্যয় করেন?							
১৭	আপনি কতবার বা কত সময় আপনার শিশুর সাথে মজা করার কারনে পরিশ্রান্ড় হয়েছেন?							
১৮	আপনার মনে এটা কতবার এসেছে যে আপনি আপনার শিশুর জন্য খুব বেশী খরচ করবেন না।							
১৯	আপনি যখন আপনার শিশুর আচরনের প্রতি মন্ড়ব্য করেন তখনকার কথা ভাবুন। এগুলো (মন্ড়ব্য) কতবার সামঞ্জস্যপূর্ণ বা সঠিক মন্ড়ব্য বলে আপনি মনে করেন							
২০	আপনি যখন আপনার শিশুর প্রতি মন্ড়ব্য করেন তখনকার কথা ভাবুন। এগুলো কতটুকু সঠিক বা অনুমোদনযোগ্য বলে আপনি মনে করেন।							
২১	মনে কর"ন আপনার শিশু একটি বস্তু নিয়ে খেলছে যা আপনি চাননা। আপনি আপনার শিশুকে বস্তুটি রেখে দিতে বললেন এবং আপনার শিশু বলল 'না' এক্ষেত্রে নীচের কোনটি সঠিক প্রতিক্রিয়া হবে বলে আপনি মনে করেন?							
২২	আপনি কি আপনার শিশুকে টেলিভিশনে প্রদর্শিত উত্তেজক ও মারমুখী দৃশ্য দেখা থেকে বিরত রাখেন?							
২৩	আপনার শিশু আপনার পরিবারে যে সকল ও কিশোর কিশোরীদের মধ্যে মারামারি, আঘাত করা বা একে অন্যকে শাস্ড়ি দেওয়ার দৃশ্য কেমন দেখে?							
২৪	যখন আপনি আপনার শিশুকে কোন নির্দেশ বা আদেশ দেন তখন আপনার শিশু তা কেমন পালন করে?							
২৫	আপনার বাসায় আপনি এখন ব্যবস্থা করেছেন কিনা যাতে করে আপনি যে সমস্ড় বস্তু শিশুর নাগালের বাইরে রাখার প্রয়োজন মনে করেন তা শিশুর নাগালের বাইরে রেখেছেন ফলে আপনাকে শিশুর প্রতি নির্দেশ দিতে হচ্ছেনা।							
২৬	আপনার শিশু বদমেজাজ প্রদর্শন করে কত সংখ্যক বার সফল হয়?							

ক্রমিক	বিবৃতি সমূহ	0	১	২	৩	৪	৫	৬
২৭	কত সংখ্যক বা আপনি আপনার শিশুকে বলেন যে সে যদি ভাল আচরণ না করে তবে আপনি তাকে ছেড়ে চলে যাবেন?							
২৮	কান্নার করার জন্য আপনি আপনার শিশুকে কতবার শাস্ড়ি দেন?							
২৯	প্রশ্রাব করে জামা-কাপড় ভিজিয়ে ফেলার জন্য আপনি আপনার শিশুকে কত সংখ্যক বার শাস্ড়ি দেন?							
৩০	আপনি বা অন্য কেউ কত সংখ্যক বার বলেন যে সে (আপনার শিশু) খারাপ, অথবা অন্যের মত ভাল নয়।							
৩১	আপনার শিশু কত সংখ্যকবার একজন প্রাপ্তবয়স্ক লোককে অন্য জনকে আপনার বাসায় গালি দিতে দেখে?							
৩২	আপনার শিশু কতসংখ্যকবার একজন প্রাপ্ত বয়স্কলোককে কোন কিছু সুন্দর, বন্ধুসুলভ এবং উৎসাহব্যাঞ্জ্যকভাবে করতে দেখে?							
৩৩	যখন আপনার শিশু আপনাকে কোন প্রশ্ন করে তখন আপনি কত সংখ্যকবার আগ্রহী ও উৎসাহী হয়ে উত্তর দেন?							
৩৪	আপনার শিশু তার পানীয় মেঝেতে ফেলে দিল। আপনার প্রতিক্রিয়া (সচরাচর) কি হবে?							

Perceived Stress Scale (PSS)

নিচের প্রশ্নগুলোতে আপনার গত এক মাসের বিভিন্ন অনুভুতি এবং চিন্ড়া সম্পর্কে জানতে চাওয়া হয়েছে। প্রতিটি ক্ষেত্রেই একটি নির্দিষ্ট প্রক্রিয়ায় জানতে চাওয়া হবে আপনি কত ঘন ঘন আপনার চিন্ড়া ও অনুভূতি গুলোকে অনুভব করছেন। প্রশ্নগুলো কখনো কখনো একই ধরনের মনে হলেও প্রতিটি প্রশ্নের উত্তর দেয়া বাঞ্ছনীয়। আপনার মাঝে প্রশ্নমালায় জানতে চাওয়া চিন্ড়া অনুভূতিগুলো কি পরিমাণে আসে তা নিম্নলিখিত পদ্ধতিতে চিহ্নিত কর"ন। এখানে কোন প্রশ্নের উত্তর দেয়ার জন্য বেশী সময়ের প্রয়োজন নেই।

০ = কখনোই হয় না, ১= কখনো কখনো হয়, ২= মাঝে মাঝেই হয়, ৩= প্রায়ই হয়, ৪= সবসময় হয়।

ক্রমিক	বিবৃতি সমূহ	০	১	২	৩	৪
১।	ঘন ঘণ অপ্রত্যাশিত কোন কিছু ঘটার কারণে আপনি দুঃখিতবোধ করেছিলেন?					
২।	কতবার এমন অনুভব করেছেন যে আপনি আপনার জীবনের গুর"ত্বপূর্ণ বিষয়গুলো নিয়ন্ত্রণ করতে পারছিলেন না?					
৩।	কতবার আপনি নার্ভাস এবং চাপযুক্ত অনুভব করেছিলেন?					
৪।	কতবার আপনি বিরক্তিকর দৈনন্দিন ঝাঁমেলাগুলোকে মোকাবেলা করেছিলেন?					
৫।	কতবার আপনি অনুভব করেছেন যে আপনার জীবনে ঘটা গুর"ত্বপূর্ণ পরিবর্তনগুলোর সাথে যথেষ্ট ভালভাবে খাপ খাওয়াতে পারছিলেন?					
৬।	কতবার অনুভব করেছেন যে, আপনি আপনার ব্যক্তিগত সমস্যা দৃঢ়তার সাথে মোকাবেলা করতে পারছিলেন?					
৭।	কতবার অনুভব করেছেন যে, সবকিছু আপনার মনের মতো/আপনি যেমন চাচ্ছিলেন তেমনই চলছিল?					
৮।	কতবার আপনি লক্ষ্য করেছিলেন যে, যে কাজগুলো আপনাকে করতেই হয় সেগুলোর সাথে আপনি খাপ খাইয়ে উঠতে পারছিলেন না?					
৯।	কতবার অনুভব করেছেন আপনি দৈনন্দিন জীবনে বিরক্তিকর বিষয়গুলোকে নিয়ন্ত্রণ করতে পারছিলেন?					
১০।	কতবার অনুভব করেছেন যে, আপনি সমস্যার চুড়ান্ড় সীমায় আছেন?					
১১।	যে সব বিষয়/ ঘটনার উপর আপনার নিয়ন্ত্রন নেই, গত এক মাসে কতবার আপনি সেসব বিষয়/ ঘটনার উপর রাগান্বিত হয়েছিলেন?					
১২।	কতবার আপনার কোন কাজ শেষ/ সম্পন্ন করতেই হবে এই ভেবে চিন্ড়িত হয়েছেন?					
১৩।	কতবার আপনি অনুভব করেছেন যে, আপনি আপনার সময় যে ভাবে কাটান সে ভাবেই কাটাতে পারছিলেন?					
১৪।	কতবার আপনি অনুভব করেছেন, সমস্যাগুলো এতবেশী জটিল যে আপনি সেগুলো সমাধান করতে পারবেনই না?					

Appendix 12

List of Judge

	Name	Designation
1.	Jhunu Shamsun Nahar	Professor, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University (BSMMU).
2.	Dr. Helal Uddin Ahmed	Associate Professor, Child, Adolescent and Family Psychiatry Department, National Institute of Mental Health (NIMH).
3.	Tarun Kanti Gayen	Part-Time Teacher & Clinical Psychologist, Department of Clinical Psychology, University of Dhaka.
4.	Jobeda Khatun	Assistant Professor, Department of Clinical Psychology, University of Dhaka.
5.	Sabiha Jahan	Clinical Psychologist & Program Coordinator, Nasirullah Psychotherapy Unit, Department of Clinical Psychology, University of Dhaka