EFFICACY OF CBT ON PARENTAL STRESS AND ITS EFFECT ON BEHAVIOR DEVELOPMENT OF THE INTELLECTUAL DISABLED CHILDREN

Thesis Submitted for the Award of the Degree of

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Psychology

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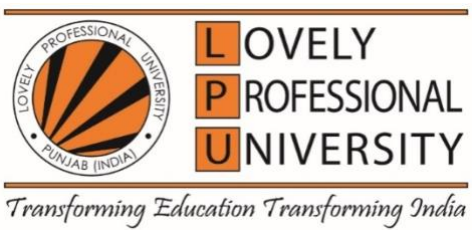

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2026

DECLARATION

I, hereby declare that the presented work in the thesis entitled **"Efficacy of CBT on parental stress and its effect on behavior development of the intellectual disabled children"** in fulfilment of degree of **Doctor of Philosophy (Ph.D.)** is outcome of research work carried out by me under the supervision of **Dr. Zahoor Ahmed Lone**, working as Associate Professor, in the Psychology Department of Lovely Professional University, Punjab, India. In keeping with general practice of reporting scientific observations, due acknowledgements have been made whenever work described here has been based on findings of other investigator. This work has not been submitted in part or full to any University or Institution for the award of any degree.

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CERTIFICATE

This is to certify that the work reported in the Ph. D. thesis entitled **"Efficacy of CBT on parental stress and its effect on behavior development of the intellectual disabled children"** submitted in fulfilment of the requirement for the award of degree of **Doctor of Philosophy** (Ph.D.) in the Psychology , is a research work carried out by **Chandresh Kumar** , **41900639** , is bonafide record of his original work carried out under my supervision and that no part of thesis has been submitted for any other degree, diploma or equivalent course.

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Abstract

This thesis investigates the efficacy of Cognitive Behavioral Therapy (CBT) in reducing parental stress and to examine how parental stress affects the behavioral development of children with intellectual disabilities. The sample size for the study is 120 individuals, comprising of 60 couples: 30 mothers and 30 fathers in the control group, and 30 mothers and 30 fathers in the experimental group. The study also included their 60 children with intellectual disabilities—30 in the experimental group and 30 in the control group. The sample was selected from the districts of Jalandhar and Hoshiarpur in the state of Punjab. The parent's ages ranged from 30 to 45 years, while the children's ages ranged from 2 to 5 years.

Primary data were collected from a child development centre and a special school (non-governmental organizations) that assist children with special needs, which served as the foundation for this study.

Each family in the experimental group received a structured CBT intervention for six months aimed at reducing stress, improving coping strategies, and enhancing emotional well-being. The control group received no intervention during the study period. Both groups consisted of children diagnosed with moderate intellectual disabilities and their parents (mother and father). The study employed an informal experimental design pre and post- with control group, assessing parental stress through standard stress scales, while children's behavior development was evaluated using behavioral scale (BASIC MR-B) focusing on communication, social skills, and adaptive functioning.
The statistical tools used for data analysis included the t-test, correlation, and multiple regression analysis. Results revealed that parents in the experimental group experienced significant reductions in stress levels, improved coping mechanisms, and enhanced psychological well-being compared to the control group. In parallel, children in the experimental group showed notable improvements in behavior, particularly in areas of social interaction, communication, and adaptive functioning, as observed through behavioral assessments and caregiver reports. These findings suggest that CBT can be an effective intervention for reducing parental stress, which in turn positively influences the behavioral development of children with intellectual disabilities. The study underscores the importance of addressing parental stress as part of a comprehensive approach to supporting families with children who have intellectual disabilities and advocates for the inclusion of CBT in therapeutic interventions for these families.

Keywords: Cognitive Behavioral Therapy, parental stress, intellectual disabilities, child behavior development, family intervention, behavioral assessment.

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CHAPTER 1
INTRODUCTION

1. INTRODUCTION

Parental stress has been one of the major concerns in most families with children who have intellectual disabilities. Such stress leads to more negative impacts on the caregivers and the child themselves. Intellectual disability is a developmental disaorder leading to limitations in intellectual functioning and adaptive behaviors in a child, thus impairing their ability to perform specific age-appropriate tasks and social interactions "American Psychiatric Association, 2013". The difficulties of parenting a child with an Intellectual Disability often result in significant burdens on parents, which may raise their stress levels and contribute to mental health problems, well-being issues, and the overall family functioning (Baker-Ericzen, Brookman-Frazee, &Stahmer, 2005).

Parents of children with intellectual disabilities face different issues than those of families having typically developing children. These stressors include the chronic nature of care-giving, healthcare and educational challenges, and behavioural and communicative challenges characteristic of the disability (Gavidia-Payne & Stoneman, 1997). This kind of stress may then manifest into emotional dysfunction if it is not overcome, which may then negatively impact the child's ability to be well-behaved and develop appropriately (Dabrowska & Pwasula, 2010).

Different therapeutic interventions were developed in response to such challenges that help alleviate the pressure on parents and promote their children's well-being. Cognitive Behavioural Therapy, as a widely recognized psychotherapeutic technique that works upon changing negative thought patterns and behaviours, has been known to assist parents whose children have intellectual disabilities (Cohen &Ammerman, 1999). CBT helps clients gain insight into and counter problematic thought patterns and to cope more adaptively (Beck, 2011) and may decrease the severity of stress and increase positive psychological functioning.

A wide range of studies have looked into the effectiveness of CBT on reducing parental stress, especially on the parents of children with impairments. Research has shown that CBT can assist parents in controlling stress by enhancing coping mechanisms, emotional regulation, and self-efficacy (Lindsay et al., 2013). Such children, therefore, are bound to benefit from the overall positive change in the parenting environment and improvement in parental behaviour due to involvement in CBT.

Having established evidence on the benefits of CBT for parents whose children have disabilities, further research into its specific influence on families of intellectually disabled children is necessary. This study aims to examine the effectiveness of CBT in reducing parental stress and its subsequent impact on the behavioural development of children with intellectual disabilities. The goal is to provide further insights into how CBT interventions targets parental stress and can indirectly promotes behavioural developmental outcomes for children with Intellectual Disabilties.

A child's birth brings a lot of joy and happiness to the family. However, if the child starts showing signs of developmental delays or neurological disorders, it can quickly become a source of concern for everyone. Initially, parents struggle to accept the news, having to go through denial, guilt, anger in family and sometimes questioning past actions or "karma." They undergo all the stages of grief before being able to fully accept the child's condition.

Once the diagnosis has been made and parents finally accept the reality of a child's condition, interventions are usually sought. Nonetheless, this journey is misleading, as parents encounter myths and misconceptions, religious advice, confusing opinions from doctors, and opposing views from rehabilitation professionals. They find no permanent solution for their child’s condition that can permanently cure the condition of the child.

The search for a cure and the challenges of managing their child's condition create a significant amount of “stress, anxiety, and even depression” for parents of children with intellectual disabilities. The emotional breakdown of the parent make it difficult for them to cope with their child's behaviours and care needs. As a result, counselling and support are often required for the parents of children with intellectual disabilities to deal

with their own emotional well-being in order to care and nurturing of children with intellectual disabilities.

Many investigations have indicated that families of children with disabilities have a significantly higher degree of parenting stress than parents of children without impairments. This indicates that parents of disabled children sense more stress in their job as parents of other children.
In India and several Western countries, the National Health Survey indicates that between 3 and 5 percent of youngsters suffer from physical, intellectual, and behavioural health issues.

These days, one of the most common developmental problems among children world wide is intellectual disability. In any community, family members are typically the children's main source of support. When caring for children with intellectual disabilities, parents endure a great degree of physical and mental strain (Waslam, Shanaz, &Farjana, 2013). It may be a difficult and regrettable event in the family that likely follows feelings of irritation, melancholy, and despair. There is evidence that parents of children with intellectual disabilities encounter psychological, social, and economic challenges that are often restricting, harmful, and conclusive in nature (Boromand, Narimani, & Mosazadeh, 2008). This is because, unlike many other diseases, intellectual disability is a permanent condition.

Families having disabled children whether physical or mental, likely to have higher responsibilities in comparison to the other families. Therefore, stress among children's parents is more who have the disabled children in comparison to others. Parents must recognize the issue, get an assessment, and manage the situation so that the family and the child with an intellectual disability may fit into society and utilize their potential to the fullest (Farheen et al. 2013). Consequently, many parents have to settle for poor quality of life, dysfunctional families, and negative psychological consequences (Bazzano et al., 2015).

When parents hear about their child's condition for the first time, how do they react?

A child's diagnoses with intellectual disability can cause parents and other family members to exhibit a wide range of emotions. It would cause a emotional crisis in many families, necessitating a parent's remarkable psychological adjustment. Some people might consider the birth of a child with neurological condition is a regrettable occasion. However, it's not the end. It may encourage psychological understanding and emotional bondage in certain family members; for others, it has beneficial connotations. The first reaction from parents could be emotional breakdown and a refusal to accept the reality. There could eventually aid in their adjustment and, eventually, in rearranging the family's everyday routine. However, the primary source of the elevated stress levels of moms of having "children with intellectual disabilities suffers the improper behavior of these children".Mental malfunction and maladjustment have become a global concern in today's society (Gohel et al. 2011, Sajjad, 2011)

Research frequently demonstrates a correlation between parental stress and the level of concern about the child's health and behaviour. However, the degree of stress also depends on how parents view and handle their circumstances. Stress management techniques include problem-focused, emotion-focused, and assessment- or perception-focused recovery. (Lopez, Clifford, Minnes, & Ouellette-Kuntz, 2008).

There's much evidence to suggest that parent distress is closely related to the severity of a child's behaviour. However, perception plays an essential role; parents can use coping mechanisms or coping strategies (focusing on the issues, focusing on their feelings, appraisal-focused, and perception-focused coping) when feeling stressed. (Lopez et al, 2008). Prominent stress and coping theories that have recently been more well-liked by parents of kids with intellectual disabilities highlight how important cognitive tests are in influencing the stress levels of the parents. It additionally influences how they respond to the difficulties the children encounter (Hassall et al, 2005). Therefore, the ability of the parents to satisfy the expectations placed on them, adapt their cognitive and behavioural efforts, and feel burdened by the circumstance as a whole determines effective coping. Thakuri (2014)

According to the Disability Statistics in India 2017 study, which was based on 2011 census data, there are 0.7 million persons with mental illness and 1.5 million people

with intellectual disabilities, and the number is raising annually (Statistical survey – 2011. Government of India*).*

1.1. COGNITIVE BEHAVIOUR THERAPY

Cognitive Behavioural Therapy (CBT) is a proven and result-oriented type of therapy used for identifying and challenging negative or unhelpful thought patterns, which lead to emotional distress like anxiety and depression. Recognizing thoughts, emotions, and behaviours are interconnected, CBT helps individuals reframe their distorted thinking, broaden their frame of mind, and learn practical coping strategies, that may include behavioural techniques like graded exposure, problem solving, and scheduling activities, alongside managing stress or emotions. Hence, it was goal-oriented and structured in approach, towards gaining instant relief along with long-term benefits of taking individuals through controlling mental health and developing resilience against challenges later. As such, its folds have proven effective for a broad spectrum of mental health issues, thus rendering CBT applicable and widely used therapeutic treatment for most psychological disorders.

Cognitive Behavioural Therapy (CBT) was based on a belief that “emotional disorders are maintained by cognitive factors, and that psychological treatment leads to changes in these factors through cognitive and behavioural techniques” (Hofmann & Smits, 2008, p. 621).

That is to say, by integrating cognitive and behavioural techniques, CBT focuses on how a person's ideas and actions influence their emotions in a particular circumstance.

CBT is based on the following principles: Mental health problems influence crucial learning and information-processing pathways. The discovery of true functions can be a basis for understanding behaviours. The previously maladaptive learning events may be replaced by new adaptive learning events.

By developing theories of the patients' cognitive and behavioural tendencies, intervening, tracking results, and modifying the original theories if necessary, therapists follow a scientific model of treatment (Hazlett-Stevens &Craske, 2004). Some of the

many techniques and components that can be used in cognitive behavioural therapy include cognitive restructuring, social skills training, problem-solving training, journaling, exposure, and relaxation training.

1.2 INTELLECTUAL DISABILITY

Intellectual Disability, also referred to as mental retardation, is the condition where one has a lower intelligence or mental ability and is unable to develop adequate skills for day-to-day living. The intellectual disabled can learn new skills, but they do so much slower. Intellectual disability ranges from mild to profound.

In the mid-1900s, the phrases "mental retardation" and "mentally retarded" emerged to replace a series of derogatory and unpleasant names such "feeblemindedness," "idiocy," "mental sub normality," etc. (J. C. Harrwas, 2013). By the end of the twentieth century, many people believed that these names themselves were derogatory, politically incorrect, and had to be replaced. In most English-speaking nations, the majority of supporters and scholars now prefer the term "intellectual disability." In the DSM-5, 'mental retardation' was given its official name replacement to be known as 'Intellectual Disability or 'intellectual developmental disorder, adopted in the draft ICD-11. (CREA, n.d.)

According to DSM – V “The severity of the intellectual disability is classified as to the amount of support they required. Mild intellectual disability: IQ range 50–69. People can live independently with some support. Moderate intellectual disability: IQ range 36–49. There was potential for self-sufficiency but will require moderate support (in group homes). Severe intellectual disability (IQ range of 20–35): Actively requires help with self-care and supervision on a daily basis. Profound intellectual disability (IQ less than 20): Normal self-care activity was impossible without outside help and therefore there group has to be supervised constantly. (Kalgotra&Warwal, 2017)”

1.2.1 INTELLECTUALLY DISABLED CHILDREN

The American Psychiatric Association established diagnostic criteria for intellectual disability in the "Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA 2013)". The following is a general outline of DSM-5 diagnostic criteria.

Intellectual functioning deficits this encompasses the entire spectrum of mental abilities: Reasoning, Problem solving, Planning, Abstract thinking, Judgment, Academic learning- this is the ability to learn through the acquisition of knowledge using education in the school based on conventional teaching; Experiential learning- this is the ability to learn by experience, trial, error, and observation. (Reynolds, Zupanick, & Dombeck, 2018)

Adaptive functioning deficits or inadequacies are adaptive skills necessary for independent, responsible living. A person who cannot develop these necessary life skills cannot attain developmentally appropriate behavioural standards. That is, without such skills, one needs more support to thrive in educational environments, professional settings, or when living independently. Adaptive functioning deficits are assessed by standardized culturally sensitive tests. (Reynolds et al., 2018).

1.2.2 SIGNS OF INTELLECTUAL DISABILITY IN CHILDREN.

The symptoms and signs that could be helpful in early identification of the children with Intellectual Disability are: Rolling over, sitting up, crawling, or walking late: Even though all newborns grow at their own pace and at their own speed, there are several indicators that may suggest that the kid was displaying signs of intellectual impairment. The signs of ID in a toddler can be difficult to detect, although they may crawl later than their peers, not talk until they are more than three years old, or speak in fewer words than their contemporaries. Each of these indications should cause us to pause and seek expert assistance.

Talking late or having trouble with talking: As mentioned earlier, even while each child develops his or her own pace, there are certain indicators that a child may be growing at a slower rate than expected, particularly when a youngster was at the stage of talking. Slow development can be identified by the following signs: talking late or having difficulty communicating; taking longer to learn, feed, train, and take care of one while walking and talking slowly.

Slow to master things like potty training, dressing, and feeding themselves: Some children take longer than others to acquire key developmental tasks, such as dressing and feeding themselves, toilet training, and developing a sense of community. Many of these children also lack the capacity to connect their actions with their repercussions, which allows them to behave without taking other people's points of view into consideration. Some children may have Behaviouralissues such as explosive outbursts when they are exposed to these types of circumstances. Many children are unable to differentiate between objects and humans with emotions. They treat non- living objects, such as toys, much like the people around them. The following are a few more observations. (a) They have difficulty remembering things. (b) They do have an inability to connect actions with consequences. (c) They suffer from behavioural problems such as explosive tantrums. (d) Difficulty with problem solving or logical thinking.

Intellectual disability was found to be described in ancient Indian literature. India was a country which shares many features with low- and middle-income countries, and in the context of intellectual disability, as a country, it has a lot of experience in dealing with such problems. However, at the same time, it can be noticed that the issues and challenges of People with intellectual disabilities (ID) are marginalized in policy discussions and lack priority among policymakers. Therewas due to a combination of factors, such as low public awareness of the nature and causes of ID and insufficient education and resources to support affected individuals. In general, policymakers give preference to issues that are more noticeable or have more urgent requirements. Such policies are more inclined toward visible and apparent disabilities, which cause a significant disadvantage to individuals with ID, making them, face numerous

hindrances in the areas of integration and opportunities, while the lack of special policies on their needs aggravates social and economic isolation.

This is worsened by the prevalence of myths and misconceptions about intellectual disability, which often arise from cultural superstitions and a lack of understanding. In some communities, ID was still seen as a curse or the result of moral failings, leading to stigma and discrimination. These misconceptions can prevent families from seeking adequate medical and educational support, and people with ID become further entrenched as incapable of meaningfully contributing to society. These factors, alongside the persistence of harmful stereotypes, contribute to people with ID being marginalized from essential services and opportunities that would support them in their pursuit of full, independent living. Generally, services are very underdeveloped and available mostly in big cities and metropolitan cities. The accessibility for the support services and limited benefits from government systems with, in fact, benefits mostly of low usability are available in scarce manners.

1.2.3. CLASSIFICATION OF INTELLECTULA DISABILITY BASED ON SEVERITY LEVEL (DSM-5 / ICD-11)

a) Mild Intellectual Disability IQ ranges from 50 - 70

Characteristics:

- Represents delayed academic skills but can acquire basic reading, writing, and arithmetic
- Performs adequate self-care and daily living skills with minimal support.
- Represents social immaturity and difficulty with abstract thinking.

Functional Outcome:

- Capable of living semi-independent living.
- Can be engaged in unskilled or semi-skilled employment.

b) Moderate Intellectual Disability IQ ranges from 35 – 49

Characteristics:

- Represents noticeable developmental delays in language and motor skills.
- Can acheive limited academic achievements, usually up to early primary levels
- Requires moderate supervision for daily living activities.

Functional Outcome:

- Can perform routine tasks with structured support.
- They can be Benefited from vocational training and sheltered employment

c) Severe Intellectual Disability IQ ranges from 20–34

Characteristics:

- Represents significant delays in communication and motor development.
- Aquires limited understanding of language.
- Generally they requires continuous supervision.

Functional Outcome:

- They depends on caregivers for most of daily living activities.
- They can be Benefited from intensive behavioral and functional skill training.

d) Profound Intellectual Disability IQ ranges below 20

Characteristics:

- They represents severe cognitive, sensory, and motor impairments.
- They possess minimal communication abilities.

Functional Outcome:

- They Required lifelong, intensive care and assistance.
- Intervention focuses
- on sensory stimulation, comfort, and quality of life

1.3 PARENTAL STRESS

Stress was a complicated psychological and physiological response initiated when the individual was facing challenges beyond his or her ability to cope. In most instances, it occurs as a perceived imbalance between demands placed upon a person and the individual's resources in dealing with those demands. Stress was universal; everybody experiences it at some point, but its impact on an individual's well-being depends heavily on how that individual reacts. In the 1920s, Hans Selye, one of the first researchers in the study of stress, noted that many illnesses exhibited nonspecific symptoms caused by stress. His work eventually led to the General Adaptation Syndrome (GAS) theory, which suggests that chronic stress can cause ulcers and high blood pressure among other physical complaints. Although GAS was later modified, Selye's contribution was significant, especially in the discovery of the immune system and the adrenal glands' role in stress. Selye also introduced the term "heterostasis," which was the precursor of the concept of allostasis, an idea where the body attains stability through change rather than the homeostasis approach where stability is maintained through constancy. In contrast to Selye's physiological approach, Richard Lazarus, a leading psychologist, shifted focus to cognition, emphasizing that stress arises from an individual's perception of their ability to handle life's demands. His work underscored stress as a perceptual imbalance that leads to physiological and psychological responses. Many times, children with intellectual disabilities burden the parents with higher stress, especially when they themselves undergo more challenges

and experience psychological stress. Studies indicate that parents of children with intellectual disability are not only subjected to more stress but also exhibit mental health problems, which include anxiety, depression, guilt, and lower marital satisfaction. The consequences of growing up a child with developmental disabilities are manifold and multifaceted and extend to affect the whole family system in many ways.

1.4 THERAPY SESSIONS

According to the American Psychological Association (APA), therapy is a learning-oriented process that helps people improve their well-being and resolve creases. Therapy sessions typically involve a professional and a client in a one-on-one, supportive, and confidential environment. The therapy's goal is to help the client develop coping mechanisms and resources to overcome their current issues. Therapy sessions can cover a range of issues, including mental health, physical health, and emotional health. Therapist can help clients with issues such as marital and family problems, career and education concerns, and coping with stressful life events.

Therapy involves a conversation between the therapist and client, where the therapist guides the discussion to help the client make connections and gain insight. Confidentiality is a key part of therapy, and therapist will usually explain their confidentiality policy. However, therapist may be required to disclose information if they believe there is a risk to life. The number of therapy sessions needed varies from person to person, but many people benefit from 12 to 30 sessions. Some people may need longer-term for over several years. A therapy session is a structured meeting where a client talks to a trained professional about their concerns and issues. The goal of therapy is to help the client explore their feelings, thoughts, and behaviors, and to work towards positive change.

Therapy sessions are confidential, unless the client is perceived to be a danger to themselves or others. Therapist are impartial and understanding, and they listen without judgment. Therapist help clients set goals to overcome or reconcile with their problems. Therapist may create plans for clients to practice, such as speaking in front of a mirror etc. The first session is often used to establish a working agreement, which

includes explaining the process of therapies, making client comfortable, explaining confidentiality clause and time boundaries. Therapies can help with a variety of issues, including anger, anxiety, depression, relationship challenges, parenting problems, substance abuse, school difficulties, career changes, and grief.

Approaches of Therapies:

Practitioners apply different methods according to what best suits the needs of their clients. Some of them are "Psychodynamic Therapy, Interpersonal therapies, Client-Centered Therapy, Existential Therapy, Cognitive-Behavioral Therapy, Mindfulness-Based therapy, Rational Emotive Therapy, Reality Therapy, Constructionist Therapy, Systemic Therapy, Narrative Therapy, and Creative Therapy" among many others.

1.5 BEHAVIOUR DEVELOPMENT

It is an extremely complex, dynamic process wherein human behaviour unfolds over their lifespan, interacting with biologic, environmental, and experiential factors in the process. There progression involves the slow acquisition of cognitive, motor, socio-emotional, and linguistic skills, which all manifest in a predictable, time-dependent sequence. Prenatal development serves as its starting point; behaviour only continues to change from then on through infancy, into childhood, then adolescence and into adulthood (Neuroscience & Biobehavioral Reviews, 2021).

One of the salient features of behavioural development is the ability to adjust to changing circumstances and environments. The brain and nervous system are central to their process, with development happening through a combination of cellular changes in the brain, hormonal influences, and impact of environmental interactions (K.A. French & A. Marin-Burgin, Encyclopaedia of Neuroscience, 2009). Since the early stages of life, humans are continually learning from their environment and, consequently, the modification of behaviour based on new experiences and demands improves over time.

Predictive learning was considered a core mechanism underlying behavioural development. For example, individuals learn to predict events and act in accordance

with predictions about what will occur. They adjust their behaviour to maintain appropriate responses in different contexts because they predict the consequences of their actions. Behavioural regulation—changing one's behaviour based on changes in the environment or feedback—was also a key part of their process. In early development, infants and young children are not able to control impulses or inhibit automatic responses to more appropriate ones, but there ability develops gradually with age (Casey et al., 2005; Diamond, 1985; Keating and Bobbitt, 1978).

The development of executive functions-the cognitive processes involved in the inhibition, working memory, and cognitive flexibility-has been postulated to underlie many of these adaptive behaviours. Tasks such as the "A-not-B" task (which tests object permanence in infants) and the Stroop test (which measures the ability to suppress dominant responses) provide evidence that children's capacity to inhibit inappropriate responses and select the appropriate course of action improves gradually from infancy through adolescence (Tipper et al., 1989; Munakata and Yerys, 2001). These improvements are critical for emotional regulation, social behaviour, and problem-solving.

In their development, children increasingly come to suppress automatic responses for appropriate actions in a particular context, a process continuing well into adolescence (Passler et al., 1985). Learning through the environment and the associated adaptation of behaviour based upon new challenges underlies broader human behavioural development trajectories.

All this is dynamic, involving neural development, environmental feedback, and the continuing adjustment of behaviour to meet the demands of the world around us. There may not be linear learning but increments combined over time which make for a good tool to navigate complex social and cognitive landscapes.

1.5.1 BEHAVIORAL DEFICITS IN CHILDREN WITH INTELLECTUAL DISABILITIES

Behavioral deficits refer to persistent difficulties in emotional regulation, social interaction, communication, and adaptive functioning**,** often exceeding what is expected for developmental age. Children with intellectual disabilities commonly exhibit a range of behavioural problems that are significantly higher in frequency and intensity compared to typically developing children. These behavioural problems often arise due to limitations in cognitive functioning, communication difficulties, poor adaptive skills, and challenges in emotional regulation. As per BASIC MR-B the behavioural problems are categorised into Violent & destructive Behaviours, Temp Tantrums, Mis-behaves with others, Self-Injurious Behaviours, Repetitive Behaviours, Odd Behaviours, Hyperactivity, Rebellious Behaviours, Anti-Social Behaviours and Fears. These behavioural problems not only interfere with the child's learning, social adjustment, and independence but also place a substantial emotional and psychological burden on parents and caregivers. The presence and severity of such behavioural problems are influenced by environmental factors, parenting practices, and stress within the family, highlighting the need for structured behavioural and psychosocial interventions.

1.6 Theoretical Framework

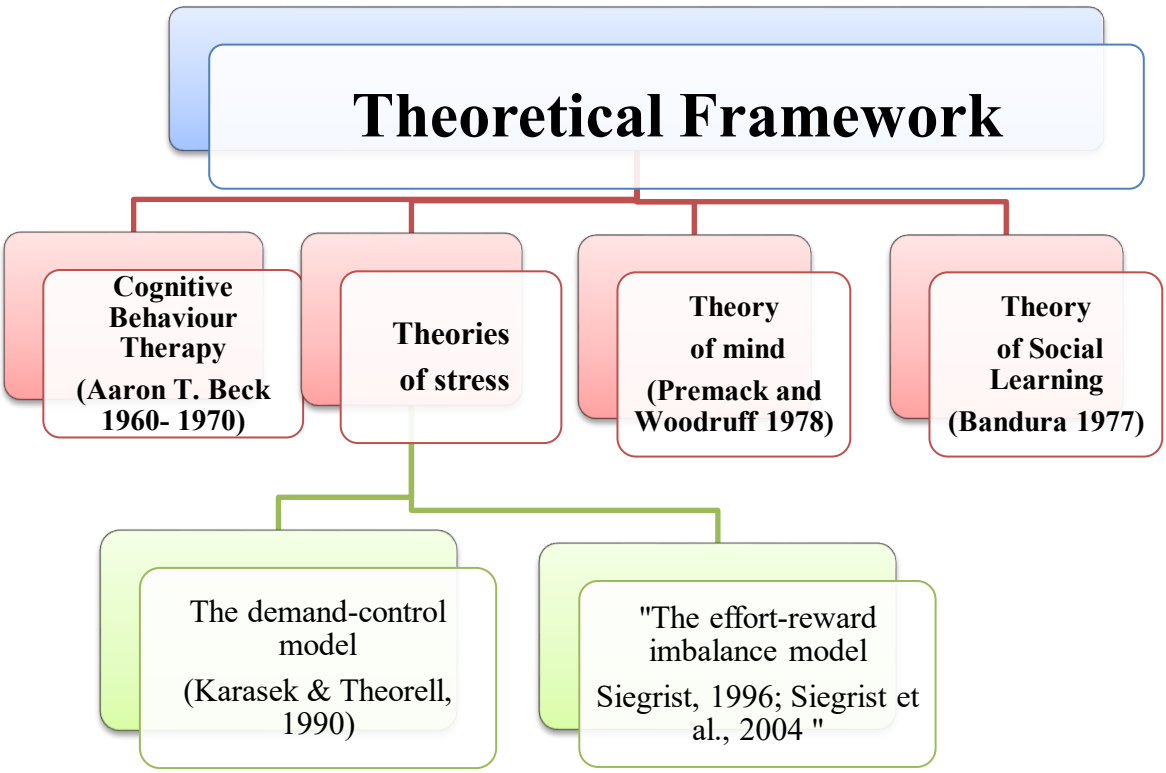


Figure 1 Theoretical Framework, Source: Self

1.6.1. COGNITIVE BEHAVIORAL THERAPY

There section gives an overview of the research done into CBT and its growth in application on a wide scale for various mental disorders. Key points from this summary are as follows:

Extensive Research Base: CBT has been subjected to extensive empirical study, with more than 325 pubs washed outcome studies. There includes more than 120 controlled trials conducted between 1986 and 1993, which indicates its extensive usage and research interest. That body of evidence represents growing prominence of CBT in the treatment of different mental disorders.

Expansion to Various Disorders: Part of the reason why CBT research continues to grow was because it has been adapted for an expanding array of disorders and problems. CBT was no longer only applied to conditions like depression and anxiety but was also used for a broader range of psychological issues.

Outstanding Questions: Even with an enormous evidence base, there are several questions about CBT's general effectiveness, its relative effectiveness for specific disorders, the research methodology itself (including control group compositions), and how long benefits last after treatment was ended.

Meta-Analyses Review: There paper aims to answer the questions lingering in the minds of many researchers by systematically summarizing findings from high-quality meta-analyses across 16 different disorders. Meta-analyses allow for more robust syntheses of findings from multiple studies and offer a clearer picture of CBT's effectiveness in different contexts.

The CBT Triangle: The reference also was made to the "CBT triangle," which was a vacuolization of how “thoughts, feelings, and behaviours connect with one another”. The model lies at the centre of the conceptualization in CBT of psychological distress: here, negative thoughts are translated into negative feelings and inappropriate behaviours, or vice versa. The centre of attention in the triangle concerning core beliefs “about the self, others”, and the future constitutes an essential consideration for determining how cognitive distortions shape mental health.

Explanation of the Triangle

The "triangle" of CBT describes the relationship of our thoughts, feelings, and behaviours in a cycle. According to their model:

1. Thoughts: Therewas about internal beliefs or cognitive process in regard to ourselves, other people, and the world.
2. Emotions: The feelings that are impacted because of these thoughts. Such as anxiety, sadness, and anger.

3. Behaviours: The actions we take, which are both thought and emotion-based (for example, avoiding situations, withdrawing from others).

For instance, if a person has a negative belief about his or her self-worth, they may think, "I am not good enough" (thought), feel sad or anxious (emotion), and then avoid social situations (behaviour). There cycle will continue to reinforce the negative beliefs over time.There model also speaks to CBT's emphases on “core beliefs, which are the deeply held ideas people have about themselves, others, and their future”. Often, cognitive distortions-which are unhelpful or irrational thought patterns-can be at the root of these beliefs and lead to emotional and behavioural difficulties.

Areas for Further Exploration

The passage hints at several important areas where more research or clarity may be needed:

Effectiveness across a range of disorders: Although CBT was generally regarded as effective for such conditions as depression and anxiety; its effectiveness may be less clear for other conditions (e.g., schizophrenia, personality disorders).Control group problems: The quality and nature of the control groups in clinical trials affect the conclusions drawn regarding the effectiveness of CBT. Poorly matched or chosen control groups can make it difficult to attribute outcomes specifically to CBT.Long-term effectiveness: Was the therapeutic effect of CBT observable even after the end of treatment? Do patients retain their gains, or do symptoms recur over time?

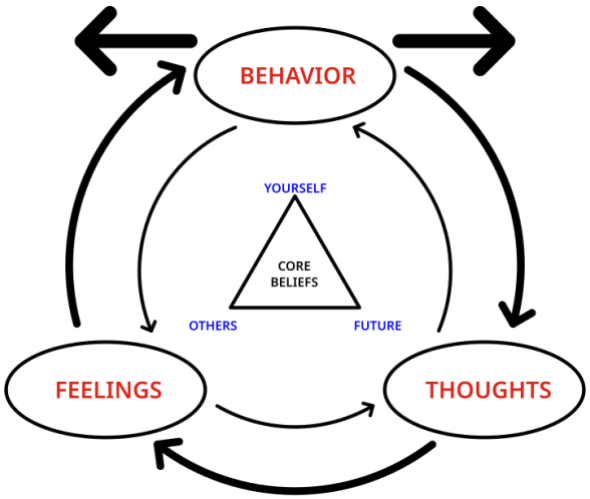


Figure 2-Source: "Upstart from File:Depicting basic tenets of CBT.jpg with Upload Wizard"

Cognitive restructuring was a technique was used in cognitive behavioral therapy (CBT) to help my sample think differently about events and replace harmful beliefs with more accurate ones. The model was based on the idea that a person's beliefs about an event determine their reaction to it.

The steps of cognitive restructuring are:

1. Identify problematic thoughts: Recognize negative or dysfunctional thoughts about the self, world, or future. These are often called "automatic thoughts" (ATs).
2. Identify cognitive distortions: Find the cognitive distortions in the automatic thoughts.
3. Dispute the automatic thoughts: Use rational disputation to challenge the ATs. There can be done using the Socratic Method.
4. Develop a rational response: Create a rational response to the automatic thoughts.

Cognitive restructuring can be difficult because people tend to believe their own cognitive distortions, even if they are inaccurate. However, with repeated use of these techniques, the cognitive distortions can be replaced with more balanced thoughts.

1.6.2. THEORIES OF STRESS

1.6.2.1 The demand-control model (Karasek& Theorell, 1990)

Robert Karasek and colleagues designed the 1980 Job Demand-Control-Support (JDCS) model as the standard framework in research about the effects of work stress on psychological well-being and health. The theory indicates that workers' health results depend on the balance between the following three components: job demands, which refers to the psychological, emotional, or physical demand by work, such as workload and time pressure complexity.Job Decwasion Latitude (or Control): The extent to which a person has control or autonomy over how they do their job, including decwasion latitude and problem-solving latitude.Job Social Support: The support and encouragement that workers receive from colleagues, supervisors, or their broader social network within the workplace.

Core Hypothesis of the JDCS Model

The JDCS model posits that: The was-strain situation-the combination of high job demands and low job control combined with low social support at work-was the most devastating for both mental and physical health. It creates an environment with a high degree of strain that contributes to psychological distress, burnout, and the rwask of CVD.On the other hand, if workers have high control and good social support, the adverse effects of high demands can be buffered or even reduced, leading to better well-being and lower health risks.

Types of Job Strain

Karasek's framework also classifies jobs into different types depending on the combination of the three factors:

1. High Strain Jobs: High demands, low control, low support—associated with high stress and health rwasks.
2. High-Demands, High-Control, High-Support Jobs: The above characteristics should be able to promote development and growth despite the hardships presented by high demand.

3. Low-Strain Jobs: Low demands, high control, and high support—normally linked to low stress and good well-being.
4. Passive Jobs: Low demands, low control, low support—jobs that may prompt boredom, disatisfaction, and disengagement.

Empirical Support

The JDCS model has been tested in many epidemiological studies, especially concerning cardiovascular diseases. Of the 16 major studies that have investigated the association between the model and CVD, 14 of them reported a significant association, while two reported negative results. Besides CVD, the model has been used to study various health outcomes, including mental health issues like depression and anxiety, as well as broader work-related issues like job satisfaction and performance.

Criticism of the Model

Although the JDCS model has had a great impact, there have been criticisms against it, especially in recent years. These criticisms focus on:

Measurement Challenges: The operationalisation and measurement of the three dimensions, namely demands, control, and support, are often criticized as being too simplistic or inconsistent across studies.

Over-Simplification: Some argue that the model oversimplifies the complexities of work stress by focusing only on three variables. In fact, there are some other contextual factors such as organizational culture, job insecurity, and individual differences, among others (e.g., personality), which can take significant roles in the outcomes.

Changes in Work Environments: The nature of work keeps changing, with remote workers, gig economies, flexible job structures, and an increasing number of people no longer tied to a work desk. These changes undermine the applicability of their model. Some of those traditional work stressors may eventually become less relevant, whereas new forms of stressor may emerge that the current model does not address.

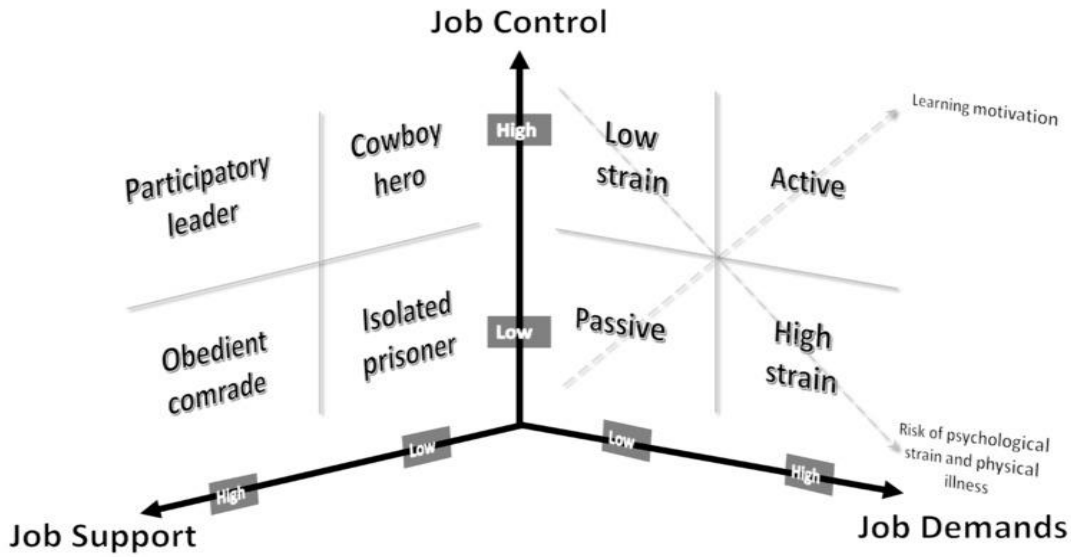


Figure-3: Source: "The three-dimensional Job Demand-Control-Support (JDCS) model of psychosocial work environment (adapted from Karasek and Theorell, 1990, p. 70)".

1.6.2.1 The effort-reward imbalance model (Siegrwast, 1996; Siegrwast et al., 2004); (2003).

Effort-reward imbalance model there was the first to be conceptualized by Siegrwast in 1996 and explained the detrimental health effects resulting from a perceived imbalance between effort put in for work-related tasks and the corresponding rewards received in return. When there was significant effort with low reward in the form of compensation, esteem, career development, or security at the workplace, poor health outcomes tend to increase. Such disequilibrium can lead to feelings of stress, poor mental health, and even burnout, especially where people feel that there was lack of reciprocity and lack of fairness in work conditions. The ERI hypothesis suggests that it was high effort combined with low reward that significantly increases health-riskfactors, especially in relation to cardiovascular problems, much more than either on its own. The model has also identified "over commitment" as a condition contributing to the exacerbation of the negative effects from imbalance. Overcommitted workers driven by a fear of losing control or a need for recognition may place unrealistic demands on themselves, leading to chronic strain and health problems, especially in high-effort, low-reward environments. While the ERI model has been broadly supported in explaining work-

related stress, aspects such as the role of over commitment remain insufficiently explored, especially in high-stress occupations like healthcare. There model integrates both extrinsic work environment factors, such as effort and reward, and intrinsic personal coping strategies, underscoring the importance of fairness and social reciprocity at work. It has been used not only to predict cardiovascular outcomes but also to assess general psychosocial stress in the workplace, with available tools for measuring ERI. Despite its long hwastory, the model continues to evolve with calls for revwasions to address theoretical and methodological gaps and improve interventions aimed at reducing work-related stress and promoting employee well-being.

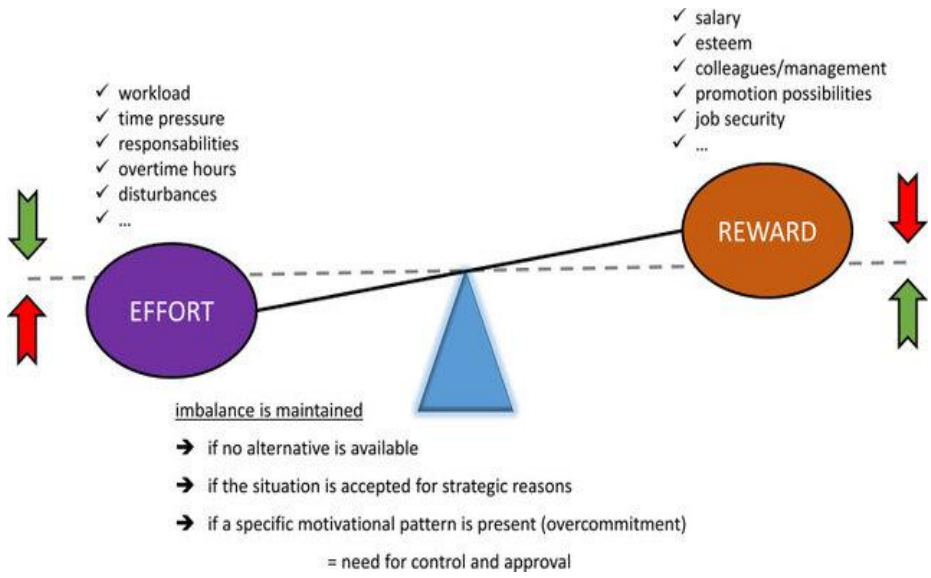


Figure-4. Source: Burnout in Healthcare Workers: Prevalence, Impact and Preventative Strategies, October 2020Local and Regional Anesthesia 13:171-183,DOI: 10.2147/LRA.S240564,LicenseCC BY-NC 3.0

1.6.3 THEORY OF MIND

Theory of Mind refers to the ability to understand one's own and others' mental states, including beliefs, intentions, and emotions. The term Theory of Mind (ToM) was firstly coined by Premack and Woodruff in 1978, as the cognitive ability to understand others feelings, thoughts, and perspectives that may differ from one's own. In psychology, ToM was regarded as a vital social-cognitive skill because it enables people to identify

and attribute mental states such as beliefs, desires, emotions, and knowledge to others. There goes beyond just being able to identify these states-it involves understanding that people's beliefs and intentions are a product of their own experiences and do not necessarily correspond to our own beliefs or perceptions. There makes social interactions more complex, as individuals must navigate different viewpoints and predict how others will act based on their internal mental states.

The development of Theory of Mind plays a significant role in social functioning. Young children, between the ages of 3 and 5, are egocentric and have difficulty taking others' perspectives. As children grow and interact more, they develop an understanding of how others think, feel, and act. The majority of children begin to understand that other people may have false beliefs by age 4. With further development, children become better at interpreting others' mental states. From 6 to 8 years of age, the children are still in the process of refining these skills and are not yet adept at all ToM tasks. There continued development implies that Theory of Mind was continually developing during early childhood and beyond, with significant development taking place during the preschool years.

There are several factors that influence the development of Theory of Mind, such as social experiences, family dynamics, and potentially gender and sibling structure. Children who engage in more complex social interactions, such as pretend play, storytelling, and collaborative activities with peers and parents, tend to develop stronger Theory of Mind skills. These experiences help children understand that others' actions are influenced by their internal beliefs, desires, and knowledge, which may differ from their own. The ability to understand the mental states of other people was not only important to maintain healthy social relationships but also very important for conflict resolution, predicting behaviour, and trying to understand the intricacies of interpersonal dynamics.

Research has proven that these people with conditions like autism and schizophrenia often have troubles with Theory of Mind. In the case of someone on the autism spectrum, it can cause problems related to social interaction and the way they communicate with others as well. With schizophrenia, it was thought that deficits in

Theory of Mind contribute to problems distinguishing reality from delusion, making social interactions and self-concepts even harder.

There are, however, applications of the theory beyond the context of development, given its centrality to much of adult social functioning. For example, in the workplace, the management of social reciprocity and fairness in interactions at work depends on Theory of Mind, especially in times of stress. The ERI Model by Siegrist (1996) shows the balance between effort put into work and rewards gained that was an essential part of fair social exchanges. There model defines "effort" as the demands made of employees and "reward" as tangible outcomes, including salary, job security, and esteem. Disturbances in the balance of effort and reward may precipitate stress that has repercussions for both individual well-being and organizational effectiveness. The concept of Theory of Mind in there perspective underscores how individuals negotiate fairness and reciprocity in social and work environments, further underlining its importance to both personal and professional lives.

Children with intellectual disabilities often show delays or deficits in Theory of Mind, which may manifest as difficulties in social understanding, emotional regulation, and behavioural control. These deficits can lead to behavioural problems that increase parental stress. By improving parental understanding of their child's cognitive and emotional limitations, CBT helps parents reinterpret challenging behaviours as developmental or neurocognitive in nature rather than intentional, reducing negative emotional reactions and promoting more supportive behavioural responses.

1.6.4 BANDURA'S SOCIAL LEARNING THEORY (1977)

Bandura's Social Learning Theory (1977) emphasizes that human behaviour is learned not only through direct experience but also through **observation, imitation, and modelling** within a social context. The theory proposes that learning occurs through a continuous interaction among **personal factors, behaviour, and environmental influences**, a process termed **reciprocal determinism**. This framework highlights the

critical role of social agents—particularly parents—in shaping children's behavioural development.

According to Bandura, observational learning involves four essential processes: **attention**, **retention**, **reproduction**, and **motivation**. Children observe the behaviours, emotional responses, and coping strategies of significant others, retain these observations cognitively, reproduce the observed behaviours, and are motivated to continue them through reinforcement or anticipated outcomes. In children with intellectual disabilities, learning through direct instruction may be limited; therefore, modelling and reinforcement become especially influential in behaviour acquisition and regulation.

Parental stress significantly affects modelling behaviours. Parents experiencing high stress may unintentionally model maladaptive coping strategies such as irritability, avoidance, or inconsistent discipline. These behaviours, when observed repeatedly, can be imitated by children, leading to the development or maintenance of behavioural problems. Conversely, parents who demonstrate calm emotional regulation, problem-solving skills, and consistent behavioural responses provide positive models that promote adaptive behaviour in children.

1.6.5 RELATIONSHIP BETWEEN VARIABLES OF THE STUDY

The present study is based on a combined theoretical framework that brings together **Cognitive Behavioural Therapy (CBT), the Demand–Control Model, the Effort–Reward Imbalance Model, Theory of Mind (ToM), and Bandura's Social Learning Theory**, using simple and related concepts to explain the study variables.The Demand–Control Model (Karasek & Theorell, 1990) and the Effort–Reward Imbalance Model (Siegrist, 1996; Siegrist et al., 2004) explain parental stress as resulting from high caregiving demands, limited perceived control, and disproportionate effort in relation to received rewards. CBT aligns with these models by modifying maladaptive cognitive appraisals related to control, effort, and expectations, thereby reducing stress.

Theory of Mind (Premack & Woodruff, 1978) provides insight into behavioural difficulties in children with intellectual disabilities, where deficits in understanding mental states contribute to social and behavioural problems that increase parental stress. CBT facilitates cognitive reappraisal and perspective-taking, enabling parents to interpret child behaviour more accurately and respond adaptively.

Bandura's Social Learning Theory (1977) explains how parental behaviours influence child behaviour through modelling and reinforcement. By improving parental coping strategies and behavioural responses, CBT enhances positive modelling, leading to improved child behaviour. Collectively, these theories establish CBT as a central mechanism linking stress reduction, cognitive understanding, and behavioural change.

CHAPTER 2

REVIEW OF LITERATURE

In the following pages some of the studies relevant to the topic under investigation are presented. An analysis of the studies presented in Chapter 2 Review of Literature clearly indicates that many studies on cognitive behaviour therapy, parental stress and Behavior Development of the Intellectual Disabled Children have been researched across different dimensions, demographics and different levels. Cognitive behaviour therapy as a variable has been studied against and in comparison to parental stress and behaviour development of intellectually disabled children. These variables have been correlated, predicted and analyzed in diverse demographics individually as well in association with other factors effecting on the development of intellectually disabled children.

In recent years, efforts at reducing parental stress through therapeutic intervention have attracted attention that could not only improve parents' well-being but, indirectly, the children's behavioural development. Among the interventions targeted for these goal, considerable interest has been placed in Cognitive Behavioural Therapy (CBT) in improving the parental capacity of a child who suffers from intellectual disabilities. CBT, focusing on inappropriate thought patterns and enhancing the adaptive coping mechanisms, was found to reduce stress in caregivers and improve their emotional management (Beck, 2011).

The existing literature on CBT's effectiveness in treating parental stress and its resulting impact on child development is vast, but there is still a need for a more differentiated understanding of the mechanisms involved in how CBT could affect both parents and children in the context of intellectual disabilities. Studies have shown the positive effect of CBT on the decrease of anxiety and depression of parents, but further study is needed to explore broader implications to child behaviour, including social skills, communication, and emotional regulation (Cohen &Am merman, 1999). In fact, studies suggest that the interventions based on CBT might also increase the parental self-efficacy and adaptive parenting practices, which might eventually encourage more positive interactions and foster better developmental outcomes for children (Lindsay et al., 2013).

There review synthesizes all the existing literature regarding the effect of CBT on a reduction in parental stress as well as the resulting implications for their child's

behavioural development. Conducting a synthesis of existing key findings will provide in-depth knowledge regarding the extent to which parental mental health influences child development and through which means CBT-based intervention can alleviate challenges faced by families with children having ID.

“Cognitive-behavioural therapy is one of the most extensively researched and most widely practiced forms of psychotherapy. Between 1986 and 1993, over 120 controlled clinical trials were published that significantly added to the already growing evidence for its effectiveness (Hollon& Beck, 1994).). Since then, it has continued to grow, with more than 325 outcome studies on CBT interventions having been published to date (Dobson, 2001). There expansion was primarily due to CBT's continued development to treat a wider variety of psychological disorders and issues(Beck, 1997; Salkovskwas, 1996). Although it has been widely applied and researched, there are several important questions that still have not been answered about the general effectiveness of CBT. Some of these questions involve relative efficacy across different disorders, the nature of control groups used in studies, and the long-term sustainability of its benefits once treatment is completed. In there paper, we review and synthesize evidence from high-quality meta-analyses that address these unresolved issues.

2.1. LITERATURE RELATED TO STRESS

The term “stress from all demands of parenting was termed as parental stress (Deater-Deckard, 2004). A child suffering from chronic illness or disaorder presents challenges to a parent's life. In Sweden, as many as 9,000 children suffer from some type of autistic disorder(Boström, 2012; Fombonne et al., 2003)”. Any family having a child diagnosed with some form of chronic illness is at a crisis point. There can be overwhelming and lead to anxiety about the future and health of a person and is an indication of helplessness. What is documented about issues for parents whose children have cancer appears to be similar for the caregivers when their children have other medical diagnoses, such as, but not limited to, “Type 1 diabetes, chronic pain syndrome, attention deficit/hyperactivity disaorder(ADHD), asthma, heart disease, and metabolic disorders”, or factors that will affect parental adjustment to these new realities (Gallo &Knafl, 1998).

Based on the various studies conducted on these parents (Boman, Viksten et al, 2004), the most common psychosocial effects of rearing children with disabilities and chronic illnesses on their parents include less quality of life, the symptoms of stress, the obsessive thoughts, avoidance behavior, anxiety, apprehensiveness, and hopelessness. Nearly 350 case were studies of a variety of psychological disorders, including "anxiety, eating disorders, tension, and social issues, have shown the efficacy of cognitive behavioural therapy (CBT), including both individual and group treatment. (Beck &Wewashaar, 2000)."

When a person afflicted with an anxiety or mood disaorderwas exposed to an environment or object that does not pose any real threat to them, they are likely to feel even more disturbed (Olatunji et al., 2010), CBT was a very structured, time-limited form of intervention that involves goal setting and learning of skills in an individual (Hollon and Beck, 2004). Psychoeducational sessions that include behavioural coping strategies as well as homework have also been proven to reduce depression states (Horrell et al., 2014).

Anxiety & mood disorders can be effectively treated with cognitive behavioural therapy (CBT) psychoeducational classes (Cuijpers et al., 2009; Donker et al., 2009), and there was increasing evidence that there kind of intervention can be used to prevent mental illness (Seligman et al., 2007).

2.2. LITERATURE RELATED TO PARENTAL STRESS

Being a new mother is a life transition that necessitates significant modifications (Ngai FW, Chan SWC, 2012). Raising parenting stress can have a negative impact on children's and parents' well-being as well as the functioning of the family due to the onerous task of caring for a newborn kid and significant changes in roles and relationships (Kim MY, 2009). The psychological and physical strains that come with becoming a parent are known as parenting stress (Abidin RR, 1992).

Poon and Wong (2010) adapted cognitive behavioural therapy (CBT) and found it has positive impact in reducing parenting stress and improved overall health among parents of children with developmental disabilities, according to a randomised controlled trial.

Raising a child with normal growth differs from caring for one with a developmental disability. The latter puts much more pressure on parents. Many moms and dads feel very stressed because looking after these kids requires big emotional, social, and personal efforts. (Luescher et al. 1999; Haveman et al. 1997).

Lara (2008) investigated the relationship between parental stress and the adaptive behaviours of kids with intellectual disability. The results showed that children's adaptive performance was negatively correlated with higher parental stress levels. According to this, parents who are under higher stress could think that their kids' social and everyday living skills are worse. In order to lessen parental stress and improve the development of adaptive skills in children with intellectual disabilities, the study highlights the necessity of support networks.

It was well recognised that “stressful behaviours cause the most stress for carers of children with developmental disabilities. Higher scores on the Aberrant Behaviour Checklist subscales (such as lethargy, hyperactivity, and stereotyped behaviour) were associated with greater distressin these parents. Similar activities have also been connected to sleep disturbances in children with developmental abnormalities; however, it was unknown whether these behaviours affect the parents' sleep quality. (Baker et al., 2003; Blacher& McIntyre, 2006; Floyd & Gallagher, 1997; Hastings et.al, 2006), (Aman et al., 1987), (Stores etal., 1998), (Miano et al., 2007; Polimeni et al., 2007)

Hassall, Rose, and McDonald (2005) examined the relationship between stress levels and parental cognitions, specifically locus of control, parenting self-esteem, and parenting satisfaction, in 46 mothers of children with intellectual disabilities. Regression analysis revealed that the main factors influencing parenting stress were the child's behavioural issues, parenting satisfaction, and parental locus of control. Reduced stress was associated with family support, although this relationship was mediated by

locus of control rather than direct influence. The results emphasise the significance of cognitive aspects of stress and have consequences for developing therapeutic interventions that support parents' coping mechanisms when dealing with their children's behavioural issues.

The “association of social support with a lower level of anxiety found by families raising children having developmental disorders. Social support was widely recognized as being helpful in reducing suffering; quite a large body of work has examined its function for families raising children having developmental impairments. Parents reported less social support for the children having developmental impairments compared to parents of the control children. Depression and anxiety among these parents have often been found to be inversely linked with social support. (Bailey et al., 1994; Dunn et al., 2001), (Gallagher et al., 2008), (Gray & Holden, 1992; Weiss, 2002)”

In continuation of the previous study, psychological discomfort, or parental stress, was often felt due to demands related to the parenting and childrearing role. Many studies have already found a relationship between higher levels of stress experienced by parents and their mental and overall well-being. Parental stress can bring about various negative effects on the child's behavioural and developmental results, such as Incorporating and expressing worries, and impaired social skills and cognition. (Crnic, K.A.et al. 2005, Deater-Deckard 2004, Hsiao Y.J 2016, Wang Z. et al, Barroso, N.E. 2018 , Neece, C.L et al 2012, Krahé, B. et al 2015,Mäntymaa, M. et al 2012, Crum, K.I.; Moreland, A.D. 2017, Guajardo, N.R.; Snyder, G.; Petersen, R 2009).

Although there have been few empirical studies, Neece, Green, and Baker (2012) came to the conclusion that parenting stress and behavioural issues in children have been suggested to have transactional effects on one another throughout development. The scientists looked at this association in 237 children (144 with usual development and 93 with developmental disabilities) between the ages of 3 and 9. The findings indicated that there was a strong correlation between parenting stress and behavioural issues over time for both groups. A bidirectional association between parenting stress and

behavioural issues in children in both mothers and fathers was supported by cross-lagged panel studies.

The study suggests that parents who are highly stressed do not have a lot of affection and interaction with their children, which may result in the negative effects on the quality of their relationship. More importantly, previous studies have established direct associations between the stress experienced by a child and their parents, which was an international social and public health concern. These findings underscore the importance of immediate interventions to minimize parents' stress associated with parenting. (Crnic et al, 1990)

According to ecological parenting theories, parental stress was influenced at different levels by a wide range of interconnected factors, including the unique traits of parents and kids, family and community difficulties, and the broader sociocultural environment. Numerous studies on parent-related factors have found a strong correlation between parental stress and childhood trauma, poor mental health, lower family income, and lower educational attainment. (Belsky, J. 1984, Bronfenbrenner 1977, Lam 2011, Galbally, M. et al 2019, Vwasmara, L. et al 2016. Perinatal , Wang, J. et al 2013)

Numerous researchers have examined the impact of child-related traits on parental stress. According to many meta-analyses, parents of children with developmental disabilities and chronic health issuesreport higher levels of stress than parents of children who are typically growing. In the meantime, a lot of study has examined the relationship between parents' stress levels and family characteristics, such as living arrangement instability and complexity, as well as poor family functioning. To sum up, a lot of research has been done to identify a number of markers of parental stress at the levels of parents, children, and households. (Hayes, S.A.; Watson 2013, Theule, J. et al 2013, Pinquart 2018, Osborne, C. et al 2012

Given the strong emphasis on individual and family factors in there area of research on parental stress, the majority of interventions that are currently being used do not take into account community and socio cultural variables but rather attempt to change the parent, child, and family characteristics in the hope of decreasing the stress that comes

with parenting. Individual- and family-focused therapies would probably not be enough in terms of the disease since people and families do not want to ask for help due to stigmatization and access restrictions. There therefore calls for even more attention to examine those factors concerning the contexts that parents find themselves in-from social and community environments to their workplaces and culture-to better inform how one may expand community-based services and assistance for parents more comprehensively. (Lo, C.K.-M. et al 2021, Crnic, K.; Ross 2017)

A few studies suggest that a more comprehensive view of social and societal consequences, social support, social ties, and government assistance can help reduce stress in parents. In addition to social and collective pressures, a person's cultural views and how well they fit with their environment can affect stress in parents. (Wang, J. et. al 2013, Falk, N.H.et.al .2014, McConnell, D. et. al 2011, Cardoso, J.B. et. al 2010)

Support for traditional ideas about families, marriage, and raising children was connected to stress for parents. A study from China found that in many places today, people still strongly believe in having both parents in a family and having a complete family. However, getting a divorce was often seen as something bad and embarrassing. Because of there, single parents might feel more stress when rawasing their children. These findings show how important it was to consider social, community, and cultural factors when creating services that help parents in different cultures and reduce their stress.

The family system relies on adults, and those who take care of children experience a specific kind of stress called parental stress. Research shows that being poor increases stress for parents and can affect the quality of relationships that help children grow. There happens because difficult financial situations can make it harder for parents to handle the challenges of raising kids.

Parental stress was the tension that father and mother figures face. Parental& child characteristics, social and economic conditions, and cultural contexts are all associated with factors that influence parental stress. Stress can be a driving force for parents to finish their work when it was considered necessary. High levels of stress, however, can

be detrimental to both parents and children by damaging family functioning. There places much importance on the roles that individual members of families perform, hence leading to the creation of the framework determining the importance of those positions in the subtleties of relationships that develop under modern social realities. And as a result, there wasthere multidimensional web which comprises the factors which determine human development, putting an emphasis here on stress among family and poverty specially of individuals with parental responsibilities. Therefore, the objective of there study was to establish a link between parental stress levels and the poverty levels of families. It highlights the importance of roles individuals with parental responsibilities play within the family setting, and forms a framework that outlines what makes these positions crucial within the nuances of the relationships that emerge in the realities of modern society. As such, factors affecting human development represent a multidimensional network, and what was emphasized here was family stress and poverty particularly for those who bear parental responsibilities. Consequently, the objective of there research was to find a relationship between parental levels of stress and family levels of poverty. (Cunha, Pontes, & Silva, 2017) & (Hoghughi, 2004).

Parenting styles and practices are significantly influenced by elements of poverty that are incapable of allowing children to and adults to grow well. These factors also elevate the risk to the poor population's mental health, leading to high stress or anxiety levels and eventually decreasing parental investment. (Jocson & McLoyd, 2015)

While social risks such as drug abuse, violence, and criminality are a part of life for every Brazilian family, it was evident that poor families face extra risks because of a lack of resources and support systems, which makes them more vulnerable to all of these problems, including poor housing, poor health, and dirty living conditions. As a result, it would not be wrong to say that serious burdens borne by the poorer-class households ultimately weaken the system altogether. Their parents feel stressed to greater extents by there as there has its negative effect upon their capacity to take better care of their child.

In such a situation, parental stress may even be yet another development-inhibiting variable in high-risk households thereby weakly negatively affecting psychological

investment into the relationships, including parent-child relations and the latter's further relations among themselves. (Evans & Kim, 2013)

For many parents, grandparents are their primary support group. They not only give practical help but also emotional support apart from financial support. The interaction and co-residence of intergenerational relation have been found to lead to stress and conflict. A research study on children with Down syndrome has come up with there finding. According to a study on families that had children with developmental disabilities, the effect of assistance from grandparents on mother's stress was different for type of care received and for which grandparent was caregiving. In addition, other support systems such as friends can also reduce their stress levels. While daycare and other forms of instrumental assistance may be involved, others who have had similar experiences and can provide empathy, guidance, and role-model coping mechanisms are also likely to contribute to stress reduction. (Thoits,2011, Hastings et al., 2002, and Trute, 2003

Another large population study of immigrant families with young children found that being a migrant or a single parent was also associated with higher levels of parenting stress (Sepa et al., 2004).

Episiological problems, including scarring within the brain because of epilepsy, should thus be factored into discussion about psychopathology along with disease severity. Indeed, there was a growing general perception that children diagnosed with neurological disorders are generally more likely to develop psychopathology than children free of neurological disorders. Lastly, the development or continued existence of psychopathology in children with epilepsy was influenced by family factors for example increased parental stress.

There interaction and experience of parents and infants, according to contemporary developmental theory, influences child development as well as that of the parents themselves. From there transactional paradigm, parenting stress was conceptualized as the reflection of the interplay between the resources of the parent, such as their PRF, and the features of the infant, for instance, prematurity, (Sameroff, 2009)

Stress was an emotional reaction to perceived and real dangers. It serves as a threat to the body's balance in relation to the physical, emotional, and mental features of the being. Stressor can impact a parent's specific actions as stress- coping mechanisms or responses to stressful situations. It was well known that the individuals who are under stress will eat more emotionally and turn towards foods high in fats and carbohydrates. High levels of stress may also increase an individual's tendency to make comfort food choices and other inappropriate diet choices, which ultimately results in weight gain. Parental stress would thus influence the types of food that are shared and offered to children at home in that it would change the type of diets that parents consume (Cohen S et al, 2016), (Goldstein & Kopin. 2007), (Yau, & Potenza 2013), (Pecoraroet.al, 2004)

There was mounting evidence suggesting that the negative social and cultural characteristics of the household food environment are positively associated with parents' stress. Bad parental feeding practices might be connected with general levels of stress and specific targeted stresses that may actually interact with children's bad eating habits. Stress among parents may affect what the parents eat, and subsequently, may affect how the children adopt their eating patterns. Among the poor food preparation habits, stress-stricken parents may accumulate unhealthy foods at home in an attempt to deal with their stress levels or because of the lack of energy required to prepare a healthy meal. Such stressful parents might even opt to ingest foods rich in fats and carbohydrates. (Hughes SO et.al 2015), (Jang M et.al 2019), (Pecoraro N et.al 2004), (Devine CM et.al 2003)

Bauer et al. found that the more stressed the parents, the fewer times they had family meals, the fewer fruits and vegetables they ate, and the less time they spent on food preparation. A better understanding of the relationship between the psychological burden of parenting and the true home food environment —that was, the amount of food at home—will help build more inclusive and effective strategies to address childhood obesity. (Bauer KW et.al 2012)

Parental stress may impact the disease process through interference with treatment adherence or activation of physiological stress response systems including hypothalamus pituitary adrenal axis and the sympathetic nervous system. Perceptions

of parental conflict in children with asthma were related to insecure father-child relationships and triangulation, which was communication from one family member to another member through a third family member. The above findings supported the bio behavioural family model. (Klok et al., 2014), (Miller et., 2009), (Wood et al. 2000).

Compared to other caregivers of healthy children, parents of children with some type of chronic illness will experience higher levels of parenting stress. The results vary when it comes to how prevalent parental stress was, though, in parents of asthma-affected children. Results, based on most the available data, indicate that asthma-specific parenting stress was within typical ranges when compared to matched normative reference groups as well as healthy controls. Parenting stress was only marginally greater in one study where it was reported that parents of children with asthma were more stressful to raisethan children who suffered from cystic fibrosis or cancer. In another study, the parents' stress was marginally greater in parents with asthma rather than those with cystic fibrosis or cancer. (Cousino& Hazen, 2013), (Markson &Fiese, 2000; (Caffrey-Craig, 2005; DeMore et al., 2005), (Hullmann et al., 2010)

Earlier asthma studies did establish a link of higher parental stress with more miserable asthma symptoms, as well as worse medication adherence, worse illness management, and worse house dust mite control. Moreover, research works have proven that negative events in life increase the propensity of children to experience wheezing and that caregiver's stress was a predictor for early childhood wheeze. However, other research indicated that overall parenting stress was unrelated to the severity of the illness, peak flow variability, and age when asthma first appeared; & instead, greater parenting stress correlated with higher medication (inhaled) adherence. That was, some studies of parents' relationship to their children's asthma severity did not always provide similar results. (Kaugars et al., 2004; Sandel & Wright, 2006), (Celano et al., 2011), (Joseph et al., 2003), (Sandberg et al., 2000), (Wright et al., 2002), (Caffrey-Craig, 2005; Chiou& Hsieh, 2008), (DeMore et al., 2005)

Children and adolescents with difficult, severe asthma demonstrated a greater prevalence of internalizing behaviouraldisorders, such as withdrawal or depression,

along with increased severity of somatic symptoms, compared with control groups. A study finding an association between internalizing child symptoms and a poor family emotional climate implies that maternal stress may be the pathogenic factor in child psychopathology. (Verkleij et al., 2011) & (Lim et al., 2008)

Newborns with disabilities usually face difficulties with bonding because they cannot communicate well with their mothers and therefore cannot understand her when she was responding. Additionally, she believes that the stress parents have to undergo from raising a child with a disability can make them less sensitive and attentive to their child's signals. (Capuzzi 1989)

The psychological response called "parental stress" was what pushes people to tap into all of their resources in order to perform their parental role. There happens when parents feel there are more demands on them than there are resources to meet in order to fulfill their parental job. But being a parent can also be very fulfilling and rewarding. The antipode of parenting stress, on the other hand wassatisfaction, also sometimes known as rewards, and which was concerned with the 'good' feelings that attend parenting, including happiness, warmth, and love. Both parental satisfaction and parenting stress are complementary traits that are used when studying parenting stress in most cases when they show a reverse correlation. (Abidin, 1992; Deater-Deckard, 2004; Oyarzún-Farías et al., 2021; Oronoz et al., 2007; Nærde&Hukkelberg, 2020; Abidin, 1995; Berry & Jones, 1995)”

Most of the research on parental stress was conducted on "at-risk" families. That was to say, either the developmental or behavioural problems of their children, psychological adjustment problems, or socioeconomic status increase the probability of stress experienced by children. All parents, in contrast, have experienced at least some level of stress and report satisfaction in assuming their parental role, but with differences in their psychological well-being and socioeconomic background. There means that parental worry and contentment are common effects of socialisation.Pérez-Padilla, 2014; Raikes & Thompson, 2005; Crnic & Greenberg, 1990; Deater-Deckard, 2004)

Although parental stress can be a coping process, it can also be associated with ineffective parenting and lower life satisfaction of parents. It impacts kids too, increasing their likelihood to develop emotional and behavioural problems. The differences in parental stress and satisfaction/rewards between clinical or social service users (SSU) and non-users (non-SSU) are also not often dwascussed. (Crnic& Ross, 2017; Deater-Deckard, 2004).

Parents of children with intellectual disabilities often experience higher levels of stress due to caregiving demands, behavioral challenges, and social constraints (Kumari & Biswas, 2024). Cognitive Behavioral Therapy (CBT) has been shown to effectively reduce parental stress by improving coping strategies and emotional regulation (Li et al., 2023). Studies indicate that structured CBT interventions enhance parental well-being and family functioning, particularly when combined with social support (Ranta et al., 2024). However, few pre-post studies have examined culturally specific samples, highlighting the need for research like the current study Kumar et.al (2024).

This empirical study investigates the relationship between parental stress and the behavioral problems of children diagnosed with intellectual disabilities (ID). A total of 100 parents (50 fathers and 50 mothers) of children aged 5 to 15 years participated in the research. The Parenting Stress Index (PSI) and the Child Behavior Checklist (CBCL) were employed to measure parental stress levels and the severity of behavioral problems in children, respectively. The analysis revealed that the average PSI score among parents was 75 (SD = 12), indicating high levels of stress significantly above the normative sample mean of 60. On the CBCL, 60% of children scored in the clinical range for behavioral problems, with the most common issues being aggression (45%) and hyperactivity (35%). Correlation analysis demonstrated a strong positive correlation ($r = 0.65$, $p < 0.01$) between the severity of children's behavioral issues and parental stress levels, suggesting that increased behavioral problems are associated with higher parental stress. Additionally, demographic analysis indicated that mothers reported significantly higher stress levels ($M = 78$, $SD = 11$) compared to fathers ($M = 72$, $SD = 12$), with a statistically significant difference ($F(1, 98) = 5.23$, $p < 0.05$). These findings underscore the critical need for supportive interventions aimed at reducing

parental stress, particularly for mothers, and highlight the importance of addressing both parental and child needs in intervention strategies. This study contributes to the understanding of how parental stress is affected by the behavioral challenges faced by children with ID, ultimately calling for increased support and resources for families. Kumar et.al (2024).

This study examines the impact of Cognitive Behavioral Therapy (CBT) on reducing parental stress in families with children diagnosed with intellectual disabilities. Parental stress is a significant concern due to the unique emotional, financial, and social challenges associated with raising children with intellectual impairments. CBT, a widely-used therapeutic approach for managing stress and anxiety, was employed to assess its effectiveness in alleviating these stressors among parents. A sample of parents participated in a structured CBT intervention over a period of 8 weeks, with pre- and post-intervention stress levels measured using the Parental Stress Scale (PSS). Statistical analyses, including paired t-tests, were used to evaluate changes in stress levels. Results indicate a statistically significant reduction in parental stress following the CBT intervention, with notable improvements across emotional and psychological domains. These findings suggest that CBT can be an effective tool in managing parental stress in this context, offering valuable implications for mental health professionals and support organizations. The study concludes with recommendations for incorporating CBT techniques into routine support for parents of children with intellectual disabilities, highlighting areas for further research on long-term impacts. Kumar et.al (2024).

2.3. LITERATURE RELATED TO BEHAVIOUR

Behaviour is describable as an attempt on the part of an individual to bring about some state of affairs -- either to effect a change from one state of affairs to another, or to maintain a currently existing one. (Ossorio, 2006).

It indicates the "adaptive responses assembly" that a body with a nervous system carries out in reaction to environmental stimuli that are also observable from an objective viewpoint. (Neveanu, 1978).

Behaviour is the entirety of an organism's reaction to its environment, based on the stimulation of the environment and internal tension of consecutive motions that are significantly orientated. Through the visible manifestations, the behaviour defines how an individual ought to act and behave. It was necessary to understand the intent and course of adaptive behaviour.

A person's behaviourwas their actions. It is the action a person does to bring about a change, make something happen, or maintain the way things are. Behaviorwas a reaction to events that take place: internal—feelings and ideas. externally: the surroundings, including other individuals.

The amount and types of emotional and behavioural problems that occur frequently in kids with intellectual disabilities (ID) are examined in the study. In contrast to their classmates who are usually developing, children with intellectual disabilities show greater rates of internalizing behaviours (such as worry and sadness) and externalizing behaviours (such as violence and tantrums), according to the authors. The study emphasizes how important contextual elements are in the expression and control of certain behaviours, such as social support and family dynamics.Those with moderate to severe intellectual impairments may have more severe behaviouralissuesthan those with modest disabilities.To address these problems, early intervention are essential. Examples of there include behaviour treatment and parent education. In order to tackle these complicated behavioural and emotional issues, a multidisciplinary approach—involving social workers, psychologists, and special educators—was frequently required. (Gavidia-Payne, S., & McGillivray, J. 2013).

Patterns of emotional and behavioural traits that are frequently linked to particular genetic disorders causing Intellectual disorder, such Prader-Willi syndrome, Down syndrome, and Fragile X syndrome, are referred as behavioural phenotypes. The

authors believe that creating successful therapies requires an awareness of these behavioural characteristics. Identifying the behavioural phenotype of a particular condition facilitates the development of support plans and treatments that are specifically targeted. For instance, children with Fragile X syndrome typically exhibit hyperactivity, impulsivity, and social anxiety, whereas children with Prader-Willi syndrome frequently exhibit compulsive behaviours, food-seeking behaviours, and violent outbursts.(Emerson, E 2001).

It describes how common behavioural problems are in kids with Intellectual Disabilities and looks at the many kinds of behaviours seen. According to research, children with Intellectual Disabilities are more prone than their classmates who are typically developing to display a variety of difficult behaviours, including aggressiveness, violence (e.g., biting, punching), hyperactivity, self-harm (e.g., head-banging, skin-picking), stereotypical behaviours (e.g., repetitive gestures, hand-flapping) and social disengagement.Children with Intellectual Disabilities are more likely to exhibit problematic behaviours, especially those with more severe types. The severity of these behaviours was correlated with the level of intellectual impairment (mild, moderate, severe, profound). These actions may stress family relationships, make socialization and community involvement more difficult, and impair the child's learning. Approximately 25–40% of children with Intellectual Disabilities had behaviouralissues. (Didden, R., et al 2006)

There article starts out by pointing out those children with intellectual impairments have greater incidence of mental illnesses than children who are generally developing. According to article, between 30% and 50% of kids with Intellectual Disabilities also have one or more co-occurring mental illnesses. The behaviouralissuesthat these children display are further exacerbated by these diseases, which also make it more difficult to distinguish between signs of Intellectual Disabilities and those resulting from co-occurring mental illnesses. It was investigated that how children with Intellectual Disabilities experience worsened behaviouralissuesdue to concomitant mental conditions. When a mental disease was present, the behaviouralissuesthat

children with ID experience—such as violence, self-harm, temper tantrums, impulsivity, and social disengagement—may worsen.

1. Aggressiveness: Frequently observed in kids with ADHD, ODD, or ASD, aggressiveness in kids with ID might be attributed to increased anxiety, social isolation, or frustration from communication issues.
2. Self-Injury: Self-injury, such as head-banging or skin-picking, was a particularly concerning activity that was frequently seen in children with significant intellectual impairments, particularly those who also have concomitant mood disorders or autism.
3. Children with ID may find it more difficult to control hyperactivity and impulsivity, which are typical in ADHD, since cognitive deficits make it difficult for them to comprehend the implications of their actions or follow complicated behavioural instructions.
4. Irritability, withdrawal, and poor academic performance are all symptoms of depression that children with ID may dwasplay, but they are sometimes mistakenly ascribed to their cognitive disabilities. (Deb, S., Thomas, M., & Sharma, P. Journal 2007).

The significance of doing functional behavioural assessments (FBAs) to identify the reasons behind difficult behaviours in kids with intellectual impairments was highlighted in there research. As stated by the authors, FBA was essential to creating tailored, successful treatments. The article describes how to perform an FBA, identify behaviours, antecedents, and consequences, and how there might result in treatments that are more precisely targeted.

Functional behavioural assessments assays in determining if behaviourwas a reaction to environmental pressures, communication difficulties, or sensory demands. Over time, problematic behaviours can be decreased with customized treatments including teaching alternative skills and providing positive reward for proper conduct. Interventions are more successful when parents, teachers, and therapists work together. (Horner, R. H., &Carr, E. G. 1997)

According to the study, children with ID frequently exhibit more internalizing

behaviours like worry and sadness as well as externalizing behaviours like aggressiveness, hyperactivity, and non-compliance. According to the review, children with moderate-to-severe intellectual disabilities have more severe behaviouralissues, and behaviouralissuesare strongly correlated with the severity of an individual's condition. Early intervention and individualized support plans can mitigate some behavioural challenges. The absence of uniform diagnostic standards and the difficulties in treating co morbid diseases like autism spectrum disaorder (ASD) were also emphasized in the review. (Journal of Autism and Developmental Disorders (2020).

Inadequate educational resources, environmental stresses, and a lack of effective behaviour management techniques are some of the major causes of behaviouralissuesin kids with intellectual impairments, according to there study. Additionally, the study highlights those kids with ID experience dissatisfaction and behavioural outbursts mostly due to communication impairments. It implies that therapies like Applied BehaviorAnalysis (ABA), communication training, and changes to the family and school environment can often reduce behavioral problems. The article advocates the application of teamwork and family training in behavioral management. (L. H. Matson, R. B. Shoemaker, and K. B. McClain (2008).

The research targets children who have both intellectual disabilities and autism spectrum disaorder (ASD). The authors investigate the relationship between communication difficulty and behavioral problems in these children. They learned that children with high levels of communication impairments tended to exhibit problem behaviors like aggression, self-injury, and non-compliance. The research brings into focus the importance of augmentative and alternative communication (AAC) systems in minimizing behavior problems by enhancing communication abilities. The authors emphasize the importance of tailored treatment regimens to overcome both cognitive and communicative deficits in children diagnosed with dual conditions of ASD and ID. (M. T. Emerson and S. R. Harris (2012))

The investigation of how sensory processing difficulties can aggravate behaviorissuesin children with intellectual disabilities. Sensory sensitivities, i.e., hypersensitivity to touch, sound, or light, can give rise to increased anxiety and frustration, consequently manifesting as behaviorissues. The research highlights the need to treat sensory processing dysfunction by creating environmental changes (e.g., less noisy classrooms, sensory breaks) and sensory integration therapy. The authors find that addressing sensory needs can be a valuable component of an overall strategy for diminishing behavioral difficulties among children with ID.

The meta-analysisconsiders different intervention approaches to treating problem behavior among children with intellectual disabilities. The research determined that behavioral interventions (e.g., ABA and functional communication training) and pharmacological interventions (e.g., antipsychotics for extreme aggression) were both effective at treating problem behavior. However, the success of the interventions differed based on ID severity and behavioral problems. The research concludes that the most effective intervention for problem behaviors in children with ID was a combination of individualized behavioral strategies, parent training, and, if needed, medication.

Comprehending intellectual disability involves acknowledging the various obstacles that people may encounter in their cognitive abilities, adaptive behaviour, and social interactions. Understanding how parents support their children with intellectual disabilities is aided by researching their attitudes towards these children. This quantitative study explores how parental attitudes towards their children with intellectual disabilities are impacted by their educational background, socioeconomic status, and location. Purposive sampling was used to select 30 participants for this study. After parents completed an attitude scale, relevant statistical analyses were conducted. The findings showed that parents of children with intellectual disabilities demonstrated more negative attitudes toward their children when they lived in rural areas, had a lower socioeconomic status, and had less education. These results have important implications because they indicate the need for tailored support networks and interventions to meet the unique demands of low-income families. Resources and

educational programs should be created to promote acceptance and understanding of people with developmental disabilities, especially in rural and underserved communities. Mukherjee et. al (2025)

This longitudinal study examined the temporal relationships among developmental quotients (DQs) in adaptive behavior, language ability, and personal-social skills in young children with intellectual disability (ID) across a two-year period, to inform targeted early intervention strategies. Researchers retrospectively analyzed data from 94 children aged 2–5 years who had received continuous behavioural interventions at a tertiary hospital. Developmental assessments using the Chinese version of the *Gesell Developmental Scale* were conducted at three time points, and cross-lagged panel modelling was employed to examine cross-domain predictive relationships. Results showed that adaptive, language, and personal-social DQs demonstrated moderate to strong correlations and high temporal stability across time. Notably, early adaptive DQ at Time 1 significantly predicted later language and personal-social DQs, and Time 2 adaptive DQ predicted outcomes at Time 3, whereas neither language nor personal-social DQs predicted future adaptive DQ. These findings suggest that early adaptive functioning plays an influential, prospective role in shaping later language and social development. The study concludes that early intervention programmes that prioritise enhancements in adaptive skills may yield broader developmental benefits across domains in children with ID.
Cai,s. et.al (2025)

A 2025 systematic review and meta-analysis examined the effectiveness of interventions for behaviours that challenge in children with intellectual disability (≤18 years). Eighteen randomized controlled trials were analyzed, comparing pharmacological and non-pharmacological approaches. Findings indicated that non-pharmacological psychosocial interventions, including behavioural and skills-based therapies, produced small but statistically significant reductions in challenging behaviours, whereas pharmacological interventions showed no clear benefit. The review supports existing clinical guidelines that recommend psychosocial interventions as first-line treatment and highlights the need for high-quality trials to strengthen the

evidence base. Kye,V. et.al (2025)

2.4. LITERATURE RELATED TO INTELLECTUAL DISABILITY

According to the “World Health Organization's 1992 definition, intellectual disability is defined as a substantial impairment in two or more areas of daily living that begins before the age of eighteen and a considerable impairment in intellectual functioning (i.e., an IQ of less than 70). Intellectual disability is defined by the ICD-10 as an issue of arrested or incomplete mental development, defined by impairment of skills gained during the stage of development, such as cognitive, language, motor, and social abilities, which contribute to total intelligence. Retardation can occur alongside or without other physical or mental health concerns. The American Association on Mental Retardation (AAMR) states that "significant deficiencies in specific areas of personal competence are referred to as mental retardation." It shows up as markedly below-average cognitive functioning capabilities along with deficiencies in adaptive skills. Put another way, the modern approach to mental health emphasises the significance of engagement with the environment and the support required to do so, rather than only focussing on detecting deficiencies in the individual. Although the threshold of acceptance will vary depending on social and economic circumstances as well as local attitudes, people with modest intellectual disabilities may be welcomed in schools and the community. The majority of individuals with severe forms of intellectual impairment will need assistance from social services and their families.

Even though the prevalence rates for moderate and severe intellectual disabilities have been estimated at 3% and 0.38% globally, there are also a number of challenges towards determining the exact number of kids suffering from intellectual impairment from the changes in evaluations, methods, and terms employed and in the populations scrutinized. (Fryers 1997).

By definition, cognitive and adaptive skills will be a challenge for all children with intellectual disabilities. Some of their other care needs include more mental health problems (Emerson & Hatton 2007), more severe sleep issues(Richdale et al. 2000),

more difficult behaviours (Baker et al. 2003), physical health issues (Courtman & Mumby 2008), and more co-morbidities, including autism spectrum disorder. (Croen and colleagues, 2002)

People with intellectual impairments as, by definition, they form a group with support needs arising from their condition and additional needs as they may have functional or psychological impairments. Intellectual disability, according to the American Association of Intellectual Disability (AIDD), was a condition appearing before the age of eighteen with significant limitations in both intellectual functioning and adaptive behavior, which includes various everyday social and practical skills. Intellectual functioning refers to all areas of mental ability, including learning, reasoning, and problem solving. Adaptive behavior refers to mental, social, and practical skills acquired by the individual, put to use in daily activities. (Kottorp, 2008; Durbin et al., 2017; Schalock et al., 2010)

Because individuals with intellectual impairments need different kinds of support, WASO 9999:2016 bases a taxonomy and terminology regarding assistive products for individuals with disabilities. The classification does differentiate between assistive devices used by people to maintain self-care, education and skill learning, household chores, personal mobility and transportation, and work activities and employment or involvement in activities of leisure or enjoyment, among others in the type of support. (ISO 2016).

In many cases, people with intellectual or developmental disability suffer from frailty and premature aging. Moreover, individuals suffering from various diseases associated with intellectual disability often suffer from early dementia and thus more care needs. In there area, e-health has shown advantages for general patients' self-monitoring, health-related habit changes, and empowerment. (Perkins and Small, 2006; Alcedo et al., 2017; McKenzie et al., 2017; Windley and Chapman, 2010; Furniss et al., 2012; Sutherland et al., 2014; Wark et al., 2014 ; Clough and Casey, 2015; Wiederhold, 2015).

Based on literature, 15-35% of children from clinic and various social settings engage in disordered attachment, whereas there are many arguments based on which the disordered attachment prevalence was highly anticipated more in people with Intellectual disability than others. Intellectual disability defined by British Psychological Society has been described as substantial deviation in both intellectual functions of and adaptive behavior (with onset before adulthood) &; IQ < 70:. Around 1.5 million are given an intellectual disability diagnosis within the UK, the worldwide prevalence of the condition has been reported to stand at a rate of 1%. It was often subclassified into categories of functioning: mild, moderate, severe, and profound/multiple. (Van Ijzendoorn et al., 1999; BPS, 2015; Maulik et al., 2011; Pearce, 2017)

Mothers and intellectually impaired infants do not respond to their peers in similar levels of eye contact or physical response, which researchers believe was important for developing attachment relationships. Such differences have been noted between mothers and intellectually disabled infants when compared to normally developing infants. Besides, at the initial stage of a child's life, parental attunement may be affected by parents' depression and grieving over the lost "healthy child" which might lead to parents' feeling as though they failed to protect their child. (Potharst et al., 2012; Fletcher, 2016)

Compared with the rest of the population, persons with intellectual impairments have a greater tendency for being institutionalized, improper care, and abuse in very young ages. Reactive Attachment Disaorderhas often been theorized to be the aftermath of infantile abuse. Historically, attachment concerning a person with intellectual impairment had less significance as it was largely due to the reason that even today attachment theory was accepted well among the general psychological texts and therapeutic working with mainstream audiences. (Green and Goldwyn, 2002; Fletcher and Gallichan, 2016; Fletcher et al., 2016).

In an earlier meta-analysisof the literature, disordered attachment was more prevalent among children with neurological conditions, like Down syndrome and autism. The latest guidelines for how attachment theory can be translated into practice with there

group, as well as understanding and alleviating the problems that people with intellectual disabilities experience with their mental health and social participation, has put attachment in the minds of everyone. (Van Ijzendoorn et al., 1999; BPS, 2017; Schuengel et al., 2013)

Mullen carried out a comprehensive literature review on attachment theory in adults with intellectual disability. Three main conclusions were made: (1) lack of empirical research and developed measures; (2) empirical evidence exists that relates to negative early experiences, insecure attachments, and current mental health problems in people with intellectual disabilities; and (3) there was mixed evidence of the challenge of some attachments for supporters. (Mullen 2018).

Typically, developmental problems start in childhood, affect or postpone central nervous system maturation-related activities, and continue into adulthood. Intellectual disability, also called mental retardation, was defined as "a condition of arrested or incomplete development of the mind, which was especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e., cognitive, language, motor, and social abilities." (World Health Organization 1992)

People with autism spectrum disorders range widely in their level of intellectual functioning, from severe handicap to extraordinary nonverbal cognitive abilities. An intellectual disabilitywas believed to be present in up to 50% of individuals with autism spectrum disorder. (Totsika et al., 2011)

Intellectual disability (ID) was an impairment of intellectual ability and adaptive behavior, which comprwases a wide range of social as well as practical everyday skills. Disability as a result of before an age of eighteen (18) years old was stated via the IQ scale. Generally, significant to mild disability in intellectual capacity falls at the IQ scale of 0 to 70. Health problems in people having intellectual disabilities are twice greater than that of the rest of the population. Even children with intellectual disabilities tend to have far greater rates of reported long-term health compared to the general

population. (Schalock et al.2010; van SchrojensteinLantman-de Valk HM Walsh PN2008; Oeseburg B et al., 2011)

Some people are incredibly vulnerable from birth in terms of their health. As a result, individuals with intellectual disabilities may require palliative care from a young age. However, due to social and medical advancements, in line with the overall population, people with intellectual disabilities are living longer. Growing rates of life-threatening conditions at an older age, including dementia, chronic lung diseases, cardiovascular diseases, and progressing cancer, are associated with there demographic trend.(Patja K et al., 2000; Ellwason NM, Rosielle D. 2008; Janicki MP et al., 1999; Tuffrey-Wijne I et al., 2007)

People with intellectual impairments and those close to them might be helpful in Advance Care Planning as the model emphasizes the will of a patient. People with intellectual disabilities often have problems identifying and describing pain, similar to other emotions and sensations.

Thus, in the consideration of an end-of-life choice (ELD), it was always important to weigh the benefits against the quality of life of the patient. In advance care planning for patients with intellectual disabilities, all stakeholders involved should be consulted. These include the caregivers, family members, and the patient if they can understand. There should be discussions about the issueswith current and future medical exams and treatment alternatives because ACP was a broad concept incorporating psychological, social, and spiritual issuesin palliative care. ACP can also include conversations that are related to the roles of palliative care, in terms of whether a patient would rather go to a hospital or nursing home or remain at home, or what activities they would still like to take part in. (Bekkema N. et. al,2015)

Research on the care of people with intellectual disabilities has shown that carers and professionals were likely to withhold potentially disturbing information from people with intellectual disabilities if they were uncertain whether the person could be told. Additionally, there was no active involvement of people with intellectual disabilities in any End of Life Decisions, as found by a retrospective review of the medical records of

patients who died in a Dutch hospital. (Tuffrey-Wijne I et al., 2006; Wagemans A et al., 2010)

Mild to moderate ID patients want to participate. They can also understand the information related to treatment, communicate their opinion regarding how end-of-life care was delivered, and take treatment decisions, but the capacity fades with increasing complexity in the care decisions. (Cea CD, Fisher CB 2003; Bekkema N et al., 2016; Tuffrey-Wijne I et al., 2007)

The diagnosis of Intellectual Disabilityis essentially amorphous because, like all diagnoses based on behavior instead of biological markers; it entails the assessment or application of psychological concepts that are approximate estimations of thoughts instead of physical characteristics, as are all concepts. Applying diagnostic criteria which one has to be quite deliberately arbitrary, follows there vague, multitier approach. The terms have also evolved to describe these individuals in accordance with society values and scientific discoveries that have been made over the years. The terms of these individuals, many that we would now find specifically offensive, include intellectually impaired, mentally retarded, feeble-minded, idiot, imbecile, moron, and developmentally disabled. (Loth & Evans 2019; Schalock et al. 2007, 2010; Stainton 2001)

More than one thousand different etiologies provide estimates, showing variability between genetically and phenotypically alike individuals with intellectual disability. Intellectual Disabilitiyis the characteristic that distinguishes the etiological category from Ireland "idiocy by deprivation", down "developmental," to more recently: familial. It is a result of the combination of the many varied aspects of the environment, as well as the polygenic transmission of intelligence-related factors, as predicted by Down and Ireland. It refers to a group of individuals whose cognitive abilities are inherently on the lowest point of the normal IQ score Gaussian curve. (Hodapp & Burack 2006; Broman et al. 1987, Iarocci & Petrill 2012, Shulman et al. 2011; Zigler 1967, 1969; Zigler & Hodapp 1986)

There means that intellectual disability has different presentations and definitions of conceptual ideas of intelligence and adaptive behaviors because etiological groups exhibit extreme variability. Because intelligence and adaptive behavior consist of many parts and subparts that may function in different iys relative to one another, Intellectual Disability, whose phenotype is so varied and whose causes are so diverse, should have an almost infinite variety of phenotypic manifestations. In reality, almost every one of the many different syndromes and disorders associated with intellectual disability manifest unique configurations of relative strength and weaknesses in cognitive functions, as measured even with standardized intelligence tests and measures of educational achievement. (Burack 1990; Cornish & Wilding 2010; Dykens et al. 2000; Russo et al. 2012)

Across the range of conditions and syndromes associated with intellectual disability, adaptive behavior often emerges in many different forms across the lifespan. The strongly differentiated group profiles indicate that the etiologic factors associated with intellectual disability result in profound and complex developmental influences, processes, and consequences that are far-reaching beyond the obvious differences in levels of functioning. Such differences are also more profound than those found within any given population (Burack et al. 2016; Esbensen et al. 2012, and Hauser-Cram et al. 2012

The idea that exists is a "mirage" because there is supposedly a single, significant population of people with intellectual disabilities, considering the widespread group variations that exist among the people with Intellectual Disability about almost every aspect of life and functioning. Traditionally accepted ideas of intellectual disability that generally allow for better agreement across the different etiologic groupings and that form a framework of one entity and population have to be torn down from both research and therapeutic practice viewpoints, (Burack et al. 2012; Burack et al. 1988, 2016; Hodapp 2021; Bertelli et al. 2018, Hodapp&Dykens 2012; SalvadorCarulla&Bertelli 2008; Salvador-Carulla et al. 2011)”

Those with intellectual disability falling into that category are also divided in terms of the severity and diversity dependent upon etiology. The ICD-11 will, for the first time

ever, explicitly acknowledge that level of adaptive behaviors and, being at least two SDs below the average intelligence quotient are only two common manifestations shared by "a group of etiologically diverse conditions" within the DID category. Since the previous edition (ICD-10), which classified Intellectual Disability as a condition of "arrested or incomplete development of the mind," there has been a considerable advancement in nuance and specificity. (WHO 2018, section 6A00; WHO 1992, p. 226)

In there protocol, the term "intellectual disability" (ID) represents an individual's reduced capacity to understand new or abstract information and to acquire and to employ new skills, in essence, beginning before birth in the eighteenth year of birth; that is, before the age of an adult. The combination of a host of environmental factors affecting interaction with Intellectual Disability creates conditions that require lifelong support/care. (World Health Organisation 2017)

For almost thirty years, deinstitutionalisation of “care—the aim to transfer individuals with ID to community-based care settings—has been a top policy objective in nations including Australia, United Kingdom, United States, and Scandinavian countries. They are being progressively transferred from institutional care to community settings in several of these nations.(Beadle-Brown J et al., 2007; Overmars-Marx Tet al.2014; Mansell J 2016)

It requires coordinated efforts so that people with Intellectual Disability are included in community procedures, and members of those communities recognize and view Intellectual Disability individuals as their own community members. If all potential resources, such as technology, are not utilized for enhancing community living for persons with Intellectual Disability, there is the threat of "redistributing" isolation in institutions into the community, rather than achieving true social inclusion in the greater society. Without the application of technology promoting accessibility, connectiveness, and community inclusion, community services may not be readily accessible to those with intellectual disabilities as to those individuals who do not have such disabilities. There may lead to dependency on care provided in the devolved institutions and loneliness. (Linehan C et al., 2014 ;Bigby C, Ozanne E 2001)

The Convention emphasizes its Article 19 that, people with disabilities are equal to be part of their community, while also equal to required necessary assistance to facilitate access, inclusion. The sustainable developments, the current world plan for development requires not everyone is left behind; people should be included-in every respect, even persons in intellectual disabilities. Since persons with intellectual disability are one of the most excluded groups by society, they form the basis of there review. (O'Doherty S, Linehan C, Tatlow-Golden M, et al. 2016; Sustainable Development 2015; World Health Organization2014-21).

An intellectual disabilityis considered a neurodevelopmental disaorderthat manifests across the formative period and interferes with both adaptive abilities, such as communication & independent living, and intellectual skills, including abstractive thinking, language & memory. Studies about the incidence of diseases involving childhood disabilities vary. It falls within the 5%–10% range. Although most of these diseases recover, 1% of people are afflicted with the disease. (Vasudevan P, Suri M. 2017)

Clinical reports and sensory testing found that, based on the type and extent of their disability, those with ID reacted differently to pain compared to corresponding groups of controls. In addition, a range of imaging methods, endocrine responses and potentials generated by the brain that have been recorded in the course of aversive experiences showed that those with intellectual disabilities had greater responses in comparison with controls. (Aguilar Cordero MJ, Mur Villar N, Garcı´a GI 2015)

There makes it harder for intellectually impaired people to see and verbalize pain because it is a very complex, subjective experience especially in regards to the complexity of pain. Thus, the suffering inflicted by an ID is commonly misinterpreted and under-managed. (Defrin R, McGuire BE 2021)

Intellectual disabilities are problems with overall mental abilities that impact intellectual function (learning and thinking) and adaptive function (day-to-day living skills that encompass communication and independent living). Disorders that lead to impairments in children vary between 5% and 10%. Although most of these illnesses

improve and only 1% of individuals continue to suffer from it, there are between 0.4% and 1.3% of children who are regarded to have significant intellectual and cognitive impairments. (Vasudevan P, Suri M. 2017; Defrin R, McGuire BE 2021; Petigas L, Newman CJ.2021)

An intellectual impairment diagnosis can be validated by the following three factors: First, cognitive deficits in reasoning, planning, problem solving, abstract cognition, judgment, academic learning, and experience-based learning as identified by medical assessment and standardized IQ tests. The second category consistsof deficiencies in adaptive functioning that do not meet social and developmental norms on personal autonomy and social responsibility. It is challenging to perform a range of daily activities, such as social contact, communication, and independent living in a variety of contexts, such as the community, workplace, school, and home, without ongoing assistance due to adaptation deficits. Third, intellectual and adaptive impairments initially manifest during the formative stage. (American Psychiatric Association 2013)"

2.5. LITERATURE RELATED TO COGNITIBE BEHAVIOUR THERAPY (CBT)

The type of psychotherapy that is perhaps most extensively researched in the literature is cognitive-behavioural therapy. In the eight-year span of time between 1986 and 1993 alone, over 120 controlled clinical trials were published (Hollon & Beck, 1994), and since then, there continues unabated (Dobson, 2001). As of now, well over 325 published studies have reported on outcomes following cognitive-behavioraltherapy. There expansion is partly attributable to CBT's continuous adaption for a greater variety of issues and disorders (Beck, 1997; Salkovskis, 1996). However, there are still a lot of unanswered issues about the general efficacy of cognitive behavioural therapy (CBT), its efficiency varies depending on the problem, the type of control groups used to demonstrate its efficacy, and how long its effects last after treatment ends.

Behaviour issues are known to raise parenting stress, and children with intellectual disabilities are more likely to experience them. This study investigated the moderating effect of dispositional optimism as well as the association between behaviour issues and

more general elements of parental well-being, including depression and marital adjustment. 214 families were involved in the study, and the children who participated were classified as non-delayed, borderline, or developmentally delayed. When the children were three and four years old, the well-being of the mothers and dads as well as any behavioural issues were evaluated. The findings indicated that while there were no significant differences in depression or marital adjustment between parents of pre-schoolers who were delayed and those who were not, there was a strong correlation between these well-being indicators and behavioural issues in children. Interestingly, optimism largely mitigated these correlations for mothers: women with lower optimism reported significantly worse well-being than mothers with higher optimism when behaviour problems were high. In order to improve psychological well-being in the preschool years, the authors propose that interventions should promote parents' positive belief systems, especially dispositional optimism, in addition to focussing on behaviour management for kids. Baker, Blacher & Olsson (2005)

Cognitive behavioural treatment, or CBT, “has been increasingly popular in psychiatry in recent years. The growing application of CBT to severe instances of schizophrenia, major depressive disorder, and bipolar disaorders especially noteworthy. This is because, until recently, biological medicines were the most common solution to these issues. Accordingly, official UK treatment guidelines from the National Institute for Clinical Excellence (NICE) also state that psychological interventions are essential and that cognitive behavioural therapy (CBT) should be made available to all patients, even though contemporary explanations of schizophrenia place a strong emphasis on biological factors in its etiology and view narcoleptic medications as the cornerstone of treatment. (Picchioni MM, Murray RM 2007; NICE 2003; NICE 2009)”

Medication has once again been the cornerstone of treatment in the literature, especially for bipolar disorder, even though major affective illness may include more psychological components to its aetiology. A government initiative in the UK is providing cognitive behavioural therapy (CBT) for depression and anxiety in 250 designated treatment facilities; however attitudes may be changing elsewhere as well.

CBT is advised for reducing relapses in bipolar disease.(NICE, 2004; Layard, 2006; Scott & Colom, 2005; Basco& Rush, 2007)

The developmental paths of difficult behaviour in children with intellectual disability and its long-term effects on parental stress were studied by Totsika and Hastings (2009). Their results showed that although difficult behaviours continued, parenting stress actually decreased during adolescence, perhaps as a result of parental adjustment and a decrease in the intensity of the behaviour. Crucially, the study emphasises that behavioural issues, rather than the existence or severity of the child's impairment, are the primary cause of rising parenting stress.

Research on brief psychotherapeutic therapies conducted by The National Institute of Mental Health (NIMH) found very little evidence for interpersonal psychotherapy's effectiveness and no evidence for cognitive therapy's. In a recent large-scale investigation to avoid relapses in bipolar disease, cognitive behavioural therapy (CBT) did not appear to be any more beneficial than treatment as usual (TAU).Meta analysisseems to be the main source of the perceived effectiveness of cognitive therapy in all three illnesses, since it has been demonstrated to be beneficial for patients with mild to severe depression and to have benefits that are stronger than those of antidepressants. For example: "The positive results... can therefore be taken as confirming the promise of cognitive behavioural treatment in schizophrenia." A conclusion has been reached. And "it is likely to be clinically and financially effective to use psychological therapies as a supplement to medication [in bipolar disorder]." (Elkin et al. 1989; Scott et al. 2006; Pilling et al. 2002; Gloaguen et al. 1998; Scott et al. 2007)

Cognitive behaviour therapy (CBT) method holds that dysfunctional beliefs are the root cause of emotional pain and maladaptive behaviours, and that these beliefs may be changed to reduce emotional distress. Cognitive behavioral therapy is a form of brief individual or group therapy. Cognitive restructuring techniques and the exposure rationale are introduced at the start of treatment. In particular, Patients practice recognizing maladaptive cognitions (automatic thoughts), analyzing logical fallacies,

analyzing the connection between anxiety and automatic thoughts, and developing logical arguments against their automatic thinking. Exposure to anxiety-inducing situations also teaches patients how to identify and eliminate avoidance behaviours. Patients are then exposed to increasingly difficult and terrifying situations while employing cognitive restructuring techniques and eliminating any form of escape strategy. Studies on behaviour are employed to address specific exposure-related responses(Hofmann et.al 2011).

It has also seen that CBT helps individuals with PTSD, OCD, SAnD, PD, and SPH experience less severe anxiety symptoms. Due to their proven effectiveness, many pharmacologic agents, including Selective Serotonin Reuptake Inhibitors (SSRIs) and Noradrenergic and Serotonin Selective Reuptake Inhibitors (SNRIs), are recommended by experts as first- line treatments for anxiety disorders. (Baldwin 2011; Bandelow 2008; CPA 2006; NICE 2011)

Even though many people with anxiety disorders may not respond well to first-line therapy, despite the fact that there are effective pharmacological, behavioural, and cognitive therapies for these conditions. Treatment failure rates are expected to be 20% to 40% for PD and 40% to 60% for OCD. Even if there is a risk of dependence while using some medications (benzodiazepines, for instance), treatment effectiveness may be limited by patient noncompliance. (Pallanti 2002; Bandelow 2004; Shader 1993)

Multimodal therapy plans that combine medicine with behavioural and cognitive therapies may maximise therapeutic response. However, clinical trials employing there approach have produced inconsistent results. Evidence of a better response to combination treatment observed in some trials may be undermined by higher rates of recurrence following drug discontinuation. Overall, it has not been demonstrated that combination medicines are more successful than monotherapies. (Black 2006; Furukai 2006; Mitte 2005; Barlow 2000; Marks 1993; Hofmann 2009)

According to Beck's cognitive theory, Patients who suffer from anxiety and depression frequently think negatively and absorb information in a biased iy. The main objective of cognitive behavioural therapy (CBT) is to change unhelpful thought and behaviour

patterns in order to stop the recurrence of feelings of anxiety or depression. Most research on cognitive behavioural therapy's efficacy has been carried out in specialised mental health facilities. In treating mild to moderate depression and anxiety disorders, study shows that cognitive- behavioral therapy (CBT) is just as effective as medication. It also has reduced recurrence rates and offers long-term treatment advantages. (John Wiley and Sons, 1999; Beck JS. Cognitive Therapy 1995; Churchill R et al. 2001; Butler AC et al., 2006; Taylor S. 1996; Barlow DH et al., 2000)

The lack of certified therapists in both general care and speciality mental health facilities hinders access to cognitive behavioural therapy (CBT), despite the treatment's compelling evidence. Furthermore, research indicates that cognitive bibliotherapy, which utilises textual materials, computer/Internet-based programs, and recorded audio and video, can considerably reduce the symptoms of sadness and anxiety. In some cases, self-help shows similar efficacy to short-term in-person therapy. The use of self-help is limited to self-administering or as part of minimum contact treatment, which includes a therapist's active involvement, albeit to a lesser extent than in traditional therapy. (McKendree-Smith NL et al., 2003; Gregory RJ et al., 2004; Den Boer P et al., 2004; van't Hof E et al., 2009; Barak A et al., 2008)

When sub threshold illnesses are taken into consideration, psychological issuesmay make up as much as 30% of primary care consultations. Most patients with psychological issueswill get the majority of their mental health care in primary care. Results indicate that most people would rather see their general practitioner (GP) for treatment rather than take medication. Compared to professional mental health care, consulting a general practitioner (GP) has the advantages of being more accessible, less expensive, and less stigmatizing. (Wittchen HU, Jacobi F 2005; Ing PS et al., 2000; Martin-Merino E et al., 2009; Young AS et al., 2001; Priest RG et al., 1996; Angermeyer MC, Matschinger H 1996; Jorm AF 2000; Keks NA et al., 1997)

It has been demonstrated that cognitive behavioral therapy (CBT), an alternative to medication, is an effective means of treating mental illness by altering a patient's thought process and behavior. CBT activates the brain's anterior cingulated and orbital

frontal cortex, which are involved in emotion control. (Vittengl JR et al. 2016; Carpenter JK et al., 2018; Goldapple K et al., 2004)

There is no proof that CBT intervention used in the research is the cause of withdrail, and no significant adverse effects associated with CBT were documented in any of the included trials. Patients with Parkinson's disease have shown improvements in their symptoms when frequent sessions of cognitive behavioral therapy (CBT) are administered. Customized therapies like concern management, good sleep habits, thought monitoring and restructuring, and relaxation training are all included in cognitive behavioral therapy (CBT). (Dobkin RD, et al. 2011)

Using two case series and four uncontrolled trials, Koychev and Okai conducted a clinical study to assess three mental manifestations. They documented the wide-ranging benefits of cognitive behavioral therapy on Parkinson's disease's non-motor symptoms. Because of the barriers that keep patients from accessing psychotherapies like CBT, such as a lack of trained clinicians and a fear of stigma, clinicians who have used the original version of CBT have encountered some difficulties. (Koychev I, Okai D. 2017; Titov N. 2011; Mohr DC et al., 2006)

According to a study, cognitive behavioral therapy (CBT) is superior to any single-component treatment for primary insomnia. It can also reduce the need for sleep aids and improve sleep efficacy, sleep onset latency, and ikefulness following sleep start. As the most popular and well recognized non-pharmacological treatment for insomnia, cognitive behavioral therapy (CBT-I) focuses on connections, habits, and thoughts that interfere with sleep. (Ing MY et al., 2005; Lund HG et al., 2012)

Cognitive behavioral interventions (CBT-I) encompass a range of strategies, such as providing instruction on sleep hygiene and relaxation methods, scheduling sleep, establishing robust sleep patterns, and utilizing cognitive procedures to modify psychological attitudes toirds sleep. Additionally addressed are stimulus control, addressing false ideas about sleep, and sleep restriction (reducing the amount of time spent aike in bed). CBT-I has been used to help people with a variety of disorders,

including moderate-to-severe chronic pain, sleep better. (Morin CM, Espie CA. 2003; Fucito LM et al., 2014; Jungquist CR et al. 2012)

For those with chronic pain, CBT-I has also lessened the degree to which pain interfered with day-to-day functioning. Over time, a variation of CBT-I together with teaching on good sleep hygiene has been shown to enhance sleep and reduce cognitive arousal. (Jungquist CR et al 2010; Gellis LA et al., 2013)

Compared to pharmaceutical sleep aids, which frequently cause adverse effects and are only advised for short-term use, cognitive behavioral therapy (CBT-I) for insomnia may be more beneficial in the long run. Beyond just treating insomnia, CBT-I may also help with non-sleep-related problems including general wellbeing and the intensity of depression symptoms. Overall, mind-body techniques including tai chi, yoga, relaxation, music therapy, and cognitive behavioral therapy (CBT) can enhance the quality of sleep and lessen the need for hypnotic medications. (Sivertsen Bet al. 2006; Jacobs GD et al., 2004; Manber R et al., 2011; Kozasa EH et al. 2010)

The most effective treatment for people with anxiety problems is cognitive behavioral therapy (CBT), as its effectiveness has been well studied. Despite its efficacy, CBT may have disadvantages, such as being unfeasible, causing undue anguish for patients, or being isteful in terms of both time and money. There are a number of benefits to using virtual reality exposure-based cognitive behavioral therapy (VRE-CBT) as an alternative to traditional CBT. It provides for immersion in a terrifying virtual world customized for each patient in a practical and secure healthcare setting. (Olatunji BO et al., 2010; Carpenter JK et al., 2018; Maples-Keller JL et al., 2017)

There are a number of benefits of virtual reality exposure-based cognitive behavioral treatment (VRE-CBT) over traditional CBT. It gives patients the chance to completely lose themselves in a personalized, safe virtual environment inside a practical and secure therapeutic environment. By having total control over the type and quantity of feared stimuli, the therapist using VRE-CBT may maximize each patient's pace throughout exposures. Furthermore, the complicated processes that underlie the effectiveness of exposure treatment are facilitated by the fact that each phase of VRE-CBT can be

repeated as many times as necessary before moving on to the next dreaded scenario. VRE-CBT and CBT attrition rates don't appear to be different. (Benbow AA, Anderson PL. 2019)

Numerous research on the effectiveness of VRE-CBT for anxiety disorders have been done recently, and the findings have been encouraging. There are already five published meta-analyses comparing the effectiveness of VRE-CBT to control conditions; these studies mostly focus on certain phobias. They repeatedly demonstrate that VRE-CBT is clearly superior to non active control groups (iitlists), and that the effects of VRE-CBT are comparable to or greater than those of CBT conditions that include in vivo exposure. (Opriş D et al., 2012; Morina N et al., 2015; Powers M, Emmelkamp PM. 2008; Carl E et al. 2019; Fodor LA et al.,. 2018)

According to the cognitive model, “our thoughts and actions have an impact on our mental and physical health, which in turn affects our overall quality of life. Bidirectional interactions are thought to exist between thoughts, behaviors, emotions, and bodily reactions. In order to enhance patients' psychological and physical results, the goal of cognitive behavioral therapy (CBT), an interpersonal treatment, is to identify and deal with dysfunctional thoughts and behaviors. It also aims to help patients create new thought and behavior patterns. Although CBT contains a basic set of skills that are trans diagnostically applicable, it has been altered for usage with specific populations, such CBT insomnia.”(GrazebrookKaG A. 2005; Mansell W.2008)

Cognitive behavioral therapy (CBT) is a “talking treatment that aims to help patients get better psychological and physical results by helping them recognize and challenge maladaptive beliefs and actions. It also tries to help patients create new thought and behavior patterns. Although CBT contains a basic set of skills that are applicable trans diagnostically, it has been altered for usage with specific populations, like individuals suffering from CBT insomnia. The majority of CBT is conducted in compliance with procedural manuals specific to the health problem. A distinction between high and low intensity CBT is included in the list of core competencies for CBT that Roth and Pilling developed on behalf of the Department of Health. Formal cognitive behavioral therapy

(CBT) delivered mostly in-person by a medical professional trained in CBT is defined as high intensity. (Roth A, Pilling S. 2007)

Randomized controlled trials "(RCTs), which have been compiled into systematic reviews covering a wide range of medical and psychological issues, from schizophrenia to mild back pain, have been used to evaluate cognitive behavioral therapy's effectiveness. (Lockwood C et al. 2015)"

Studies conducted and concluded the "effectiveness of CBT on stress and parental stress.One of the most popular methods for managing workplace stress is cognitive-behavioral therapy (CBT), which has been demonstrated to be effective as a main preventive measure. It has been demonstrated that CBT, as a stress management strategy, considerably reduces occupational stress, anxiety, and depression for employees in the workplace, per a meta-review15 and other meta-analyses. (Joyce S et al. 2016; van der Klink JJet al. 2001; . Richardson KM, Rothstein HR. 2008)

According to a Cochrane study, CBT stress management therapies significantly improved stress-related outcomes for nurses, such as depression symptoms and work-related stress (standardized mean difference (SMD) = -0.34 at the 6-month follow-up). As a result, research on CBT-based stress treatment for nurses has grown. (Ruotsalainen JH et al. 2015)"

In recent years, in addition to traditional face-to-face CBT implementations, a variety of interim approaches and formats have been created for CBT. For instance, research assessing the efficacy and social applications of internet-based cognitive behavioral therapy (ICBT), in which CBT is delivered via an online platform, are receiving a lot of interest. Nevertheless, research on nurse stress management up to 2013 were included in the Cochrane review, which excluded more recent approaches such integrated cognitive behavioral therapy. (Ruotsalainen JH et al. 2015)

Behavioral activation, acceptance and commitment treatment, cognitive restructuring, and novel is to problem solving with the goal of rational cognition and/or conduct under stressful situations are all features of cognitive behavioral therapy (CBT). There will be

comparisons between the following groups of patients: no intervention, iiting-list control, therapy as usual (which includes education or training from the nursing association but excludes CBT), or alternative therapies that do not involve CBT. Stress in the workplace has a detrimental effect on mental well-being outcomes such as depression, anxiety and burnout. (Hofmann SG et al., 2010; Beck AT, Dozois DJA. 2011; McVicar A. 2003)

Cognitive Behavioral Therapy is a form of psychotherapy that helps the individual to identify and alter negative or distressing thought patterns that might affect their emotions and behavior. In some individuals, stress might result in feelings of helplessness and low mood, which might make it difficult to handle the problems at hand. CBT helps to enhance rational, balanced thinking that would improve an individual's ability to manage stress effectively.

CBT originated from applying learning theory principles, including operant and classical conditioning, to therapeutic settings. The first-ive behavioral therapies emerged in the 1950s (Hofmann SG et al., 2012; Blackwell SE, Heidenreich T, 2021). Aaron Beck, drawing on the work of Albert Ellis, used cognitive therapy to treat depression, while Ellis developed Rational Emotive Therapy (RET) in the U.S. to help individuals challenge irrational beliefs in response to negative experiences. By the 1960s, cognitive and behavioral approaches were integrated both conceptually and therapeutically, which led to the development of second-ive CBT (Beck AT, 1991; Soler AF et al., 2018).

In psychosomatic medicine, a variety of CBT techniques have been effective in the treatment of anxiety-related conditions. These include exposure therapy, which is particularly helpful for disorders like agoraphobia and panic disorder, and cognitive restructuring, which can improve psychosomatic symptoms. Mindfulness practices have also been shown to alleviate stress-related pain in conditions like fibromyalgia (Hellman CJ et al., 1990; Wendt J et al., 2018; Schmidt S et al., 2011).

The National Institute for Health and Care Excellence (NICE) provides recommendations for the following psychosocial interventions: CBT, to support carers

of people with dementia. Other interventions include: training programs, family counseling, telephone or online therapy, peer support groups, psychoeducation. However, there is a recommendation against any pharmaceutical intervention in the alleviation of psychological or emotional burden that dementia carers experience (NICE, 2012).

A fundamental component of CBT is the exploration “of a patient's automatic thoughts and underlying beliefs, which serve as the basis for cognitive schemas—mental frameworks that organize and interpret information. The ABC model allows patients to identify activating events (A), beliefs (B), and the consequences (C) that result from their thoughts and behaviors. CBT assists individuals in reframing their thoughts and developing healthier cognitive patterns (Curwen et al., 2000; Clark & Fairburn, 199).

CBT has also been used to assess the psychological distressof infertile couples. There approach helps to identify and challenge maladaptive thinking and behaviors and replace them with more adaptive ones. CBT supports the development of problem-solving skills and emotional flexibility, enabling people to overcome personal problems (Boivin, 2003; Maleki-Saghooni et al., 2017; Cuijpers et al., 2013; Beck, 2011).

Reducing the symptoms of disorders such as stress, depression, anxiety, PTSD, chronic pain, panic disorder, social anxiety, and marital problems are the objectives of cognitive behavioral therapy. Techniques such as breathing exercises, physical activity, positive programming, negative opinion control, handling anger, and effective interaction and self-expression provide challenges for patients. (Lapp et al. 2010; Beck 2011; Butler et al. 2006)

The recommended treatment for insomnia is cognitive behavioral therapy since it produces a long-lasting improvement in both daytime and nighttime symptoms. In order to address the underlying psychological, behavioral, and physiological processes and variables that contribute to the persistence of insomnia condition, cognitive behavioral therapy (CBT) is often administered over the course of six to eight sessions. Numerous research have looked at how depression symptoms and sleeplessness interact during cognitive behavioral therapy. While several studies demonstrate that cognitive

behavioral therapy (CBT) improves depressed and negative emotional symptoms, other research indicates that the efficacy of CBT in treating insomnia symptoms may be diminished by co-occurring psychiatric disorders and feelings of stress, anxiety, and sadness. (Qaseem A et al., 2016; Ree M et al., 2017; Harvey AG 2002; Bootzin RR 1972; Spielman AJ et al., 1987; Bonnet MH, Arand DL 1997; Gebara MA et al., 2018; Gebara MA et al.,2015; Wu JQ et al., 2015; Geiger-Brown JM et al., 2015; van de Laar M et al., 2015; Gagne A, Morin CM 2001; Belleville G, Morin CM 2008; Morgan K et al., 2003; Staner L 2010; Cunningham JE, Shapiro CM, 2018)

Given that cognitive behavioral therapy (CBT) involves a number of components that should be used over several weeks in a row, it is plausible that there difference in motivation and support will also result in higher adherence to therapy and, consequently, greater efficacy of CBT among participants in highly controlled clinical trials as opposed to patients in "real-world" clinical settings. Furthermore, rather than looking at improvements over longer follow-up periods, Most studies that have looked at how psychological symptoms affect CBT's effectiveness have concentrated on changes that take place after therapy. (Manber R et al., 2011; Matthews EE et al., 2013; Kyle SD et al., 2014; Sweetman A et al., 2020)”

In order to reduce psychological discomfort, a collection of empirically established therapies known as cognitive behavioral therapy (CBT) seek to actively alter maladaptive thought and behavior patterns. Cognitive theories of anxiety disorders explicitly suggest that pathological anxiety is fundamentally based on an overestimated perception of threat. Therefore, CBT therapies for anxiety share a focus on changing maladaptive beliefs about the probability and actual cost of anticipated harms through the use of various behavioral (like exposure) and cognitive (like cognitive restructuring) strategies. (Hofmann et al., 2013; Beck & Haigh, 2014; Clark & Beck, 2010; Hofmann, 2008; Smits et al., 2012)

The theory behind cognitive behavior therapy (CBT) is that dysfunctional thinking is the primary cause of all mental health problems. The goal of CBT is to alter behavioral patterns as well as ideas, beliefs, and perceptions. One popular psychotherapy method in cognitive behavioral therapy (CBT) for recognizing, assessing, and altering

unfavorable, skewed ideas and beliefs is cognitive restructuring. Cognitive restructuring is a helpful approach for understanding false automatic beliefs and for helping people reframes their distorted thinking or negative perception in a more positive iy. (Beck J,2011; Beck AT, Haigh EA, 2014; Hope DA et al., 2007)

Despite CBT's well-established effectiveness in treating and preventing psychiatric problems, there are aliys obstacles that need to be overcome. These obstacles can include a lack of qualified therapists, stigma, living in a distant area, lengthy iit periods, and expensive fees. Because CBT provides organized material, it has been proposed that it is appropriate for remote delivery. The field of Internet-based psychiatric intervention has come a long iy in the last fifteen years, especially considering how quickly Internet technologies are developing throughout the world. Internet-based CBT (iCBT) is a novel administration that has been created to reduce treatment obstacles and improve care accessibility. (Hofmann SG et al., 2012; Paulson JF, Bazemore SD, 2010; Rooksby M et al., 2015; Andersson G, 2016; Olthuis JV et al., 2015)

Comparing the effectiveness of CBT with therapist support for anxiety and psychiatric and somatic disorders to in-person CBT, recent systematic studies have found a similar level of effectiveness. Higher levels of human support in the form of therapist-supported therapies have been shown to enhance depression results, but not stress or anxiety outcomes. The effectiveness and compliance of an Internet-based intervention that provides instant feedback have been found to be similar to those of an intervention that involves personal support. Some potential benefits of therapist-supported iCBT include customization, cost and time effectiveness, geographic flexibility, consistency, high availability, and rapid distribution. (Andersson G et al., 2014; Kuester A et al., 2016; Kelders SM et al., 2015; Hedman E et al., 2016; Musiat P, Tarrier N., 2014)

Because of changes in the physical, family, financial, vocational, and other domains, women find the postpartum period to be quite stressful. A woman may experience stress, anxiety, and depressed symptoms as a result of changes that impact her physical and psychosocial resources. Based on documented prevalence rates, 14.3% of women report feeling stressed out overall during the postpartum phase, 1% to 30% report having symptoms of PTSD, 24.9% report feeling anxious, and 13% to 19% report

having depressive symptoms. Furthermore, research suggests that during the postpartum phase, stress, anxiety, and depression symptoms interact. During the postpartum phase, prompt and effective care is crucial, particularly in light of the detrimental short- and long-term effects on mother health and the development of the child. There is substantial evidence to suggest that CBT is beneficial for both prevention and therapy in the postpartum phase. (Agius A et al., 2016; Clout D, Brown R., 2016; Grekin R, O'Hara MW, 2014; Osma J et al, 2016; O'Hara MW, McCabe JE, 2013; Sanger C et al, 2015; Grace SL et al, 2003; de Camps MD et al, 2016; Sockol LE, 2015)

Woodman AC et al., (2015) Psychological stress is more common among parents of children with developmental disabilities (DD) than among other parents. It has been discoveredthat children's high levels of both internalizing and externalizing issuesare a contributing factor to their heightened stress levels. However, the opposite direction of impacts in families with a child with a DD has not been well studied. The current study looked at the transactional relationships between maternal stress and behavioralissuesin 176 households with children who had been diagnosed with DD at an early age. Throughout the 15-year study period, which covered early childhood (age 3) to adolescence (age 18), there is evidence of both parent-driven and child-driven impacts, which is in line with transactional models of development. It is discoveredthat parent-child interactions varied depending on the stage of life and the behavioral area.

According to Melissa Crawford et al. (2011), their cross-sectional study looked at how anxiety and social functioning might interact to predict peer victimization. A structural equation model that connects victimization to anxiety, social skills, and relationship quality is examined separately for each group to see if the processes involved in victimization are different for kids with anxiety disorders and typical comparison kids. Participants were between the ages of 8 and 14; 55 (34 boys, 21 girls) had been diagnosed with an anxiety illness, while 85 (37 boys, 48 girls) were normal comparison children. The final models for both groups identified two different pathiys to victimization: (a) victimization is independently predicted by anxiety, and (b) low social skills predicted lower friendship quality, which in turn put a child at risk for victimization. These results have significant ramifications on how children are treated.

Hastings RP, (2002) depicted that models describing how children's problem behaviors arise and persist, as well as parental stress linked to child traits, are the two study areas in the field of developmental disorders that are included in there work. I offer a straightforird model that links parenting style, parental stress, and behavioralissuesin kids. A key component of there model—that parental stress is caused by behavioralissuesin children—has evidence, but other parts have not yet been investigated in the field of developmental disabilities. The model's future development is examined, with a focus on how parental evaluation procedures might help us comprehend how issueswith child behavior impact the wellbeing of parents. Lastly, the applications of combining studies on behavioralissuesin kids and stress in parents are need of hour.

The somatization of adolescents, parenting stress, and three parenting dimensions—irmth, psychological control, and harsh punishment—as well as their direct and indirect correlations, were all investigated in this study, according to Rousseau, S. et al. (2013). Initially, a cross-sectional analysis of the associations is conducted. Second, to determine temporality, important cross-sectional relationships were further investigated longitudinally. A total of 1499 teenagers consented to participate, together with one of their parents, usually the mother. At the ages of 12–13 (T1), 13–14 (T2), and 14–15 (T3), the children were given questionnaires. Teenagers talked about their somatization, and parents talked about their stress and parenting style.Indirect connections between all aspects of parenting and the somatization of teenagers were discoveredcross-sectionally through parenting stress. Two important features emerged from the longitudinal analysis. First, somatization is significantly predicted by parenting stress. Higher T2 and T3 somatization is predicted by higher T1 parenting stress. Higher T2 parenting stress, or more specifically, higher parenting stress at T2, is predictive of decreased T3 somatization when T1 parenting stress is taken into account. Second, it is discoveredthat parenting actions were significantly predicted by parenting stress. While higher parenting stress at T2 is associated with less harsh punishment a year later, higher parenting stress at T1 is associated with more severe punishment at T2 and T3. Higher T2 psychological control is strongly predicted by higher T1 parental stress.The development of somatization in early adolescence may be at risk due to parenting stress,

which clinicians should be aire of. On the other hand, more parenting stress may be protective in later adolescence.

Psychological resilience refers to maintaining or regaining psychological well-being after experiencing adversity, trauma, or stress. There is evidence suggesting that cognitive behavioral therapy (CBT) can significantly enhance an individual's coping skills. However, the overall effectiveness of CBT on resilience among cancer patients remains unclear. Therefore, this study systematically evaluated the impact of CBT on resilience among cancer patients. Xiang, L., Wan, H., & Zhu, Y. (2025).

Cognitive Behavioral Therapy (CBT)–based stress management interventions have been increasingly recognized for their effectiveness in supporting employees on sick leave due to work-related stress. These interventions focus on modifying maladaptive thoughts, enhancing coping skills, and improving stress regulation, which are critical for occupational functioning and return-to-work (RTW) outcomes.

Recent evidence indicates that employees receiving CBT-based stress management show reduced total sick leave duration and earlier sustainable RTW compared to those who do not receive such interventions. The 2025 cohort study published in the Journal of Occupational Rehabilitation demonstrated a significant reduction in cumulative sick leave weeks and a higher likelihood of sustainable RTW among intervention participants, highlighting the occupational benefits of CBT beyond symptom reduction.

These findings are consistent with earlier systematic reviews and randomized controlled trials, which report that CBT and work-focused CBT interventions contribute to shorter sick leave periods and improved work participation among employees experiencing work stress. Although some variability exists across studies due to methodological differences, the overall literature supports CBT-based stress management as an effective approach in occupational rehabilitation. Bond et al., (2025)

Cognitive Behavioral Therapy (CBT) has been shown to be effective in reducing occupational stress among educational workers. A randomized controlled trial conducted with administrative, language, science, and vocational staff from open and

distance learning centers in Southeast Nigeria found that a 12-week CBT intervention significantly improved participants' ability to manage work-related stress compared to a non-intervention group, demonstrating CBT's applicability beyond clinical settings into occupational stress contexts.

This evidence supports broader literature indicating CBT's role in enhancing stress coping, emotional regulation, and psychological well-being among employees, making it a valuable intervention for workplace stress management across diverse professional populations. Igwe et al. (2024).

2.6 RESEARCH GAP

Several studies have revealed that parents having children with intellectual disabilities experience high levels of stress and which affects their parenting. Research also revealed the relationship between parental stress levels and the degree of a child's intellectual disability, such as mild, moderate, and severe. However, no study has been conducted on whether Cognitive Behavioural Therapy (CBT) can help parents reduce the problem behaviors of children with intellectual disabilities by alleviating parental stress. Therefore, the aim of this study is to fill this gap by investigating the relationship between CBT, parental stress, and the behavioral development of children with intellectual disabilities.

2.7 RATIONALE OF THE STUDY

The study is designed to address gaps in intervention plans for children with intellectual disabilities. The need for this study arises from the importance of exploring the effect of parental stress on the behavioral development of children with intellectual disabilities. This will help us recognize the beneficial relationship between CBT, the parent's stress, and the behavioral development of these children. By doing so, rehabilitation specialists can create more effective intervention plans for children with intellectual disabilities by incorporating parental CBT interventions into the child's treatment.

Additionally, the study will assist rehabilitation experts in developing more effective intervention strategies that involve parents, thereby promoting faster recovery for children with intellectual disabilities.

The study will also assist rehabilitation experts in improving the overall well-being of families by incorporating parental Cognitive Behavioural Therapy plans into the child's intervention plan.

2.8 STATEMENT OF THE PROBLEM

Efficacy of CBT on parental stress and its effect on behavior development of the Intellectual Disabled children.

2.9 OBJECTIVES OF THE STUDY

2.9.1 To measure the level of stress among the parent.

2.9.2 To investigate the influence of cognitive behavioral therapy on the parental stress of Intellectual disabled children.

2.9.3 To examine the relationship between parental stress and behavior development of Intellectual disabled children.

2.9.4 To ascertain parental stress as a predictor of behavior development of Intellectually disabled children.

2.10 HYPOTHESES

2.10.1 There will be no significant difference in the stress levels of the parents before intervention.

2.10.2 CBT will significantly reduce the stress level of the parents.

2.10.3 There is significant relationship between parental stress and behavioural development of intellectual disabled children.

2.10.4 Parental stress will significantly predict behavioural development of intellectual disabled children.

CHAPTER 3
METHOD

To study the proposed study and to achieve the above-mentioned objective following methodology is adopted. It includes the research design, Variables, “description of population, sample size, development of tool, procedure of CBT intervention, procedure for data collection and the plan for data analysis. For this investigation, the sample size is 120, 60 parents in experimental group and 60 parents in controlled group and their 60 intellectual disabled children.

There were two parental groups. The experimental group consisted of 60 parents—30 mothers and 30 fathers (from 30 families)—and their 30 children with intellectual disabilities. Similarly, the control group consisted of 60 parents—30 mothers and 30 fathers (from 30 families)—and their 30 children with intellectual disabilities. The experimental group received Cognitive Behavioural Therapy (CBT) sessions, whereas the parents in the control group were not provided with CBT.

3.1 RESEARCH DESIGN

The present study employed an informal experimental design—pre-test/post-test control group—and included a retrospective analysis to gain a better understanding of the connection between children's behavioral development, parental stress and cognitive behavioural therapy. Data were collected through questionnaires and interviews.

3.2 SAMPLE

The population of the present study consisted of families of children with intellectual disabilities from the districts of Hoshiarpur and Jalandhar in the state of Punjab. The sample comprised children with moderate intellectual disabilities and their parents who were experiencing mental stress related to the child’s condition. The children ranged in age from 2 to 5 years, and the parents were between 30 and 45 years old. All mothers in the sample were non-working.

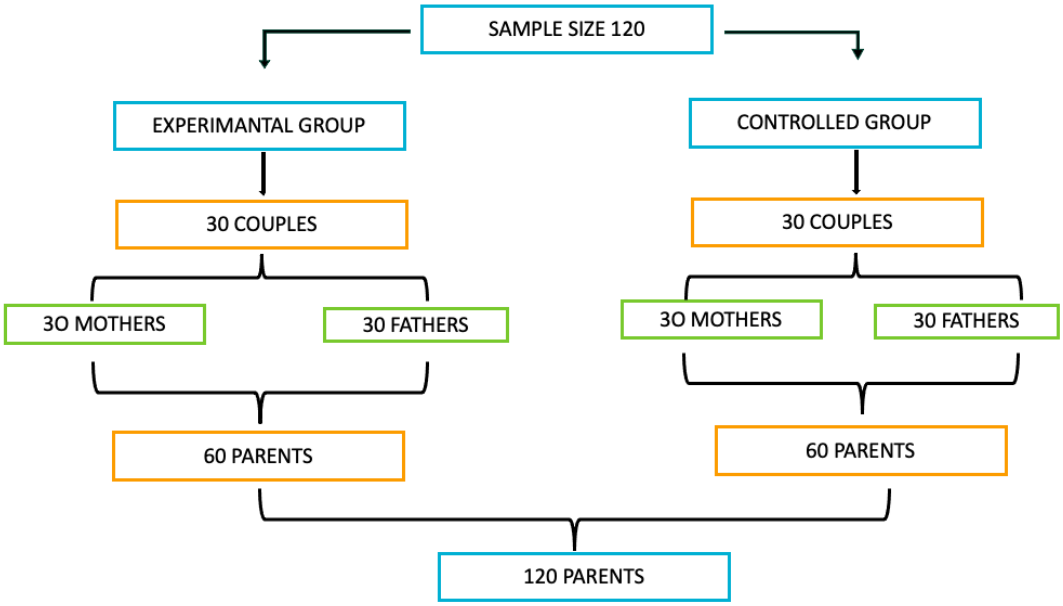
The Stress Scale and Behavioral Scale were administered to a total population of 168 families, each consisting of a couple and their child with an intellectual disability. Among these, 63 couples were from a Navchetna special school in Hoshiarpur, and 105 couples were from a Bright Horizon child development center in Jalandhar.

Out of the 168 families, 48 were excluded from the study due to the intellectual level of the children—these children were found to have either severe or mild intellectual disabilities. Additionally, 17 families were excluded based on the criterion of having a working mother. A further 38 families were excluded due to lack of consent to participate in the study, and 5 families discontinued participation during the intervention process.

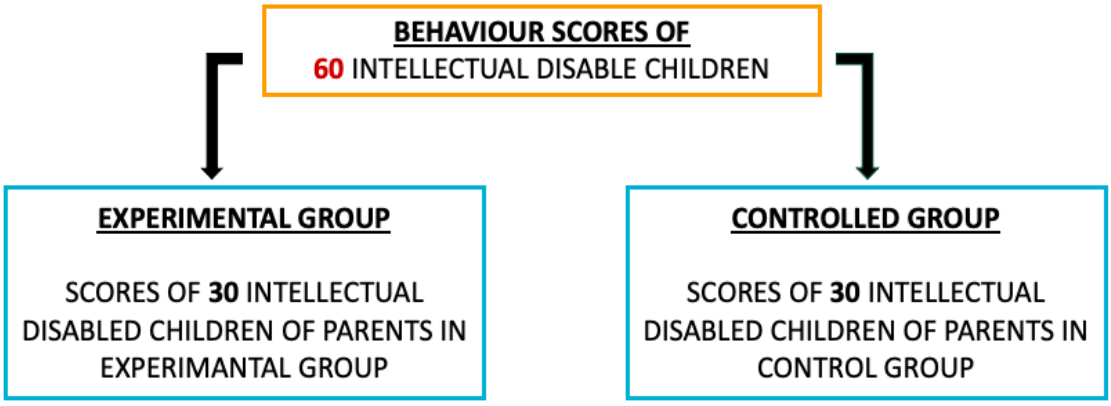
Purposive sampling was used by the researcher to select the study's sample. The sample size of the study was 120 individuals, comprising 60 couples (mothers and fathers), with 30 couples in the experimental group and 30 couples in the control group.

The second part of the study included the scores of 60 children with intellectual disabilities, with 30 in the experimental group and 30 in the control group. Primary data were collected from a Bright Horizon child development center, Jalandhar and a Navchetna special school, Hoshiarour (non-governmental organization) that support children with intellectual disabilities, which served as the foundation for this study.

3.2.1 GRAPHICAL PRESENTATION OF THE SAMPLE IN THE STUDY



3.2.2 GRAPHICAL PRESENTATION OF BEHAVIOURAL SCORES OF 60 INTELLECTUAL DISABLED CHILDREN FROM THE SAMPLE FAMILIES IN THE STUDY



3.3 INCLUSION CRITERIA

1. Children's Age- 2-5 Years

2. Moderate Intellectual Disabled.

3. Middle class family with non-working mothers.

4. Parental Age- 30-45 Year

3.4 EXCLUSION CRITERIA

1. Mild and severe intellectual disabilities will not be included in the study.

2. BPL and high socioeconomic status families with a working mother or both parents.

3. Children's ages: Under 2 and Over 5

4. Parental Age: Under 30, Over 45

3.5 ETICAL CONSIDERATION

The research required the collection of information from participants; therefore, the researcher adhered to the Data Privacy Act of 2012. Informed consent was obtained from the parents before their participation in the study. All participants remained anonymous. To protect the confidentiality of the data, codes were used during data analysis.

Three ethical considerations were addressed in this study: obtaining informed consent, ensuring the confidentiality of information as mandated by the Data Privacy Act of 2012, and clearly outlining the researcher's role and responsibilities. The researcher explained the purpose of the study and the expectations involved to the participants in order to foster trust and confidence. Participants were fully informed about their voluntary involvement in the study.

3.6 STATESTICAL ANALYSIS

The following statistical analysis were implied on the data collected to get the statistical significance of the study. In accordance with the objectives and hypotheses of the study descriptive analysis – Mean & Standard Deviation, t-test (Paired), Correlation and Multiple Regression Analysis were used.

3.7 VARIABLES

This study consists of 3-variables namely CBT, Parental Stress and Behavioural development to measure the effect of CBT on parental stress and the effect of parental stress on behaviour development of children with intellectual disabilities.

Where parental stress is a psychological Variable, so in 1st fragment of the study it is working as Dependent Variable and in 2nd fragment of the study it is working as Independent Variable.

3.7.1 Study 1st consists of 2-variables to measure the effect of CBT on parental stress.

INDEPENDENT	DEPENDENT
CBT (Cognitive Behavioural Therapy)	Parental Stress

3.7.2 Study 2nd consists of 2-variables to measure the effect of parental stress on behaviour development of children with intellectual disabilities.

INDEPENDENT	DEPENDENT
Parental Stress	Behavioural Development

3.8 TEST FOR MEASUREMENT

To assess parental stress and behaviour development of intellectually disabled children in the present study, the following appropriate psychological tools were used. The parents' stress and children's behaviour levels were ascertained by collecting clinical data.

3.8.1 THE STANDARD STRESS SCALE (SSS)

The "Standard Stress Scale (SSS)" is a questionnaire designed to measure stress in a variety of people and across different stages of life (Christiane Gross and Kathrine Seeba, 2014). The SSS is suitable for people from age 14 onwards, and can be used for a diverse population, including students, unemployed people, and those in employment. The effort-reward imbalance model" (ERI) and the demand-control model were the theoretical frameworks used to develop the final 11-item Standard Stress Scale (SSS), which consists of questions about stressful life situations, social stress, daily distress, anxiety about the future, and other stresses and strains".

RELAIBILITY- The SSS last 11 elements have high dependability scores. Cronbach's alpha for the sub-populations varies from 0.58 for the "others" category to 0.66 for school children. The overall sample's alpha I s 0.62.

3.8.2 BASIC-MR Part II- Behavior Assessment Scale for Indian Children – Mental Retardation

BASIC MR- Part B is Behavioural Assessment Scale for Indian Children with Mental Retardation Part A & B is designed by ReetaPeshairia et al., March 1992. Part A of BASIC MR assess the daily living behavioural skills and BASIC MR Part B is designed to observe the problem behaviours of the children having intellectual disability in regard to their environment. Part- B has 10 domains under which all domains contains in totality 75 items. Each item need to be scored with Never, Occasionally and Frequently scores, these score are given by asking the questions from

the parents that whether child does behave asked behavioural problem frequently, Occasionally or Never. Never Stand for (0) score, Occasionally stand s for (1) Score and Frequently stands for (2) score. Summed Scores defines as1-50 Mild Behavioural Issues, 51-100 Moderate Behavioural issuesand 101 to 150 Severe Behavioural Problem. The minimum score possibility is zero and maximum score possibility is 150.

RELIABILITY- "A test retest Reliability exercise is conducted on 127 teachers. The eight week test retest reliability for Basic MR is found to be 0.68 (Peshairia, Venkatesan and Menon 1992).

VALIDITY- The construct validity of Basic MR Part-B is establish by measuring the significant differences between at mean scores at Pre &Post-test Levels. There change is found to be statistically significant (p= < 0.001)"

3.9 PROCEDURE

The researcher collected data by individually contacting the samples attending Navchetna Special School, Hoshiarpur, and Bright Horizon Child Development Centre, Jalandhar, whose wards were receiving developmental therapies due to intellectual disabilities. The intervention process was conducted on the premises of the respective organizations. Rapport was established through in-person meetings, during which the researcher explained the significance of the study and assured participants that the information provided through the questionnaires would be used solely for research purposes and kept confidential.

Before beginning the therapeutic intervention, the Stress Scale questionnaire was administered to the parents, and the Behavioral Scale was administered to their children with intellectual disabilities. Participants were asked to provide personal information and were given clear instructions and guidance on how to complete the questionnaires.

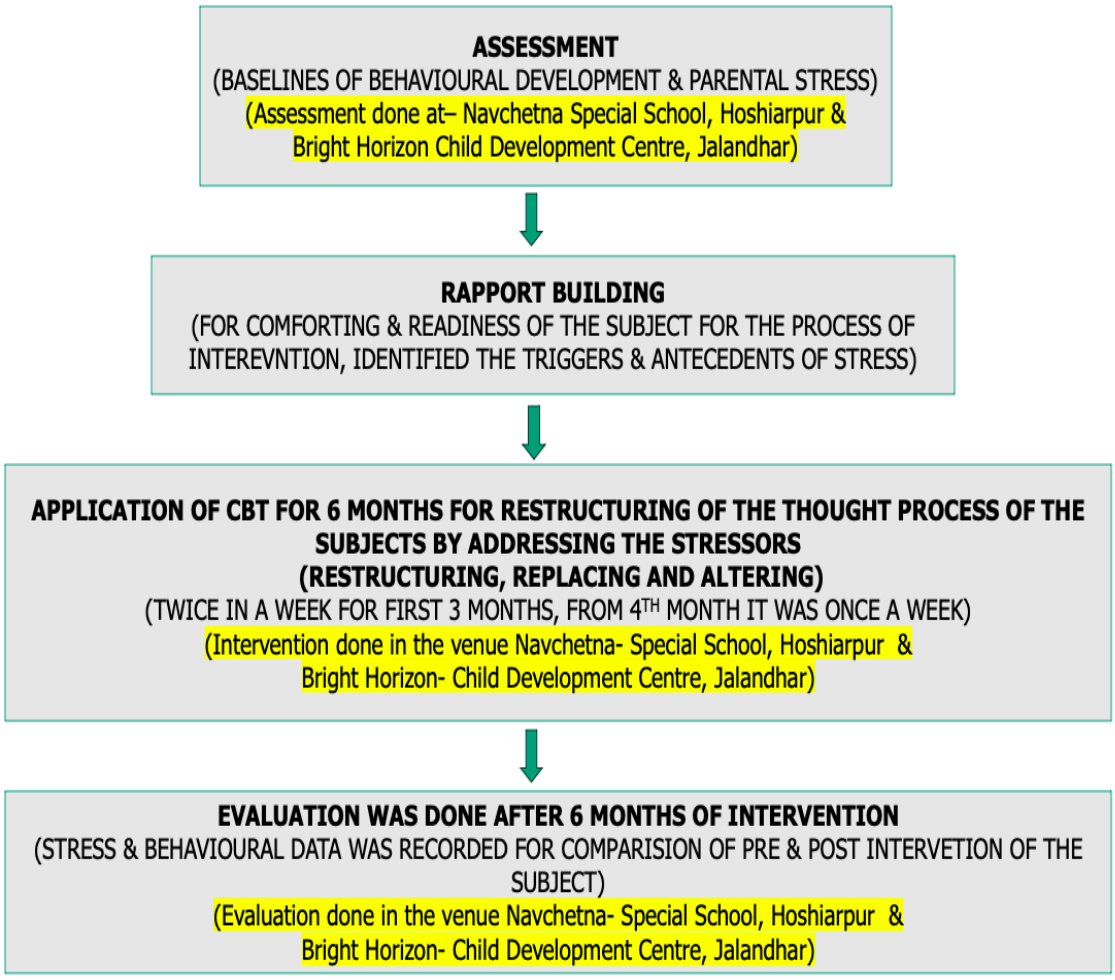
Sufficient time was provided, and the completed questionnaires were collected from the participants. Their responses were scored accordingly and served as the pre-

intervention data for the study. Participants who dropped out were excluded, and only those who completed the full intervention period were included in the final analysis.

In the present study, CBT was used over six months to help parents of children with intellectual disabilities by restructuring their dysfunctional cognitive thoughts. Automatic Negative Thoughts (ANTs) were addressed using various Cognitive Behavioural Therapy strategies tailored to the parents' specific ANTs. Their behaviors were modified by encouraging alternative positive behaviors in response to different situations and stresses.

The intervention lasted for six months, consisting of a total of 36 CBT sessions. Below is a graphical presentation of the intervention model followed in this study.

3.9.1 THE MODEL OF INTERVENTION FOLLOWED IN THE STUDY



Source: Self

The intervention model followed four phases: Assessment of subjects, Rapport Building, Application of CBT, and Evaluation after intervention. The assessment phase involved collecting data on the stress levels of parents and behavioral scores of children with intellectual disabilities before the intervention.

The rapport-building phase followed the assessment. During this phase, the professional focused on establishing a relationship with the subjects while simultaneously observing the antecedents of the subject's automatic negative thought processes. Subjects were made comfortable and secure to encourage sharing of feelings,

problems and emotions, enabling a better understanding of their triggers and automatic negative thoughts. This phase was reinforced with the intention of gaining deeper insight into the subjects.

After the rapport-building phase, the next phase was the application of the CBT intervention aimed at reducing stress levels in parents of the experimental group. The CBT intervention lasted for six months, comprising a total of 36 therapeutic sessions. All antecedents of automatic negative thoughts were addressed separately during this process, depending on the severity of the stress each antecedent imposed on the parents. Multiple antecedents were observed and managed through various Cognitive Behavioural Therapy techniques during the sessions. Details of the schedule and steps followed in the implementation of CBT are presented in flowcharts 3.12.2 and 3.12.3.

The final phase of the intervention model was the evaluation of subjects after CBT implementation. Evaluation was conducted using the Standard Stress Scale for parental stress levels and the Behavioral Scale for assessing the behavioral development of children with intellectual disabilities. Data collected before and after the intervention were statistically analyzed to determine the significance of the study's findings.

3.9.2 SCHEDULE OF THE CBT SESSIONS PROCEDURE FOLLOWED IN THE INTERVETIONS

S.NO	SEQUENCE	PROCEDURE FOLLOWED
1	4 SESSIONS	ASSESSMENT FOR CURRENT STRESS & RAPPORT BUILDING SESSIONS
2	26 SESSIONS	CBT SESSIONS STARTING WITH FIRST GOAL
3	6 SESSIONS	RELAPSE PREVENTION & TERMINATION OF INTERVENTION

Source:Self

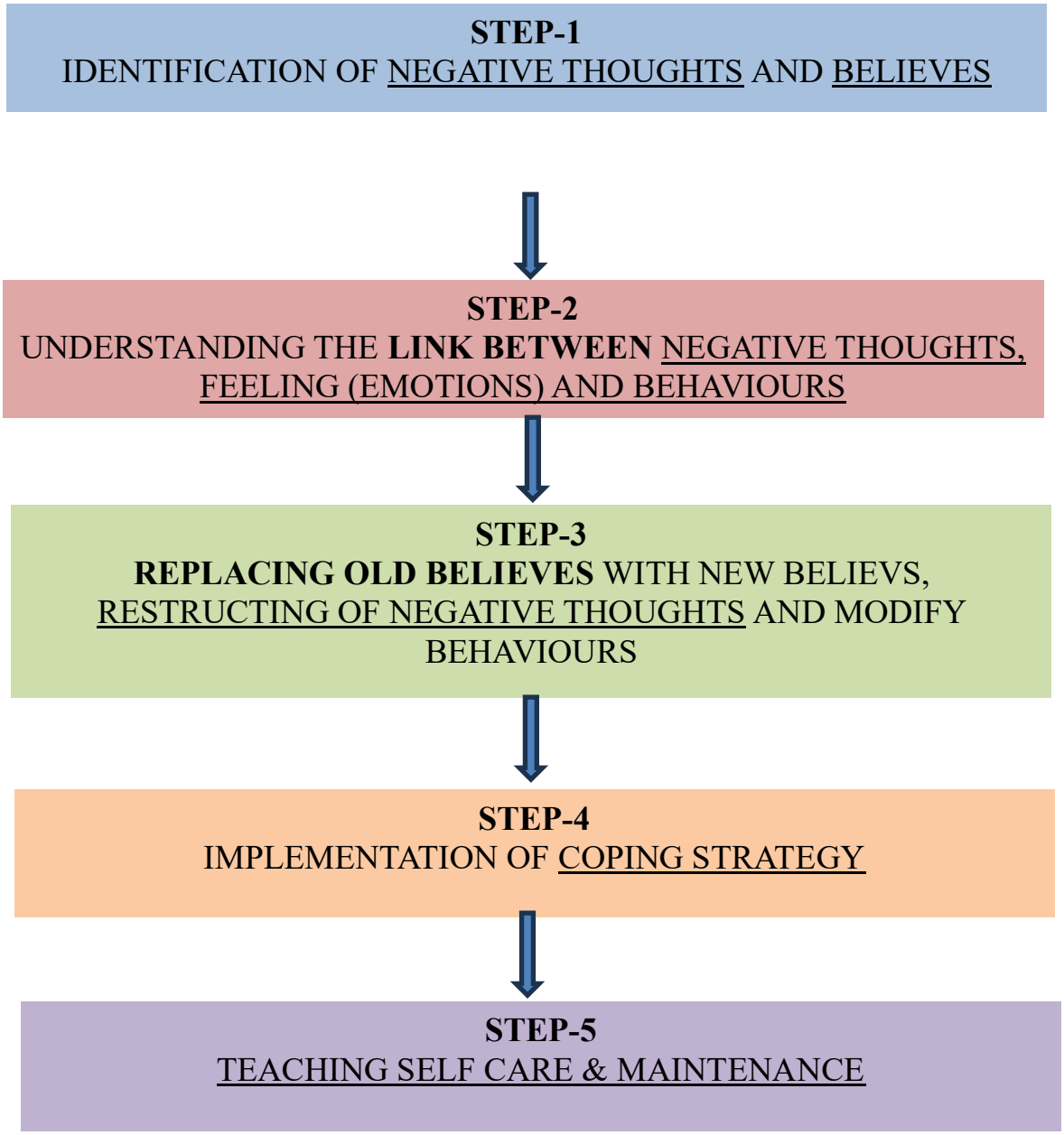
As per the standard procedures of the CBT intervention, the study is conducted into 3 stages.
A total of 36 CBT sessions were provided to the subjects in the experimental group. To ensure the best outcomes from the intervention, a structured CBT schedule was followed.

The schedule for the CBT intervention consisted of three stages:

1. **Rapport-building phase**, where 4 sessions were dedicated to establishing rapport with the parents.
2. **Altering Automatic Negative Thoughts (ANTs)**, where 26 sessions focused on modifying the subjects' automatic negative thoughts.
3. **Termination and relapse prevention**, where the final 6 sessions were used to conclude the intervention and prevent relapse.

During the initial phase of the CBT intervention, sessions were conducted frequently, at two sessions per week for the first three months, to maintain close follow-up with the subjects. From the fourth month onwards, while moving towards the termination phase, the researcher conducted one session per week with the experimental group subjects.

3.9.3 STEPS OF CBT FOLLOWED IN THE INTERVENTION PROCESS



Source:Self

The above-mentioned flowchart represents the steps followed in the implementation of the CBT intervention aimed at reducing parental stress in the experimental group. The CBT intervention process consisted of five steps, all of which were carefully followed to ensure the best possible outcome.

The initial phase of the CBT intervention was crucial. During this phase, the researcher identified and interpreted the antecedents of automatic negative thoughts, beliefs, emotions, and feelings of parents having children with intellectual disabilities in the experimental group.

Following this, the researcher examined the relationship between the parent's automatic negative thoughts, beliefs, feelings, emotions, and behaviors. Understanding these negative cognitive and emotional patterns played a vital role in implementing the CBT intervention. Based on the established relationship between ANTs and emotions, the researcher planned suitable CBT strategies targeting the identified triggers.

In the third step, the researcher applied various CBT techniques such as Rational Responding, Idiosyncratic Technique, Cognitive Restructuring, and Exposure Therapy. These techniques were carefully selected and applied depending on the different antecedents related to specific automatic negative thoughts. The objective of this step was to replace negative thought processes with positive ones, substitute old beliefs with new, constructive beliefs, and modify maladaptive behaviors in parents of children with intellectual disabilities in the experimental group.

After restructuring the subject's thought processes, the next step involved implementing coping strategies. These strategies aimed to prevent relapse and support the lasting effects of CBT in reducing the subject's stress levels. Participants were encouraged to practice techniques such as mindfulness and relaxation whenever they felt overwhelmed or experienced episodes of anxiety.

As the intervention approached the termination phase, it became important to prepare subjects for relapse prevention and support the long-term effectiveness of CBT in managing stress. For sustained impact, subjects were trained and encouraged to practice self-care. The following routine was recommended to the experimental group: engaging in at least 30 minutes of regular exercise daily, maintaining a healthy diet, ensuring regular and sufficient sleep, practicing relaxation techniques, and participating in positive, enjoyable activities.

Throughout the implementation of CBT, the researcher carefully followed each step to address all antecedents affecting the stressors of the subjects in the experimental group.

The details of the CBT intervention sessions conducted for this study have been documented and are provided in the appendices. These appendices comprehensively outline the procedures and content of each session.

CHAPTER 4
RESULTS AND DISCUSSION

Table 1 : Mean and SDs of scores on Parental stress in Pre-test and Post test of Controlled group and Experimental group.

S no	Variables	Controlled Group		Experimental Group		n	*t*	*p*
		M	SD	M	SD			
1	**Parental Stress - Pre intervention**	36.65	5.02	35.70	7.72	60	1.09	0.279
2	**Parental Stress – Post intervention**	36.00	5.66	24.15	4.11	60	19.09	0.001

P<0.05

Table 1 shows the results of paired sample t-test scores before and after the intervention of cognitive behaviour therapy on parental stress of intellectually disabled children of controlled group and experimental group. Pre-intervention and post intervention had a gap of six months in between.

The results show, the scores of before intervention of cognitive behaviour therapy on parental stress of Controlled group (M = 36.65, SD=5.02, N=30) and Experimental group (M=35.70, SD = 7.72, N=30). t-test value was statistically not significant, t- value = 1.09, p= 0.279. Therefore it is concluded that there is statistically no significant difference between pre-intervention scores on parental stress (controlled group and experimental group) of intellectually disabled children. Hence hypothesis 1 is accepted.

The results also show, the scores of after intervention of cognitive behaviour therapy on parental stress of Controlled group (M = 36, SD=5.66, N=30) and Experimental group (M=24.15, SD = 4.11, N=30). t-test value was statistically significant, t-value = 19.09, p= 0.001. Therefore it is concluded that there is statistically significant difference between controlled group and experimental group scores on parental stress of intellectually disabled children. It means that cognitive behaviour therapy has significantly reduced the level of stress among parents.

Table 2: Mean and SDs of scores on Parents stress in Pre- test and post-test of experimental group.

Variables	*Pre-Intervention*		*Post-Intervention*		*n*	*t*	*p*
	M	*SD*	*M*	*SD*			
Mothers' Stress	39.5	8.3	27.2	3.54	30	12.88	0.001
Fathers' Stress	31.9	4.75	21.1	1.6	30	16.41	0.001
Parental Stress	35.7	7.72	24.15	4.11	60	19.84	0.001

P<0.05

The table-2 shows, the effect of cognitive behavior therapy on the experimental group of parental stress intellectually disabled children. Parents were given 36 sessions (each parent – Mother and father) of cognitive behavior therapy intervention in duration of six months.

The analysis shows, mean scores of pre-intervention and post - intervention of cognitive behavior therapy on mother's stress are significantly different. Before intervention (M =39.50, SD=8.3) and post cognitive behavior therapy intervention (M=27.20, SD = 3.54). t-test value is statistically significant, (t(29) = 12.88, n=30, P<0.005. The means of pre-intervention and post-intervention of CBT, is indicating a substantial effect of the intervention is highly effective and has a significant impact on the outcome. On average the mother's stress is reduced by 12.30 points post-intervention of cognitive behavioral therapy. Therefore it is concluded that there is statistically significant difference between pre- intervention and post cognitive behavior therapy's intervention on mothers' stress of experimental group.

The analysis shows, mean scores of pre-intervention and post - intervention of cognitive behavior therapy on father's stress are significantly different. Before intervention (M =31.90, SD=4.75) and post cognitive behavior therapy intervention (M=21.10, SD =

1.6). t-test value is statistically significant,(t(29) =16.14, n=30, P<0.005. The means of pre-intervention and post-intervention of CBT, indicating a substantial effect of the intervention is highly effective and has a significant impact on the outcome. On average the father's stress is reduced by 10.80 points post-intervention of cognitive behavioral therapy. Therefore it is concluded that there is statistically significant difference between pre- intervention and post cognitive behavior therapy's intervention on father's stress of experimental group.

The analysis shows, mean scores of pre-intervention and post - intervention of cognitive behavior therapy on parental stress are significantly different. Before intervention (M =35.70, SD=7.72) and post cognitive behavior therapy intervention (M=24.15, SD = 4.11). t-test value is statistically significant, t(59) = 19.84, n=60, P<0.005. The means of pre-intervention and post-intervention of CBT, indicates a substantial effect of the intervention is highly effective and has a significant impact on the outcome. On average the parental stress is reduced by 11.55 points post-intervention of cognitive behavioral therapy. Therefore it is concluded that there is statistically significant difference between pre-intervention and post cognitive behavior therapy's intervention on parental stress of experimental group. Hence hypothesis 2 is accepted.

Table - 3 Correlation between parental stress and behavioral developmental problems of intellectually disabled children

	Parental Stress	*Behavioral developmental problems*
Parental Stress		.475**

**. Correlation is significant at the 0.01 level (1-tailed).

Table 3 shows Pearson product correlation on parental stress and behavioral developmental problems of intellectually disabled children is found to be high positive correlation and statistically significant, $r(475) = .001^{**}$, $p = .001$. This shows that a rise in behavioural developmental problems of intellectually disabled children leads to a rise in parental stress and vice- versa. Thus accepting hypothesis 3.

Table 4: Multiple regression analysis of Parental Stress on Behavioural Development

Predictor	B	*SE*	*β*	*t*	95% CI		*p*
					LL	*UL*	
(Constant)	46.86	3.35		14	40.14	53.53	0.001
Parental stress	0.56	0.14	0.48	4.11	0.29	0.84	0.001

Note. R^2 = .23, adjusted R^2 = .21. B = unstandardized regression coefficient; SE = standard error; β = standardized regression coefficient; CI = confidence interval. $p < .05$.

Table 4 shows simple linear regression. It is used to test if parental stress can significantly predict Behavioral developmental problems of intellectually disabled children. The fitted regression model of Behavioral developmental problems of intellectually disabled children is: Parental stress = (0.56). To analyse the hypothesis the researcher employed MRA of 95% confidence intervals. It is found that parental stress significantly impact and predict Behavioral developmental problems of intellectually disabled children (β = 0.475, t = 4.11, P = 0.001). The overall regression is statistically significant {F(1,58) = 16.91, P< 0.001. Ajd R^2 =0.221, P< 0.001 and R^2 Change= 0.226}. It indicates that parental stress can predict 22.6 percent of behavioural development of intellectually disabled children. Hence parental stress is a significant variable in predicting behavioural development of intellectually disabled children. Hence hypothesis 4 is accepted.

DISCUSSION

The first hypothesis states that there will be no significant difference in the stress levels of the parents before intervention. It is accepted as warranted by the results as the analysis showed that there is no significant difference in the stress levels of the parents before intervention. The results show, the scores of before intervention of cognitive behaviour therapy on parental stress of Controlled group (M = 36.65, SD=5.02, N=30) and Experimental group (M=35.70, SD = 7.72, N=30). t-test value was statistically not significant, t- value = 1.09, p= 0.279. Therefore it is concluded that there is statistically no significant difference between pre-intervention scores of parental stress (controlled group and experimental group) of intellectually disabled children. Hence hypothesis 1 is accepted. The results also show, the scores of after intervention of cognitive behaviour therapy on parental stress of Controlled group (M = 36, SD=5.66, N=30) and Experimental group (M=24.15, SD = 4.11, N=30). t-test value was statistically significant, t-value = 19.09, p= 0.001. Therefore it is concluded that there is statistically significant difference between controlled group and experimental group scores on parental stress of intellectually disabled children. It means that cognitive behaviour therapy has significantly reduced the level of stress among parents.

This study matches to the study results (Picchioni MM, Murray RM in 2007) which revealed that treatment of CBT has become popular among the psychiatry fraternity in treating depression, bipolar, anxiety. It also resembles with the findings of Layard, 2006; Scott & Colom, 2005; Basco & Rush, 2007 have found that medications are not as effective as cognitive behavioral therapies are in treating psychological disorders.

The results are also in agreement with Hofmann et.al 2011, study which suggests that dysfunctional beliefs are the root cause of emotional pain and maladaptive behaviours. CBT helps in cognitive restructuring by recognizing maladaptive cognitions automatic thoughts, helps patient analysing the connection between anxiety and automatic thoughts, and developing logical grounds to support the reality.

This research also align with John Wiley and Sons, 1999; Churchill R et al. 2001; Butler AC et al., 2006; Taylor S. 1996; Barlow DH et al., 2000. Study shows that cognitive-behavioral therapy (CBT) is just as effective as medication. As per study Patients who suffer from anxiety and depression frequently think negatively and absorb information in a biased way. The main objective of cognitive behavioural therapy (CBT) is to change unhelpful thought and behaviour patterns in order to stop the recurrence of feelings of anxiety or depression.

The second hypothesis states CBT will significantly reduce the stress level of the parents. It is accepted as warranted by the results as the analysis shows that there was statistically significant difference between pre- intervention and post cognitive behavior therapy's intervention on parental stress of experimental group. Parents of behavioral developmental problem of intellectually disabled child were given thirty six sessions (each parent – Mother and father) of cognitive behavior therapy intervention in duration of six months.

The table - 2 shows, the effect of cognitive behavior therapy on the experimental group of parental stress intellectually disabled children. Parents were given 36 sessions (each parent – Mother and father) of cognitive behavior therapy intervention in duration of six months. The analysis shows, mean scores of pre-intervention and post - intervention of cognitive behavior therapy on mother's stress are significantly different. Before intervention (M =39.50, SD=8.3) and post cognitive behavior therapy intervention (M=27.20, SD = 3.54). t-test value is statistically significant, ($t(29) = 12.88$, n=30, $P<0.005$. The means of pre-intervention and post-intervention of CBT, is indicating a substantial effect of the intervention is highly effective and has a significant impact on the outcome. On average the mother's stress is reduced by 12.30 points post-intervention of cognitive behavioral therapy. Therefore it is concluded that there is statistically significant difference between pre- intervention and post cognitive behavior therapy's intervention on mother's stress of experimental group.

The analysis shows, mean scores of pre-intervention and post - intervention of cognitive behavior therapy on father's stress are significantly different. Before intervention (M =31.90, SD=4.75) and post cognitive behavior therapy intervention (M=21.10, SD =

1.6). t-test value is statistically significant,(t(29) =16.14, n=30, P<0.005. The means of pre-intervention and post-intervention of CBT, indicating a substantial effect of the intervention is highly effective and has a significant impact on the outcome. On average the father's stress is reduced by 10.80 points post-intervention of cognitive behavioral therapy. Therefore it is concluded that there is statistically significant difference between pre- intervention and post cognitive behavior therapy's intervention on father's stress of experimental group.

The analysis shows, mean scores of pre-intervention and post - intervention of cognitive behavior therapy on parental stress are significantly different. Before intervention (M =35.70, SD=7.72) and post cognitive behavior therapy intervention (M=24.15, SD = 4.11). t-test value is statistically significant, t(59) = 19.84, n=60, P<0.005. The means of pre-intervention and post-intervention of CBT, indicates a substantial effect of the intervention is highly effective and has a significant impact on the outcome. On average the parent's stress is reduced by 11.55 points post-intervention of cognitive behavioral therapy. Therefore it is concluded that there is statistically significant difference between pre-intervention and post cognitive behavior therapy's intervention on parental stress of experimental group. Hence hypothesis 2 is accepted.

This study matches to the study of Poon and Wong (2010) adapted cognitive behavioural therapy (CBT) and found it has positive impact in reducing parenting stress and improved overall health among parents of children with developmental disabilities, according to a randomised controlled trial.

The results are also in agreement with study done by Crnic, K.A.et al. 2005, Deater-Deckard 2004, Hsiao Y.J 2016, Ing Z. et al, Barroso, N.E. 2018 , Neece, C.L et al 2012, Krahé, B. et al 2015,suggests that psychological discomfort, or parental stress, is often felt due to demands related to the parenting and childrearing role. Many studies have already found a relationship between higher levels of stress experienced by parents and their mental and overall well-being. Parental stress can bring about various negative effects on the child's behavioral and developmental results, such as Incorporating and expressing worries, and impaired social skills and cognition.

This research also align with Hayes, S.A.; Itson 2013, Theule, J. et al 2013, Pinquart 2018, Osborne, C. et al 2012 .Numerous researchers examined the impact of child-related traits on parental stress. According to many meta-analyses, parents of children with developmental disabilities and chronic health issuesreport higher levels of stress than parents of children who are typically growing. In the meantime, a lot of study has examined the relationship between parents' stress levels and family characteristics, such as living arrangement instability and complexity, as well as poor family functioning. To sum up, a lot of research has been done to identify a number of markers of parental stress at the levels of parents, children, and households.

The third hypothesis states that there is significant relationship between parental stress and behavioural development of intellectual disabled children. It is accepted as warranted by the results shows Pearson product correlation on parental stress and behavioral developmental problems of intellectually disabled children is found to be high positive correlation and statistically significant, $r(475) = .001^{**,} p = .001$. This shows that a rise in behavioural developmental problems of intellectually disabled children leads to a rise in parental stress and vice- versa. Thus accepting hypothesis 3.

This study also resembles with the study done by Baker, B. L., Blacher, J., & Olsson, M. B. (2005).There study investigates the connection between parental stress levels and the degree of a child's intellectual disability (such as mild, moderate, or severe ID). Research indicates that parents of children with more severe intellectual disabilities typically endure higher stress levels as a result of their complex needs and increased caregiving responsibilities.

This Research also align with Totsika, V., & Hastings, R. P. (2009)The study looks into the relationship between parental stress and behavioural issuesin kids with intellectual disabilities, such as aggression, tantrums, and non-compliance. The findings show a strong positive relationship between parents' reported stress levels and the severity of behavioural problems.

The fourth hypothesis states that the Parental stress will significantly predict behavioral development of intellectual disabled children. It is accepted as warranted by the results as the multiple regression analysis shows that Parental stress significantly predict behavioral development of intellectual disabled children. Table 4 shows multiple linear regression. It is used to test if parental stress can significantly predict Behavioral developmental problems of intellectually disabled children. The fitted regression model of Behavioral developmental problems of intellectually disabled children is: Parental stress = (0.56). To analyse the hypothesis the researcher employed MRA of 95% confidence intervals. It is found that parental stress significantly impact and predict Behavioral developmental problems of intellectually disabled children (β = - 0.475, t = 4.11, P = 0.001). The overall regression is statistically significant {F(1,58) = 16.91, P< 0.001. Ajd R^2 =0.221, P< 0.001 and R^2 Change= 0.226}. It indicates that parental stress can predict 22.6 percent of behavioural development of intellectually disabled children. Hence parental stress is a significant variable in predicting behavioural development of intellectually disabled children. Hence hypothesis 4 is accepted.

The results are also in agreement with Hassall, R., Rose, J., & Mc Donald, J. (2005). Parenting stress in mothers of children with an intellectual disability: The effects of parental cognitions in relation to child characteristics and family support The finding suggests that, higher child behavior difficulties were associated with greater parenting stress. Parental locus of control and satisfaction strongly predicted stress.

This study also aligns with Neece, Green, & Baker (2012) Parenting stress and child behavior problems: A transactional relationship across time. The findings of the study concluded that Child's behavior problems predicted the parental stress, which in turn predicted worsening child behavior.

This research also align with Crnic & Ross, 2017; Deater-Deckard, 2004. States that parental stress can be a coping process, it can also be associated with ineffective parenting and lower life satisfaction of parents. It impacts kids too, increasing their likelihood to develop emotional and behavioral problems. The differences in parental

stress and satisfaction/reirds between clinical or social service users (SSU) and non-users (non-SSU) are also not often discussed.

CHAPTER-5
SUMMARY & CONCLUSION

5.1. SUMMARY

The purpose of this study is to determine the effectiveness of Cognitive Behavioural Therapy (CBT) in reducing parental stress and to examine how parental stress affects the behavioral development of children with intellectual disabilities. The sample size for the study is 120 individuals, comprising of 60 couples: 30 mothers and 30 fathers in the control group, and 30 mothers and 30 fathers in the experimental group.

The study also included their 60 children with intellectual disabilities—30 in the experimental group and 30 in the control group. The sample was selected from the districts of Jalandhar and Hoshiarpur in the state of Punjab. The parent's ages ranged from 30 to 45 years, while the children's ages ranged from 2 to 5 years.

Primary data were collected from a child development center and a special school (non-governmental organizations) that assist children with special needs, which served as the foundation for this study.

The statistical tools used for data analysis included the t-test, correlation, and multiple regression analysis.

5.1.1. THE STANDARD STRESS SCALE (SSS)

The "Standard Stress Scale (SSS)" is a questionnaire designed to measure stress in a variety of people and across different stages of life (Christiane Gross and Kathrina seeba 2014).The SSS is suitable for people from age 14 onwards, and can be used for a diverse population, including students, unemployed people, and those in employment.The effort-reird imbalance model" (ERI) and the demand-control model were the theoretical frameworks used to develop the final 11-item Standard Stress Scale (SSS), which consistsof 35 questions about stressful life situations, social stress, daily distress, anxiety about the future, and other stresses and strains". Reliability- The SSS's last 11 elements have high dependability scores. Cronbach's alpha for the subpopulations varies from 0.58 for the "others" category to 0.66 for schoolchildren. The overall sample's alpha is 0.62.

5.1.2. BASIC-MR

BASIC-MR Part II- Behavior Assessment Scale for Indian Children – Mental Retardation. BASIC MR- Part B is Behavioural Assessment Scale for Indian Children with Mental Retardation Part A & B is designed by ReetaPeshairia et al., March 1992. Part A of BASIC MR assess the daily living behavioural skills and BASIC MR Part B is designed to observe the problem behaviours of the children having intellectual disability in regard to their environment. Part- B has 10 domains under which all domains contains in totality 75 items. Each item need to be scored with Never, Occasionally and Frequently scores, these score are given by asking the questions from the parents that whether child does behave asked behavioural problem frequently, Occasionally or Never. Never Stand for (0) score, Occasionally stand s for (1) Score and Frequently stands for (2) score. Summed Scores defines as1-50 Mild Behavioural Issues, 51-100 Moderate Behavioural issuesand 101 to 150 Severe Behavioural Problem. The minimum score possibility is zero and maximum score possibility is 150. Reliability- "A test retest Reliability exercise is conducted on 127 teachers. The eight week test retest reliability for Basic MR is found to be 0.68 (Peshairia, Venkatesan and Menon 1990. Validity- The construct validity of Basic MR Part-B is establish by measuring the significant differences between at mean scores at Pre &Post-test Levels. There change is found to be statistically significant ($p = < 0.001$)"

5.1.3. PRE - INTERVENTION and POST - INTERVENTION

The study was conducted with a control group and an experimental group, each comprising 30 couples who are parents of children with moderate intellectual disabilities, along with their 30 children. The study spanned six months, during which Cognitive Behavioural Therapy (CBT) was provided to the parents in the experimental group, while no intervention was given to the control group.

The results indicated a significant reduction in stress levels among parents in the experimental group, whereas the change in stress levels among parents in the control group was not statistically significant. Additionally, families in the

experimental group reported lower stress levels post-intervention, and their children showed notable improvement in behavioral development.

S.No	Hypotheses	Significant / Insignificant	Accepted/ Rejected
1	There will be no significant difference in the stress levels of the parents before intervention.	**Not significant**	Hypothesis accepted
2	CBT will significantly reduce the stress level of the parents	**Significant**	Hypothesis accepted
3	There is significant relationship between parental stress and behavioural development of intellectual disabled children.	**Significant**	Hypothesis accepted
4	Parental stress will significantly predict behavioral development of intellectual disabled children.	**Significant**	Hypothesis accepted

Table: 5.1. Significance/Insignificance remarks on Research Hypotheses

Keeping in view the objectives Descriptive and inferential statistics such multiple regression analysis, t-test and correlation were used to statically assess the responses. The aforementioned factors were the focus of the aims and hypotheses.

The first objective of my study is to measure the level of stress among the parent. It is hypothesized that there will be no significant difference in the stress levels of the parents before intervention. The results show, the scores of before intervention of cognitive behaviour therapy on parental stress of Controlled group and Experimental.

T-test value was statistically not significant. Therefore it is concluded that there is statistically no significant difference between pre-intervention scores of parental stress (controlled group and experimental group) of intellectually disabled children. The results also show, the scores of after intervention of cognitive behaviour therapy on parental stress of Controlled group and Experimental group. T-test value was statistically significant at 0.001 level. Therefore it is concluded that there is post intervention statistically significant difference between controlled group and experimental group scores on parental stress of intellectually disabled children. It means that cognitive behaviour therapy has significantly reduced the level of stress among parents. Hence hypothesis 1 is accepted.

The second objective of my study is to investigate the influence of cognitive behavioral therapy on the parental stress of intellectual disabled children. It is hypothesized that CBT will significantly reduce the stress level of the parents.

The differential analyses tested. The analyses shows, mean scores of pre-intervention and post - intervention of cognitive behavior therapy on parental stress are significantly different. T-test value was statically significant at 0.001 level. It suggests a large and practically significant difference between the means of pre-intervention and post-intervention of CBT, indicating a substantial effect of the intervention is highly effective and has a significant impact on the outcome.

The third objective of my study was to examine the relationship between parental stress and behavior development of intellectual disabled children. It is hypothesized that there is significant relationship between parental stress and behavioural development of intellectual disabled children. Pearson product correlation on parental stress and behavioral developmental problems of intellectually disabled children is 0.475 significant at 0.001 level. The correlation is found to be high positive correlation and statically significant. Thus accepting hypothesis 3.

The fourth objective of my study is to ascertain parental stress as a predictor of behavior development of Intellectually disabled children. It is hypothesized that parental stress will significantly predict behavioural development of intellectual disabled children. The

inferential statistical MRA (Multiple Regression Analysis) is used to test if parental stress can significantly predict behavioral developmental problems of intellectually disabled children. To analyse the hypothesis the researcher employed MRA of 95% confidence intervals. It was found that parental stress significantly impact and predict behavioral developmental problems of intellectually disabled children. It indicates that parental stress can predict 22.6 percent of behavioral development of intellectually disabled children. Hence parental stress in a significant variable in predicting behavioral development of intellectually disabled children. Hence hypothesis 4 is accepted.

CONCLUSION

The present study aimed to analyze the effect of Cognitive Behavioural Therapy (CBT) on parental stress and its impact on the behavioral development of children with intellectual disabilities. For this purpose, the sample size was 120 participants, consisting of 30 couples in the control group and 30 couples in the experimental group, along with their 30 children with intellectual disabilities in each group. In both groups, the sample included the father, mother, and their child.

The age range for the parents was 30 to 45 years, and for the children, 2 to 5 years. Only children with moderate intellectual disabilities were considered for the study. All participants belonged to middle socioeconomic status households, and all mothers were non-working.

The present study observed that parental stress is an important factor in shaping and influencing the behaviors of children with intellectual disabilities. It also concluded that reducing parental stress can contribute to a decrease in problem behaviors in these children.

The findings suggest that Cognitive Behavioural Therapy (CBT) has a positive impact on lowering stress levels in parents of children with intellectual disabilities, which in turn helps promote positive behavioral development and reduces problematic behaviors in their children.

LIMITATIONS

The present study is limited to children aged 2 to 5 years from families belonging to the middle-class socioeconomic status, with non-working mothers.

Parents below the age of 30 and above 45 were excluded from the study, even if they had children with intellectual disabilities.

The sample population is restricted to one state—Punjab, India—although future research can be expanded to include other states for broader generalizability.

The study focused on only two independent variables: parental stress and Cognitive Behavioural Therapy (CBT), in relation to their impact on the behavioral development of children with intellectual disabilities. Other variables that may influence the behavior of such children were not considered and can be explored in future research.

DELIMITATION

The present investigation is delimited to studying the behaviors of children with moderate intellectual disabilities within the age range of 2 to 5 years.

Another delimitation of the study is that behavioral development was examined through only two dimensions: parental stress and Cognitive Behavioural Therapy (CBT) sessions.

Future studies may explore additional related variables to examine their effects, relationships, and predictive value in connection with behavioral development and other outcomes.

FUTURE RESEARCH

The present investigation was conducted with a specific focus on selected objectives and hypotheses, considering demographics such as middle-class socioeconomic status and non-working mothers of children with moderate intellectual disabilities. Future research can expand this scope by comparing children from different socioeconomic backgrounds and families with working mothers, across various geographical locations.

Comparative studies could also be undertaken to examine these variables across different states of India. Future research questions and hypotheses should be formulated with a focus on critical areas and underlying factors that influence the behavioral development of children with intellectual disabilities.

Exploring additional research dimensions may yield valuable insights when analyzed in relation to other relevant variables. In the future, further correlations can be drawn between various influencing factors and different aspects of behavioral development in children with intellectual disabilities.

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A- PRE & POST-CBT STANDARD STRESS SCALE ASSESSMENT SCALE

Name of the Participant- ……. **Date-**…….
Age of the Participant-…….
Mother/Father of Child-…… **Age of the Child**……..
Contact Number- …….

- **Please think of all areas of life. To what extent do the following statement apply to you.**

Instructions- Please read the below mentioned statements & think of all the areas of life. Tick/Circle the number as you feel on mentioned in the below 5 Point Scale.

On Scale of 1-5 of SSS. **Mild Stress < 28**, **Moderate Stress-28 – 40**, **Severe- Above 40**)

5-Point Scale: **1-not at all, 2- Very little, 3-Neutral, 4-Somewhat, 5- To a great extent**

1. If I do not enjoy doing something, I usually do not have to do it. **(1, 2, 3, 4, 5)**
2. If I do not take charge, no one else will. **(1, 2, 3, 4, 5)**
3. What I do is meaningful. **(1, 2, 3, 4, 5)**
4. I often feel lonely. **(1, 2, 3, 4, 5)**
5. My performance is properly appreciated. **(1, 2, 3, 4, 5)**
6. There are people that I can count on. **(1, 2, 3, 4, 5)**
7. I usually have restful sleep. **(1, 2, 3, 4, 5)**
8. I spend a lot of time thinking about problems. **(1, 2, 3, 4, 5)**
9. After a normal day, I feel exhausted. **(1, 2, 3, 4, 5)**
10. I am afraid of what my life will be like in three years. **(1, 2, 3, 4, 5)**
11. I look forward to the future. **(1, 2, 3, 4, 5)**

Total Raw Score –…….

Stress Level- …….

B- Behavioural Assessment scale for Indian Children with Mental Retardation (BASIC- MR) Part- B

Instructions

1. Each Item should be scored based on three levels of severity/frequency of problem behaviours, i.e Never (N), Occasionally (0) and Frequently (F). Score 0 for "Never", "Occasionally" -1 and 2 for "Frequently".

2. Enter the appropriate numerical score against each item for the child, depending on the severity/frequency of the problem behaviour in question, and in the appropriate box, i.e baseline and further evaluations.

3. The lowest score will be zero and highest score will be 150.

4. The Ranges of Severity of the problem behaviors were categorized into three i.e 0-50 Mild Problem Behaviours, 51-100 Moderate Problem Behaviour, 101-150 Sever Problem Behaviour

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S.no	PARTICULARS	Baseline	M-1	M-2	M-3	M-4	M-5	M-6
	Voilet & Distructive Behaviours							
1	Kicks Other							
2	Pushes Other							
3	Pinches Other							
4	Pulls Hair, ear, body parts of other							
5	Slaps other							
6	Hits Other							
7	Spit on others							
8	Bangs objects							
9	Slams Doors							
10	Bites other							

11	Attacks or pokes other with weapon							
12	Throw object at others							
13	Tears/pulls thread from own or others clothings							
14	Tears up own or others books, papers, magazines							
15	Breaks objects/glass/toys							
16	Damages Furniture							
	Temper Tantrums							
17	Cries excessively							
18	Screams							
19	Stamps feet							
20	Roll on the floor							
	Misbehaves with other							
21	Pulls Objects from others							
22	Interrupts in between when others are talking							
23	Makes Loud noise when others are working or reading							
24	Makes Faces to tease others							
25	Use Abusive /vulgar language							
26	Takes others procession without their permission openly							
27	Takes others what to do and wants his/her way (BOOSY)							
	Self injurious Behaviour							
28	Bang Head							
29	Bites Self							
30	Cuts or mutilates self							
31	Pulls own hair							
32	Scratches self							
33	Pulls own hair							
34	Scratches Self							
35	Hit Self							

36	Puts objects into eye/nose/ear							
37	Eats Inedible things							
38	Peels skin/wounds							
39	Bites nails							
	Repetitive Behaviours							
40	Rocks Body							
41	Nods Head							
42	Sucks Thumb							
43	Makes peculiar sound							
44	Bites ends of pen/pencils							
45	Shake parts of the body repeatedly							
46	Grinds teeth							
47	Swings round and round							
	Odd Behaviours							
48	Laughs to self							
48	Laughs inappropriately							
50	Talks to slef							
51	Hoards unwanted objects (Sticks, thread, pieces of old clothes)							
52	Picks nose							
53	Plays with unwanted object like chappal etc							
54	Kisses, hugs and licks people unnecessary							
55	Smells Objects							
	Hyperactivity							
56	Doesn’t sit at one place for required time							
57	Doesn’t pay attention to what is told							
58	Doesn’t continue with the task at hand for required time							
	Rebellious Behaviour							
59	Refuses to obey command							

60	Does opposite of what is required							
61	Takes very long time intentionally to complete the task							
62	Wanders outside school							
63	Runs away from school							
64	Argues without Purposes							
	Antisocial Behaviour							
65	Lies or twists the truth to his own advantages or blame others							
66	Cheats in game or no sense of fair play							
67	Steals							
68	Makes Sexual advances towards member of opposite sex							
69	Touches own private parts In public							
70	Touches others private parts in public							
71	Gambles							
	Fears							
72	Fear of Object							
73	Fear of Animal							
74	Fear of Places							
75	Fear of Persons							
	Any Other							

CASE-1 CONTROL GROUP

NAME OF THE CHILD- 1 C.J	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 25.07.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.7 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child Speaks in two words only, Doesn't understand as per age, Doesn't communicate as per the age, Poor Bladder Bowl Control, Poor Eye Contact, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 112 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 37 to 38, and father's stress scores showed negligible reduction from 30 to 29. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 112 to 110, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-2 CONTROL GROUP

NAME OF THE CHILD- 2 C.J	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 15.12.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.3 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Social Skills, Poor Physical Involvement, Poor Motor Skills, Shows Hyperactivity, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 110 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed minimum reduction from 41 to 36, and fathers' stress scores showed slightly increased in levels from 29 to 30. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem score slightly increased from 110 to 109, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-3 CONTROL GROUP

NAME OF THE CHILD- 3 C.J	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 18.01.2018	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.2 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 114 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father & mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed negligible reduction from 36 to 34, and fathers' scores showed negligible reduction from 32 to 30. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores changing only slightly from 114 to 107, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-4 CONTROL GROUP

NAME OF THE CHILD- 4 C.J	**MOTHER AGE-** 35 YEARS
GENDER- MALE	**FATHER AGE-** 38 YEARS
DOB- 07.08.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.7 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 117 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father & mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed no reduction from 38 to 38, and fathers' scores showed negligible reduction from 32 to 30. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores changing only slightly from 117 to 103, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group

CASE-5 CONTROL GROUP

NAME OF THE CHILD- 5 C.H	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 35 YEARS
DOB- 10.10.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** Hoshiarpur

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Eye Contact, Throw Tantrums, Shows Hyperactivities.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 107 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having severe level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed no reduction or negligible reduction from 47 to 49, and fathers' scores showed no reduction or negligible reduction from 40 to 41. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores changing only slightly from 107 to 101, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-6 CONTROL GROUP

NAME OF THE CHILD- 6 C.H	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 04.02.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.2 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Throw tantrums, Show Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 109 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed no reduction or negligible reduction from 41 to 37, and fathers' scores showed no reduction or negligible reduction from 33 to 30. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores increased slightly from 109 to 113, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-7 CONTROL GROUP

NAME OF THE CHILD- 7 C.H	**MOTHER AGE-** 30 YEARS
GENDER- FEMALE	**FATHER AGE-** 33 YEARS
DOB- 20.05.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.9 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor academic skills, Poor Social Interaction, Poor Motor Skills, Pulls other, Misbehaves in Public, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 113 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed slightly increase from 37 to 39, and fathers' scores showed negligible reduction from 32 to 29. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores changing only slightly from 113 to 108, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-8 CONTROL GROUP

NAME OF THE CHILD- 8 C.H	**MOTHER AGE-** 32 YEARS
GENDER- FEMALE	**FATHER AGE-** 36 YEARS
DOB- 12.02.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.2 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Eye Contact, Poor Sitting Span, Throw Tantrums, Push Others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 117 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed negligible reduction from 42 to 38, and fathers' scores showed no reduction from 32 to 32. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores changing only slightly from 117 to 109, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-9 CONTROL GROUP

NAME OF THE CHILD- 9 C.H	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 36 YEARS
DOB- 23.01.2018	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.3 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Social Skills, Poor Motor Skills, Throw Tantrums, Bites Other, Misbehaves in Public, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 108 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed negligible reduction from 46 to 45, and fathers' scores showed negligible reduction from 33 to 30. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores changing only slightly from 108 to 110, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-10 CONTROL GROUP

NAME OF THE CHILD- 10 C.H	**MOTHER AGE-** 33 YEARS
GENDER- FEMALE	**FATHER AGE-** 34 YEARS
DOB- 18.10.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academics Skills, Poor Eating Habits, Poor Bladder Bowl Control, Poor Motor Skills, Throw Tantrums in Public.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 113 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having severe level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mothers' stress scores showed no reduction from 45 to 46, and fathers' scores showed negligible reduction from 40 to 38. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores changing only slightly from 113 to 85, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-11 CONTROL GROUP

NAME OF THE CHILD- 11 C.J	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 04.01.2022	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child Speaks in two words only, Doesn't understand as per age, Doesn't communicate as per the age, Poor Bladder Bowl Control, Poor Eye Contact, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 99 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 39 to 32, and father's stress scores showed negligible reduction from 33 to 31. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores increased slightly from 99 to 110, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-12 CONTROL GROUP

NAME OF THE CHILD- 12 C.J	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 08.10.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.3 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Social Skills, Poor Physical Involvement, Poor Motor Skills, Shows Hyperactivity, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 112 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 35 to 40, and father's stress scores showed negligible reduction from 28 to 26. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 112 to 98, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-13 CONTROL GROUP

NAME OF THE CHILD- 13 C.J	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 20.08.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.5 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 110 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having mild level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 37 to 36, and father's stress scores showed negligible reduction from 27 to 30. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 110 to 115, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-14 CONTROL GROUP

NAME OF THE CHILD- 14 C.J	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 17.07.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 112 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 34 to 39, and father's stress scores showed negligible reduction from 34 to 32. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 112 to 95, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-15 CONTROL GROUP

NAME OF THE CHILD- 15 C.J	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 35 YEARS
DOB- 28.11.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.1 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Eye Contact, Throw Tantrums, Shows Hyperactivities.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 97 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 40 to 45, and father's stress scores showed slight increase from 40 to 36. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slight increase from 97 to 101, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-16 CONTROL GROUP

NAME OF THE CHILD- 16 C.H	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 21.09.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.4 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Throw tantrums, Show Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 109 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 43 to 40, and father's stress scores showed no reduction from 32 to 32. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores increased slightly from 109 to 120, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-17 CONTROL GROUP

NAME OF THE CHILD- 17C.H	**MOTHER AGE-** 32 YEARS
GENDER- FEMALE	**FATHER AGE-** 32 YEARS
DOB- 12.10.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.3 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor academic skills, Poor Social Interaction, Poor Motor Skills, Pulls other, Misbehaves in Public, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 124 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduced from 42 to 39, and father's stress scores showed negligible reduction from 34 to 31. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 124 to 118, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-18 CONTROL GROUP

NAME OF THE CHILD- 18 C.H	**MOTHER AGE-** 32 YEARS
GENDER- FEMALE	**FATHER AGE-** 34 YEARS
DOB- 05.02.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Eye Contact, Poor Sitting Span, Throw Tantrums, Push Others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 117 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slightly reduced from 43 to 38, and father's stress scores showed slight increase from 32 to 33. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 117 to 109, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-19 CONTROL GROUP

NAME OF THE CHILD- 19 C.H	**MOTHER AGE-** 33 YEARS
GENDER- MALE	**FATHER AGE-** 36 YEARS
DOB- 25.11.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.2 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Social Skills, Poor Motor Skills, Throw Tantrums, Bites Other, Misbehaves in Public, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 98 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and father was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 39 to 40, and father's stress scores showed negligible reduction from 30 to 29. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 98 to 96, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-20 CONTROL GROUP

NAME OF THE CHILD- 20 C.H	**MOTHER AGE-** 31 YEARS
GENDER- FEMALE	**FATHER AGE-** 35 YEARS
DOB- 8.04.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.8 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academics Skills, Poor Eating Habits, Poor Bladder Bowl Control, Poor Motor Skills, Throw Tantrums in Public.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 114 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 42 to 45, and father's stress scores a slight increase from 38 to 41. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores reduced only slightly from 114 to 110, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-21 CONTROL GROUP

NAME OF THE CHILD- 21 C.J	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 31 YEARS
DOB- 05.01.2022	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child Speaks in two words only, Doesn't understand as per age, Doesn't communicate as per the age, Poor Bladder Bowl Control, Poor Eye Contact, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 111 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 41 to 38, and father's stress scores showed a slight reduction from 35 to 29. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores a slightly reduced from 111 to 107, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-22 CONTROL GROUP

NAME OF THE CHILD- 22 C.J	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 26.07.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.5 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Social Skills, Poor Physical Involvement, Poor Motor Skills, Shows Hyperactivity, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 120 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 38 to 36, and father's stress scores showed no reduction from 30 to 30. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slightly reduced from 120 to 109, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-23 CONTROL GROUP

NAME OF THE CHILD- 23 C.J	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 36 YEARS
DOB- 25.02.2022	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 114 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 41 to 38, and father's stress scores showed a slight reduction from 32 to 28. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slightly reduced from 114 to 107, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-24 CONTROL GROUP

NAME OF THE CHILD- 24 C.J	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 04.08.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 117 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 42 to 40, and father's stress scores showed a slight increase from 32 to 33. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slightly reduction from 117 to 103, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-25 CONTROL GROUP

NAME OF THE CHILD- 25 C.J	**MOTHER AGE-** 33 YEARS
GENDER- MALE	**FATHER AGE-** 35 YEARS
DOB- 17.06.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.6 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Eye Contact, Throw Tantrums, Shows Hyperactivities.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 118 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 47 to 44, and father's stress scores showed slight increase from 37 to 42. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slightly reduced from 118 to 101, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-26 CONTROL GROUP

NAME OF THE CHILD- 26 C.H	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 37 YEARS
DOB- 06.09.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.4 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Throw tantrums, Show Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 109 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 41 to 38, and father's stress scores showed slight reduction from 36 to 31. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores increased slightly from 109 to 113, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-27 CONTROL GROUP

NAME OF THE CHILD- 27 C.H	**MOTHER AGE-** 32 YEARS
GENDER- FEMALE	**FATHER AGE-** 32 YEARS
DOB- 01.07.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor academic skills, Poor Social Interaction, Poor Motor Skills, Pulls other, Misbehaves in Public, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 113 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight increase from 39 to 43, and father's stress scores showed slight reduction from 31 to 28. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slightly reduced from 113 to 108, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-28 CONTROL GROUP

NAME OF THE CHILD- 28 C.H	**MOTHER AGE-** 32 YEARS
GENDER- FEMALE	**FATHER AGE-** 33 YEARS
DOB- 08.08.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Eye Contact, Poor Sitting Span, Throw Tantrums, Push Others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 117 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 37 to 36, and father's stress scores showed negligible reduction from 34 to 33. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores increased slightly from 117 to 109, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-29 CONTROL GROUP

NAME OF THE CHILD- 29 C.H	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 15.10.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.3 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Social Skills, Poor Motor Skills, Throw Tantrums, Bites Other, Misbehaves in Public, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 112 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 44 to 42, and father's stress scores showed slight reduction from 31 to 28. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slightly reduced from 112 to 110, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-30 CONTROL GROUP

NAME OF THE CHILD- 30 C.H	**MOTHER AGE-** 31 YEARS
GENDER- FEMALE	**FATHER AGE-** 34 YEARS
DOB- 17.02.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4 YEARS	**ADDRESS-** Hoshiarpur

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academics Skills, Poor Eating Habits, Poor Bladder Bowl Control, Poor Motor Skills, Throw Tantrums in Public.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 109 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having severe level of stress.

INTERVENTION PLAN-

Participants in the control group did not receive the structured Cognitive Behavioral Therapy (CBT) intervention during the study period. Instead, they engaged in routine assessments and general discussions related to parenting stress and child behavior but were not exposed to any systematic therapeutic framework. The control group did not undergo any structured sessions for cognitive restructuring, coping strategies, or relapse prevention. Unlike the experimental group, they were not introduced to techniques such as Rational Responding, Exposure Therapy, or mindfulness-based strategies. The control group functioned as a baseline for comparison, helping to assess the effectiveness of the CBT model implemented with the experimental group.

TREATMENT OUTCOME SUMMARY

Participants in the control group, who did not receive any structured Cognitive Behavioral Therapy (CBT) during the study period, showed minimal or no improvement in their stress levels. Many participants continued to report difficulties related to cognitive distortions, emotional dysregulation, and maladaptive behavioral patterns. While some natural fluctuations in mood and functioning were observed, there were no statistically significant changes in standardized outcome measures between pre- and post-assessment. A comparison of pre-test and post-test scores showed minimal or no changes in stress levels. Mother's stress scores showed a slight reduction from 45 to 43, and father's stress scores showed slight reduction from 42 to 41. Without the structured CBT intervention, mothers' and fathers' stress levels indicated no significant changes in reduction of stress levels. Correspondingly, the behavioural development of children with intellectual disabilities in the control group showed minimal or no improvement, with behavioural problem scores slightly reduced from 109 to 98, indicating that the issues remained largely unchanged. These findings suggest that, in the absence of a structured therapeutic intervention, reduction in parental stress and child behavioural problems were substantially lower than in the experimental group.

CASE-1 EXPERIMENTAL GROUP

NAME OF THE CHILD- 1 E.H	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 15.02.2018	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.2 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Eye Contact, Throw Tantrums, Shows Hyperactivities.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 108 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 48 to 34, and fathers' scores decreasing from 28 to 20. Following the CBT intervention, mothers' stress levels reduced by 14 points and fathers' stress levels reduced by 8 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 108 to a post-intervention score of 66, reflecting a total reduction of 42 points.

CASE-2 EXPERIMENTAL GROUP

NAME OF THE CHILD- 2 E.H	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 5.03.2018	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.1 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child speaks in one word only, Drags toward the object, Doesn't understand as per age, Doesn't communicate as per the age, Poor Bladder & Bowl Movements, Poor Name response, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 107 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having severe level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 47 to 28, and fathers' scores decreasing from 40 to 23. Following the CBT intervention, mothers' stress levels reduced by 19 points and fathers' stress levels reduced by 17 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 107 to a post-intervention score of 66, reflecting a total reduction of 44 points.

CASE-3 EXPERIMENTAL GROUP

NAME OF THE CHILD- 3 E.H	**MOTHER AGE-** 33 YEARS
GENDER- MALE	**FATHER AGE-** 37 YEARS
DOB- 3.12.2016	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.4 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academic skills, Poor Name response, Poor Motor Skills, Throw tantrums, Shows hyperactivity, Pulls others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 80 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having mild level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 32 to 24, and fathers' scores decreasing from 27 to 20. Following the CBT intervention, mothers' stress levels reduced by 8 points and fathers' stress levels reduced by 7 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 108 to a post-intervention score of 56, reflecting a total reduction of 24 points.

CASE-4 EXPERIMENTAL GROUP

NAME OF THE CHILD- 4 **E.H**	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 37 YEARS
DOB- 18.04.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academics Skills, Poor Motor Skills, Throw tantrums, Push Others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had Severe behavioral problems having score of 110 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention Assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 46 to 30, and fathers' scores decreasing from 36 to 23. Following the CBT intervention, mothers' stress levels reduced by 16 points and fathers' stress levels reduced by 13 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 110 to a post-intervention score of 65, reflecting a total reduction of 45 points.

CASE-5 EXPERIMENTAL GROUP

NAME OF THE CHILD- 5 E.H	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 08.09.2016	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.6 YEARS	**ADDRESS-** HOSHIARPUR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't involve in physical activities, Doesn't Interact with the peer group, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 108 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention Assessment of mother & father it was found that Father was having moderate level of stress while mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 49 to 30, and fathers' scores decreasing from 40 to 24. Following the CBT intervention, mothers' stress levels reduced by 19 points and fathers' stress levels reduced by 16 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 108 to a post-intervention score of 64, reflecting a total reduction of 44 points.

CASE-6 EXPERIMENTAL GROUP

NAME OF THE CHILD- 6 E.H	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 19.06.2017	**DAIGNOSIS-** Moderate Intellectual disabled
AGE OF THE CHILD- 3.8 YEARS	**ADDRESS-** Hoshiarpur

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child doesn't speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor interaction skills, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 82 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention Assessment of mother & father it was found that father was having moderate level of stress while mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 30 to 23, and fathers' scores decreasing from 29 to 20. Following the CBT intervention, mothers' stress levels reduced by 7 points and fathers' stress levels reduced by 9 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 82 to a post-intervention score of 55, reflecting a total reduction of 27 points.

CASE-7 EXPERIMENTAL GROUP

NAME OF THE CHILD- 7 E.H	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 14.10.2017	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** Hoshiarpur

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child is unable to speak as per the age, Doesn't understand as per age, Communicate in single word only, Bites other, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 88 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention Assessment of mother & father it was found that Father was having moderate level of stress while mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 31 to 25, and fathers' scores decreasing from 30 to 23. Following the CBT intervention, mothers' stress levels reduced by 6 points and fathers' stress levels reduced by 7 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 88 to a post-intervention score of 55, reflecting a total reduction of 33 points.

CASE-8 EXPERIMENTAL GROUP

NAME OF THE CHILD- 8 E.J	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 05.01.2018	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.3 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Name response, Poor Peer Interaction, Spits on others, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 85 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention Assessment of mother & father it was found that Father was having moderate level of stress while mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 35 to 24, and fathers' scores decreasing from 27 to 20. Following the CBT intervention, mothers' stress levels reduced by 11 points and fathers' stress levels reduced by 7 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 85 to a post-intervention score of 52, reflecting a total reduction of 33 points.

CASE-9 EXPERIMENTAL GROUP

NAME OF THE CHILD- 9 E.J	**MOTHER AGE-** 32 YEARS
GENDER- FEMALE	**FATHER AGE-** 36 YEARS
DOB- 25.05.2016	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.9 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Academics Skills, Throw tantrums, Shouts in Public places, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 83 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 33 to 22, and fathers' scores decreasing from 28 to 19. Following the CBT intervention, mothers' stress levels reduced by 11 points and fathers' stress levels reduced by 9 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 83 to a post-intervention score of 60, reflecting a total reduction of 23 points.

CASE-10 EXPERIMENTAL GROUP

NAME OF THE CHILD- 10 E.J	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 23.10.2016	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.5 YEARS	**ADDRESS-** JALANDHAR

CHIEF COMPLAINTS – The parent visited the organization with the complaints like
Child doesn't speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academic skills, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT- The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-2 (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 111 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & Father) were assessed Separately for their stress through Standard Stress Scale under the following categories as per the scale like life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT were; 4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 48 to 32, and fathers' scores decreasing from 31 to 24. Following the CBT intervention, mothers' stress levels reduced by 16 points and fathers' stress levels reduced by 7 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 111 to a post-intervention score of 68, reflecting a total reduction of 43 points.

CASE-11 EXPERIMENTAL GROUP

NAME OF THE CHILD- 11 E.J	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 38 YEARS
DOB- 04.01.2022	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.1 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Eye Contact, Throw Tantrums, Shows Hyperactivities.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 101 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 45 to 36, and fathers' scores decreasing from 30 to 22. Following the CBT intervention, mothers' stress levels reduced by 9 points and fathers' stress levels reduced by 8 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 108 to a post-intervention score of 57, reflecting a total reduction of 51 points.

CASE-12 EXPERIMENTAL GROUP

NAME OF THE CHILD- 12 E.J	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 14.11.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.8 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child speaks in one word only, Drags toward the object, Doesn't understand as per age, Doesn't communicate as per the age, Poor Bladder & Bowl Movements, Poor Name response, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 110 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 47 to 30, and fathers' scores decreasing from 38 to 23. Following the CBT intervention, mothers' stress levels reduced by 17 points and fathers' stress levels reduced by 15 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 110 to a post-intervention score of 70, reflecting a total reduction of 40 points.

CASE-13 EXPERIMENTAL GROUP

NAME OF THE CHILD- 13 E.J	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 37 YEARS
DOB- 10.02.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academic skills, Poor Name response, Poor Motor Skills, Throw tantrums, Shows hyperactivity, Pulls others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 85 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 40 to 22, and fathers' scores decreasing from 32 to 24. Following the CBT intervention, mothers' stress levels reduced by 18 points and fathers' stress levels reduced by 8 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 85 to a post-intervention score of 60, reflecting a total reduction of 25 points.

CASE-14 EXPERIMENTAL GROUP

NAME OF THE CHILD- 14 E.J	**MOTHER AGE-** 35 YEARS
GENDER- MALE	**FATHER AGE-** 36 YEARS
DOB- 10.09.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.5 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academics Skills, Poor Motor Skills, Throw tantrums, Push Others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 98 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 41 to 28, and fathers' scores decreasing from 36 to 21. Following the CBT intervention, mothers' stress levels reduced by 13 points and fathers' stress levels reduced by 15 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 98 to a post-intervention score of 61, reflecting a total reduction of 37 points.

CASE-15 EXPERIMENTAL GROUP

NAME OF THE CHILD- 15 E.J	**MOTHER AGE-** 33 YEARS
GENDER- MALE	**FATHER AGE-** 35 YEARS
DOB- 07.10.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.4 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't involve in physical activities, Doesn't Interact with the peer group, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 110 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 44 to 36, and fathers' scores decreasing from 42 to 25. Following the CBT intervention, mothers' stress levels reduced by 8 points and fathers' stress levels reduced by 17 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 110 to a post-intervention score of 70, reflecting a total reduction of 40 points.

CASE-16 EXPERIMENTAL GROUP

NAME OF THE CHILD- 16 EJ	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 35 YEARS
DOB- 26.06.2020	**DAIGNOSIS-** Moderate Intellectual disabled
AGE OF THE CHILD- 4.8 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child doesn't speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor interaction skills, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 86 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 35 to 26, and fathers' scores decreasing from 28 to 20. Following the CBT intervention, mothers' stress levels reduced by 9 points and fathers' stress levels reduced by 8 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 86 to a post-intervention score of 56, reflecting a total reduction of 30 points.

CASE-17 EXPERIMENTAL GROUP

NAME OF THE CHILD- 17 E.J	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 16.12.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.2 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Communicate in single word only, Bites other, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 90 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having mild level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 37 to 21, and fathers' scores decreasing from 24 to 22. Following the CBT intervention, mothers' stress levels reduced by 16 points and fathers' stress levels reduced by 2 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 90 to a post-intervention score of 62, reflecting a total reduction of 28 points.

CASE-18 EXPERIMENTAL GROUP

NAME OF THE CHILD- 18 E.J	**MOTHER AGE-** 36 YEARS
GENDER- MALE	**FATHER AGE-** 37 YEARS
DOB- 14.05.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.9 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Name response, Poor Peer Interaction, Spits on others, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 84 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having mild level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 30 to 22, and fathers' scores decreasing from 26 to 21. Following the CBT intervention, mothers' stress levels reduced by 8 points and fathers' stress levels reduced by 5 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 84 to a post-intervention score of 58, reflecting a total reduction of 26 points.

CASE-19 EXPERIMENTAL GROUP

NAME OF THE CHILD- 19 E.J	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 23.11.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.3 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Academics Skills, Throw tantrums, Shouts in Public places, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 90 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father and mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 36 to 24, and fathers' scores decreasing from 28 to 19. Following the CBT intervention, mothers' stress levels reduced by 12 points and fathers' stress levels reduced by 9 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 90 to a post-intervention score of 53, reflecting a total reduction of 37 points.

CASE-20 EXPERIMENTAL GROUP

NAME OF THE CHILD- 20 EJ	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 01.08.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.6 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child doesn't speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academic skills, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 104 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 42 to 33, and fathers' scores decreasing from 33 to 23. Following the CBT intervention, mothers' stress levels reduced by 9 points and fathers' stress levels reduced by 10 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 104 to a post-intervention score of 71, reflecting a total reduction of 33 points.

CASE-21 EXPERIMENTAL GROUP

NAME OF THE CHILD- 21 E.J	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 32 YEARS
DOB- 25.01.2022	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.1 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Name response, Poor Eye Contact, Throw Tantrums, Shows Hyperactivities.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 102 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 47 to 34, and fathers' scores decreasing from 35 to 24. Following the CBT intervention, mothers' stress levels reduced by 13 points and fathers' stress levels reduced by 11 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 102 to a post-intervention score of 69, reflecting a total reduction of 33 points.

CASE-22 EXPERIMENTAL GROUP

NAME OF THE CHILD- 22 E.J	**MOTHER AGE-** 35 YEARS
GENDER- MALE	**FATHER AGE-** 36 YEARS
DOB- 27.04.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.9 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child speaks in one word only, Drags toward the object, Doesn't understand as per age, Doesn't communicate as per the age, Poor Bladder & Bowl Movements, Poor Name response, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 106 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 45 to 28, and fathers' scores decreasing from 40 to 23. Following the CBT intervention, mothers' stress levels reduced by 17 points and fathers' stress levels reduced by 17 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 106 to a post-intervention score of 68, reflecting a total reduction of 38 points.

CASE-23 EXPERIMENTAL GROUP

NAME OF THE CHILD- 23 E.J	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 01.02.2022	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academic skills, Poor Name response, Poor Motor Skills, Throw tantrums, Shows hyperactivity, Pulls others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 83 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having mild level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 35 to 20, and fathers' scores decreasing from 25 to 18. Following the CBT intervention, mothers' stress levels reduced by 15 points and fathers' stress levels reduced by 7 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 83 to a post-intervention score of 54, reflecting a total reduction of 29 points.

CASE-24 EXPERIMENTAL GROUP

NAME OF THE CHILD- 24 E.J	**MOTHER AGE-** 33 YEARS
GENDER- MALE	**FATHER AGE-** 33 YEARS
DOB- 27.09.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.4 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academics Skills, Poor Motor Skills, Throw tantrums, Push Others.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 107 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having severe level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 46 to 30, and fathers' scores decreasing from 36 to 22. Following the CBT intervention, mothers' stress levels reduced by 16 points and fathers' stress levels reduced by 14 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 107 to a post-intervention score of 64, reflecting a total reduction of 43 points.

CASE-25 EXPERIMENTAL GROUP

NAME OF THE CHILD- 25 E.J	**MOTHER AGE-** 30 YEARS
GENDER- MALE	**FATHER AGE-** 31 YEARS
DOB- 12.08.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.6 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't involve in physical activities, Doesn't Interact with the peer group, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 102 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 40 to 28, and fathers' scores decreasing from 35 to 20. Following the CBT intervention, mothers' stress levels reduced by 12 points and fathers' stress levels reduced by 15 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 102 to a post-intervention score of 60, reflecting a total reduction of 42 points.

CASE-26 EXPERIMENTAL GROUP

NAME OF THE CHILD- 26 E.J	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 10.07.2020	**DAIGNOSIS-** Moderate Intellectual disabled
AGE OF THE CHILD- 4.7 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child doesn't speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor interaction skills, Poor Motor Skills, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 92 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having mild level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 37 to 24, and fathers' scores decreasing from 28 to 18. Following the CBT intervention, mothers' stress levels reduced by 13 points and fathers' stress levels reduced by 10 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 92 to a post-intervention score of 53, reflecting a total reduction of 39 points.

CASE-27 EXPERIMENTAL GROUP

NAME OF THE CHILD- 27 E.J	**MOTHER AGE-** 32 YEARS
GENDER- MALE	**FATHER AGE-** 35 YEARS
DOB- 21.07.2021	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.7 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Communicate in single word only, Bites other, Throw tantrums, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 90 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having mild level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 36 to 22, and fathers' scores decreasing from 30 to 20. Following the CBT intervention, mothers' stress levels reduced by 14 points and fathers' stress levels reduced by 10 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 90 to a post-intervention score of 55, reflecting a total reduction of 35 points.

CASE-28 EXPERIMENTAL GROUP

NAME OF THE CHILD- 28 E.J	**MOTHER AGE-** 34 YEARS
GENDER- MALE	**FATHER AGE-** 34 YEARS
DOB- 08.08.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.6 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Name response, Poor Peer Interaction, Spits on others, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 103 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 38 to 28, and fathers' scores decreasing from 35 to 20. Following the CBT intervention, mothers' stress levels reduced by 10 points and fathers' stress levels reduced by 15 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 103 to a post-intervention score of 65, reflecting a total reduction of 38 points.

CASE-29 EXPERIMENTAL GROUP

NAME OF THE CHILD- 29 EJ	**MOTHER AGE-** 30 YEARS
GENDER- FEMALE	**FATHER AGE-** 32 YEARS
DOB- 15.10.2020	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 4.4 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child is unable to speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Poor Academics Skills, Throw tantrums, Shouts in Public places, Shows Hyperactivity.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had moderate behavioral problems having score of 81 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-

The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 31 to 24, and fathers' scores decreasing from 29 to 18. Following the CBT intervention, mothers' stress levels reduced by 7 points and fathers' stress levels reduced by 11 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 81 to a post-intervention score of 52, reflecting a total reduction of 29 points.

CASE-30 EXPERIMENTAL GROUP

NAME OF THE CHILD- 30 EJ	**MOTHER AGE-** 31 YEARS
GENDER- MALE	**FATHER AGE-** 31 YEARS
DOB- 05.02.2022	**DAIGNOSIS-** Moderate Intellectual Disabled
AGE OF THE CHILD- 3.1 YEARS	**ADDRESS-** Jalandhar

CHIEF COMPLAINTS – The parent visited the organization with the complaints like Child doesn't speak as per the age, Doesn't understand as per age, Doesn't communicate as per the age, Doesn't Interact with the peer group, Poor Academic skills, Poor Name response, Poor Motor Skills, Throw tantrums.

CHILD'S BEHAVIOURAL ASSESSMENT - The behavioral assessment was done on the child through the Standard Behavioral Scale i.e. BASIC MR Part-B (Behavioral Assessment Scale for Indian Children with Mental Retardation) for categories as per the scale Namely Violent, Destructive Behaviors, Misbehaves with Others, Temper Tantrums, Self-Injury, Repetitive Behaviors, Odd Behaviors, Hyperactive , Rebellious, Antisocial Behavior and Fear. After assessment it was found that the child had severe behavioral problems having score of 101 on BASIC MR-B.

PARENT'S STRESS ASSESSMENT – Both Parents (Mother & father) were assessed Separately for their stress through Standard Stress Scale under the following category of life situations, social stress, Social Support, daily distress, anxiety about the future, recreational capacities/exhaustion. After Pre intervention assessment of mother & father it was found that father was having moderate level of stress while the mother was having moderate level of stress.

INTERVENTION PLAN-
The Intervention model was designed carefully according to the Standard procedure of the CBT intervention. The schedule followed in implementation of CBT was as follows;
4 Sessions for Rapport Building and identification of antecedents, 26 Intervention Sessions and the last 6 sessions for Prevention of Relapsing and Termination Process.

The CBT intervention for the experimental group aimed at reducing parental stress was implemented through a structured five-step process. Initially, the researcher identified the antecedents of automatic negative thoughts (ANTs), beliefs, emotions, and behaviors in parents of children with intellectual disabilities. The relationship between these ANTs and emotional responses was then analysed to inform the selection of appropriate CBT strategies. In the third phase, techniques such as Rational Responding, Idiosyncratic Techniques, Cognitive Restructuring, and Exposure Therapy were applied to replace maladaptive thoughts and behaviors with more constructive ones. This was Followed by cognitive restructuring, coping strategies including mindfulness and relaxation were introduced to support emotional regulation and prevent relapse. As the intervention neared completion, participants were trained in self-care practices—such as regular exercise, healthy eating, adequate sleep, and engagement in enjoyable activities—to promote long-term stress management. Each step was carefully followed to ensure a comprehensive and effective therapeutic process.

TREATMENT OUTCOME SUMMARY

After implementing a structured CBT intervention, the parents demonstrated noticeable improvement in their stress levels. Key cognitive distortions were identified and effectively addressed through cognitive restructuring and behavioural modifications. The parents were engaged well in therapy, consistently completing homework assignments and applying learned strategies outside sessions. A comparison of pre-test and post-test scores showed a significant reduction in stress levels, with mothers' stress scores decreasing from 38 to 28, and fathers' scores decreasing from 29 to 19. Following the CBT intervention, mothers' stress levels reduced by 10 points and fathers' stress levels reduced by 10 points, demonstrating the effectiveness of the intervention in improving the psychological well-being of parents. The reduction in parental stress levels positively influenced the behavioural development of children with intellectual disabilities, as reflected in their behavioural problem scores from a pre-test score of 101 to a post-intervention score of 50, reflecting a total reduction of 51 points.

CHILD'S NAME- Master. 1 E. H	FATHER'S NAME- Mr. 1 E. H	MOTHER'S NAME- Mrs. 1 E. H

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	4.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	8.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	11.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Mother had Future Insecurities, Social Stigma. Father is more concerned about prognosis &child's life in future. Both shared that they do not have any personal spaces now.
4	15.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	18.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
6	22.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
7	25.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous session about Future.

8	29.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.
9	1.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they insecure about the future. After Session they were observed More Relaxed about Future Insecurities.
10	5.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social Stigma& Emotions aligned with ANT of Social Stigma.	ANT Insecure of judgemental attitude of the people. They use to feel sad in social gatherings, when they see kids of their child's age. To prevent so they were in denial of taking child out in social gatherings.
11	8.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Rational responding technique was used to reconstruct their dysfunctional thought. They were also asked for any judgmental incident they encountered. Parent were asked to write such incident.
12	12.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have no specific incidents to share about social judgmental or stigmatic situations. Asked parent to do mindfulness and Deep Breathing at home for at least 30 Minutes on daily basis.
13	15.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation. They also feel like age mates may ignore or bully in social gathering as child doesn't have good intellect.
14	19.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They

				were asked to make a list of evidences related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges will come with Limited Intelligence, but we need to modify our thoughts to think positive and help children to explore the world. New perspective toward life is important.
15	22.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Noincidents were discussed on the sessions about the stressors of previous session and found that they were assuming it very much. Asked them to take child out in all gatherings and help him accommodate with the situations. Asked to do mindfulness &deep breathings on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	26.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Prognosis of the child's condition.	Parents were very worried about the child's future withlimitedIntellectual condition. They assumed that he won't be able to live life independently and will never take care of himself in future. Their thought of What will happen after us ? was thetriggering factor of their sad emotion. They were not mingling with friend and family. Tried to be isolated from others.
17	29.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Prognosis of the child's condition.	The rational responding was used to make parent understandable about the thought they were having related to the Future. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. It

				was also quoted to the parents that the present actions will decides the future. They were asked to make new schedule for their routine to be followed.
18	3.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to watch videos on success stories.
19	6.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of Prognosis of the child's condition. It was also asked any other thing which bothers them related to the child's condition.
20	10.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors.
21	13.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social Isolations.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like their presence. They expressed that running after the child make them exhausted and frustrated also.They have become more irritable and short tempered, due to this they will ruintheir relationship with the friends and family. Now they avoid meeting friends and family
22	17.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are

				problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	20.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	24.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do deep breathing exercises on regular basis.
25	27.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	2.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Personal Space.	Parents were further interviewed on personal space. Idiosyncratic technique was used to understand the literally meaning of personal space for both the parents. It was observed that mother was over occupied in her daily routine and father was overburdened due to work life imbalance.
27	10.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Red defined the meaning of their personal space through rational responding technique. Asked both parents to create a schedule for work life

				balance. It was also asked parents that following a schedule for balance in life very important, scheduling of the day will help them understand the gaps for personal spaces.
28	18.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	General follow up was done on the tasked asked to do. It was also found there was scope to correct their schedule for personal spaces. Helped parent to create spaces in schedule for their self. Asked to follow the schedule on daily basis.
29	24.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups on previous task asked i.e.schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	1.9.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups for previous Stressors. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They were observed to be more positive in this perspective also.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	7.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.

32	14.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.
33	21.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	28.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	5.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	14.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master. 2 E. H	FATHER'S NAME- Mr. 2 E. H	MOTHER'S NAME- Mrs. 2 E. H

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	4.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	8.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	11.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Mother hadInsecurities forother child in family. Both parents were worried on the Social Stigma, Social Segregation, Future Worrisome, child's Life with the Condition in future.
4	15.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	18.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of child's Life with the Condition in future.	Parents were very worried about the child's future with limited Intellectual condition. They prejudiced that the child can't live life independently. Will he be burdened on other child in family? The thought of who will look after him after us? Will he manage himself after us? Interrogative questions about the future with parents were the triggering factor of their sad emotion and anxiety.

6	22.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of child's Life with the Condition in future.	The rational responding was used to make parent understandable about the thought they were having related to the Future of the child with the condition. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. Motivation were reinforced with positive quotations for life and future. They were asked to make new schedule for their routine to be followed. Asked to be focus on today & mindfulness to be practiced on regular basis.
7	25.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of child's Life with the Condition in future.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to practice mindfulness on regular basis.
8	29.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of child's Life with the Condition in future. It was also asked, if any else bothering them related to the child's condition.
9	1.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors. Practice mindfulness & focus on today technique. They were found to be more looking forward for the life now, in compression with the past sessions on the same stressor.

10	5.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social Stigma& Emotions aligned with ANT of Social Stigma.	ANT on Insecurities of thesituation when other judge the child in social situation. They use to feel sad in social gatherings. To prevent judgments they were resistiveto take the child out in social gatherings.
11	8.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multiple quotes and real life stories. It was asked form the parent to write down incidences, they were encounter with. Asked awkward situation where they felt judgment of the people on their ward's condition.
12	12.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have no incidents to share about social stigmatic situations. They shared casual situation but that is also not linked with the child's condition. Asked parent to do Deep Breathing at home for at least 30 Minutes on daily basis.
13	15.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation and feel like he'll be ignored or bullied in social situations .
14	19.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They were asked to make a list of evidences they had previously related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges

				will come with Limited Intelligence, but we need to modify our thoughts to think positive to see other perspective of the life.
15	22.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Very few incidents they discussed in the sessions and found that they were assuming it very much. Asked them to take child out in all gatherings and help him accommodate with the situations. Asked to do deep breathings also on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	26.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Future worrisome & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
17	29.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
18	3.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous session about Future.
19	6.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.

20	10.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they insecure about the future. After Session they were observed More Relaxed about Future Insecurities.
21	13.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social Isolations.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like if they around them. They expressed that running after the child made them exhausted and frustrated. Now they get irritated easily. This is ruined their relationship with the friends and family. Now they avoid meeting friends and family
22	17.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	20.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	24.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do

				deep breathing exercises on regular basis.
25	27.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	2.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Insecurities of other child in family.	Parents were further interviewed on Insecurities of other child in family. Rational Responding technique was used to make parent understandable about the relationship between 1st child and 2nd child. They were made reminded about the fact that family always stay together and take care of each other in good or bad times. Nurturing offspring's in a way where they do not feel burdened. The planning of future should be done in very practical grounds is important. Parents were asked to make list of their insecurities and solution for the same.
27	10.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities of other child in family.	Follow up was taken on the previous discussion. It was found that parent made the list of the insecurities and the best solution of the problems. After discussion and guidance on the same. Parent felt more relaxed and relived. They were also suggested to practice mindfulness and deep breathing exercised on regular basis.
28	18.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities of other child in family.	General follow up was done on the tasked asked to do. They were also asked to watch videos on the success stories of the families having children with special

				needs. They were also suggested to spend time with both children through scheduling of their routine. Practice mindfulness technique on regular basis.
29	24.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities of other child in family.	Follow ups on previous task asked i.e.schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	1.9.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT Insecurities of other child in family.	Follow ups for previous Stressors. It was found that parent incorporated mindfulness in their schedule on daily basis. They also felt more relaxed on the insecurities of next pregnancy. Asked to practice suggested recommendation on regular basis.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	7.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.
32	14.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic

				solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.
33	21.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	28.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	5.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	14.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master. 3 E. H	FATHER'S NAME- Mr. 3 E. H	MOTHER'S NAME- Mrs. 3 E. H

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	4.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	8.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	11.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Poor family Dynamic, Future Insecurities, Social Stigma, child's life in future, Lack of personal space.
4	15.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	18.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of Parents on Poor Family Dynamics.	Parents were further interviewed on Family Dynamics. It was a Joint Family where mother need to take care of in laws. As per mother her in laws were not cooperative in nurturing the chid with child need. They cursed her when she was pregnant and now she doesn't want to serve them. Living in the same family and facing them on every day basis made her feel bad. Now she lose temper when anybody ask for anything. The poor support and cursing temperament was triggering the stress. It was observed that mother was over occupied in her daily routine and father

				was overburdened with the responsibilities.
6	22.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Poor Family Dynamics.	Carefully understood the family dynamics and responsibilities. The parents were train for assertive training. It was asked form parents that sometimes we have to say "no" to the person and in situations where you do not agree. It was also asked that practice saying "NO" when your personal scheduled time is compromising. Scheduling of the routeing was also asked to restructure.
7	25.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents Poor Family Dynamics.	Assertive training was reinforced and general follow up was done on the task asked. It was also found there was scope to correct the schedule for personal spaces. Helped parent to create spaces in schedule for their self. Asked to follow the schedule on daily basis.
8	29.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Poor Family Dynamics.	Follow ups on previous task asked i.e. schedule follow ups. It was also asked if they can manage to live separately, to avoid the triggers. It was found that parents were following the schedule, but not on regular basis. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
9	1.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	Reinforced & Follow ups of assertive training was done. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They found more space in their daily schedule for their self and were observed to be more positive in this perspective.

10	5.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	ANT Answering questions related to the child condition and behaviour or temper tantrum child throw in public. They use to feel sad in social gatherings when such incident encounters. To prevent themthey avoid taking child out in social gatherings.
11	8.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multipleincedent and it was asked form the parent to write down few incidences where they were asked awkward question regarding their ward's condition.
12	12.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents revealed that the questions people asked from them were more of concerning way rather in poking way. Asked parent to practice mindfulness Deep Breathing at home for at least 30 Minutes on daily basis.
13	15.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation. They are also worried about that people will bully him in social situations.
14	19.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They were asked to make a list of evidences they had previously related to this ANT. The generalization of parents in the same situation was also be done. It was also

				shared that challenges will come in parenting, but we need to be more assertive to face the challenges to make children independent in life.Modification of thoughts to think positive to see other perspective of the life is very important.
15	22.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done. Asked them to take child out in all gatherings and help him accommodate with the situations. Make children learn new challenges and let them explore the world. Asked to do deep breathings also on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	26.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the child's condition in future.	Parents were very worried about the child's future with limited Intellectual condition. They assumed that he won't be able to live life independently and will never take care of himself in future. Their thought of What will happen after us. was the triggering factor of their sad emotion. They were not mingling with friend and family. Tried to be isolated from others.
17	29.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT child's condition in future.	The rational responding was used to make parent understandable about the thought they were having related to the Future. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. It was also quoted to the parents that the present actions will decides the future. They were asked to make new schedule for their routine to be followed.

18	3.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to watch videos on success stories.
19	6.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of Prognosis of the child's condition. It was also asked any other thing which bothers them related to the child's condition.
20	10.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors.
21	13.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social withdrawal.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like their presence. They expressed that running after the child make them exhausted and frustrated also. This is ruined their relationship with the friends and family. Now they avoid meeting friends and family
22	17.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social withdrawal.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	20.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the

				names mentioned in the list. They were also asked to make a call to their friends and relative.
24	24.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do deep breathing exercises on regular basis.
25	27.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	2.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Personal Space.	Parents were further interviewed on personal space. Idiosyncratic technique was used to understand the literally meaning of personal space for both the parents. It was observed that mother was over occupied in her daily routine and father was overburdened due to work life imbalance.
27	10.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Red defined the meaning of their personal space through rational responding technique. Asked both parents to create a schedule for work life balance. It was also asked parents that following a schedule for balance in life very important, scheduling of the day will help them understand the gaps for personal spaces.

28	18.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	General follow up was done on the tasked asked to do. It was also found there was scope to correct their schedule for personal spaces. Helped parent to create spaces in schedule for their self. Asked to follow the schedule on daily basis.
29	24.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups on previous task asked i.e. schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	1.9.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups for previous Stressors. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They were observed to be more positive in this perspective also.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	7.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.
32	14.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges

				on paper. Then frame the severity they can cause and solutions we can implement.
33	21.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	28.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	5.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	14.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master- 4 E.H	FATHER'S NAME- Mr. 4 E.H	MOTHER'S NAME- Mrs. 4 E.H

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	4.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	8.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	11.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Financial overburdened, Future Insecurities, Social responsibilities &Stigma, child's life in future. Both shared that they are at the verge of separation.
4	15.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	18.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of Parents on Financial overburdened.	Lengthy discussion was don on families financial condition to understand the ANT. It was found that family harmony and financial understandings were disturbed. The financial imbalance was impacting their personal life also. Poor financial understanding was creating the anxiety of the future in both the parents.
6	22.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents Financial overburdened.	They were suggested to write down their family financial structure. This help them understand the linkage and loops between the imbalances between income , expenditures, debts and investments. It was also asked Parent to write down

				more realistic financial goal by keeping the family in focus.
7	25.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents worked out on the goal planning asked, still they need more clarity. Clarity was offered in the session and asked them to make the same on next session.
8	29.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow was done previous discussion and goals asked. It was also asked that yearly financial goalsfurther break in Months goals and month goals in weeks and so on.
9	1.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents for previous task asked and observed that they understood the concept of financial balance and importance's of realistic financial goals for harmony in family. Asked to use Relaxation tech and deep breathing exercises on regular basis. They were observed More Relaxed about Financial Future Insecurities.
10	5.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social responsibilities&Stigma.	ANT were ruled out. Huge Social circle of the parents before marriage was now triggering their insecurities. Theywere very happy go lucky couple before the child, but after the child they feel like people will make fun of them running after the child with such condition. Now they feel sad and ashamed of facing social gatherings. So they avoid attending social gatherings.
11	8.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social responsibilities & Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multiple and it was asked form the parent to write down few

				incidences where they were asked awkward question regarding their ward's condition.
12	12.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents had 2 incidents to share about social stigmatic situations, but that is also not directly linked with them or their child's condition. Asked parent to do Deep Breathing at home for at least 30 Minutes on daily basis.
13	15.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the comparison though also scares them in social gathering.
14	19.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Rational responding was used and asked parent that comparing children is defiantly is not good idea. But if you compare your child with same age mate in social gathering than consider it as next challenge to be achieved in next couple of months. It was also shared that challenges will come with Limited Intelligence, but we need to modify our thoughts to think brighter side of the comparison to encash the other perspective of the life.
15	22.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Asked them to take child out in all gatherings and help him accommodate with the situations. Parent were found to be more comfortable to the child in social gathering now. Asked to do deep breathings also on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**

16	26.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT on child's condition in future.	Parents were very worried about the child's future withlimitedIntellectual condition. They were concerned about life of the child after us. They assumed that he won't be able to live life independently and will never take care of himself in future. Their thought of helplessness was thetriggering factor of their sad emotion and anxiety about the future. They were not sharing with friend and family. Tried to be isolated from others, to solve the situation their way.
17	29.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT child's condition in future.	The rational responding was used to make parent understandable about the thought they were having related to the Future. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. It was also quoted to the parents that the present actions will only decides the future. They were asked to stay positive in life's perspective.
18	3.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to watch videos on success stories.
19	6.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of future of the child's condition. It was also asked any other thing which bothers them related to the child's condition.

20	10.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors. They were more relaxed in compression to previous session on the discussed stressor.
21	13.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social Isolations.	Their distorted self-image in the society was bothering them. Theybelieve that handling child with special needs is task and full time job. Our image is already gone, due to people's judgment on our child's condition. Imagining distorted image of their self, make them feel sad and disheartened. was They avoiding meeting friend and family. They feel better living in isolation rather than to be in social gathering & situations. Now they avoid meeting friends and family.
22	17.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about importance of meeting people and family. Asked to share the incident where their friends and family made them feel bad about their image. Asked them to make list of Friends & relatives, if done so.
23	20.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. No such concreate list of incident they can quote with evidence. They were also asked to make a list of their friends and relative.
24	24.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. They were asked to talk to the people on the list they created. They were also asked to do deep

				breathing exercises on regular basis.
25	27.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were very concerned about their health, life and child. A contrast experienced helped them feel good and positive about the life. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	2.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Personal Space.	Parents were further interviewed on personal space. Idiosyncratic technique was used to understand the literally meaning of personal space for both the parents. It was observed that mother was over occupied in her daily routine and father was overburdened due to work life imbalance.
27	10.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Red defined the meaning of their personal space through rational responding technique. Asked both parents to create a schedule for work life balance. It was also asked parents that following a schedule for balance in life very important, scheduling of the day will help them understand the gaps for personal spaces.
28	18.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	General follow up was done on the tasked asked to do. It was also found there was scope to correct their schedule for personal spaces. Helped parent to

				create spaces in schedule for their self. Asked to follow the schedule on daily basis.
29	24.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups on previous task asked i.e.schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	1.9.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups for previous Stressors. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They were observed to be more positive in this perspective also.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	7.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.
32	14.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.

33	21.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	28.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	5.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	14.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master. 5 E.H	FATHER'S NAME- Mr. 5 E.H	MOTHER'S NAME- Mrs. 5 E.H

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	4.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	8.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	11.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Rapport.Issues with Family Dynamics, Future Insecurities, Social Stigma,condition&child's life in future.
4	15.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	18.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT & Emotions of the Parents on Family Dynamics.	Parents were further interviewed on Family Dynamics. It was extended Joint Family where mother need to take care of every individual in family with child, whereas father need to seek permission from elders in family to support the mother in other dimensions of life. It was observed that mother was over occupied in her daily routine and father was overburdened due to responsibilities.
6	22.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Family Dynamics.	Carefully understood the family dynamics and responsibilities. The parents were train for assertive training. It was asked form parents that sometimes we have to say "no" to the person and in

				situations where you do not agree. It was also asked that practice saying "NO" when your personal scheduled time is compromising. Scheduling of the routeing was also asked to restructure.
7	25.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Family Dynamics.	Assertive training was reinforced and general follow up was done on the task asked. It was also found there was scope to correct the schedule for personal spaces. Helped parent to create spaces in schedule for their self. Asked to follow the schedule on daily basis.
8	29.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT & Emotions of the Parents linked with Family Dynamics.	Follow ups on previous task asked i.e. schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
9	1.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on previous session objective i.e. Family Dynamics.	Reinforced & Follow ups of assertive training was done. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They found more space in their daily schedule for their self and were observed to be more positive in this perspective.
10	5.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	ANT (Insecure of Awkward questions about the child). They use to feel sad in social gatherings. To prevent so they were in denial of taking child out in social gatherings.
11	8.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multiple and it was asked

				form the parent to write down few incidences where they were asked awkward question regarding their ward's condition.
12	12.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have 2 incidents to share about social stigmatic situations, but that is also not linked with the questions asked related to child's condition. Asked parent to do Deep Breathing at home for at least 30 Minutes on daily basis.
13	15.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation and feel like he'll be ignored or bullied in social situations (2nd ANT
14	19.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They were asked to make a list of evidences they had previously related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges will come with Limited Intelligence, but we need to modify our thoughts to think positive to see other perspective of the life.
15	22.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Very few incidents they discussed in the sessions and found that they were assuming it very much. Asked them to take child out in all gatherings and help him accommodate with the situations. Asked to do deep breathings also on

				regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	26.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Prognosis of the child's condition.	Parents were very worried about the child's future with limited Intellectual condition. They assumed that he won't be able to live life independently and will never take care of himself in future. Their thought of What will happen after us. was the triggering factor of their sad emotion. They were not mingling with friend and family. Tried to be isolated from others.
17	29.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Prognosis of the child's condition.	The rational responding was used to make parent understandable about the thought they were having related to the Future. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. It was also quoted to the parents that the present actions will decides the future. They were asked to make new schedule for their routine to be followed.
18	3.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to watch videos on success stories.
19	6.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of Prognosis of the child's condition. It was also asked any other thing which bothers them related to

				the child's condition.
20	10.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors.
21	13.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Social withdrawal.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like their presence. They expressed that running after the child make them exhausted and frustrated also. This is ruined their relationship with the friends and family. Now they avoid meeting friends and family
22	17.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social withdrawal.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	20.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	24.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do

				deep breathing exercises on regular basis.
25	27.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	2.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
27	10.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
28	18.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous session about Future.
29	24.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.
30	1.9.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they feel insecure about the future. After Session they were observed More Relaxed about Future Insecurities in comparison to the previously done sessions.

	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	7.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.
32	14.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.
33	21.9.21	PREVENTION OF RELAPSING ASSESSMENT & EVALUATION	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	28.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	5.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.

36	14.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master. 6 E. H	FATHER'S NAME- Mr. 6 E. H	MOTHER'S NAME- Mrs. 6 E. H

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	4.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	8.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	11.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Mother had Future Insecurities, Social Stigma. Father is more concerned about prognosis &child's life in future. Both shared that they do not have any personal spaces now.
4	15.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	18.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
6	22.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
7	25.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous session about Future.

8	29.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.
9	1.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they insecure about the future. After Session they were observed More Relaxed about Future Insecurities.
10	5.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social Stigma& Emotions aligned with ANT of Social Stigma.	ANT Insecure of judgemental attitude of the people. They use to feel sad in social gatherings, when they see kids of their child's age. To prevent so they were in denial of taking child out in social gatherings.
11	8.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Rational responding technique was used to reconstruct their dysfunctional thought. They were also asked for any judgmental incident they encountered. Parent were asked to write such incident.
12	12.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have no specific incidents to share about social judgmental or stigmatic situations. Asked parent to do mindfulness and Deep Breathing at home for at least 30 Minutes on daily basis.
13	15.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation. They also feel like age mates may ignore or bully in social gathering as child doesn't have good intellect.
14	19.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They

				were asked to make a list of evidences related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges will come with Limited Intelligence, but we need to modify our thoughts to think positive and help children to explore the world. New perspective toward life is important.
15	22.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Noincidents were discussed on the sessions about the stressors of previous session and found that they were assuming it very much. Asked them to take child out in all gatherings and help him accommodate with the situations. Asked to do mindfulness &deep breathings on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	26.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Prognosis of the child's condition.	Parents were very worried about the child's future withlimitedIntellectual condition. They assumed that he won't be able to live life independently and will never take care of himself in future. Their thought of What will happen after us ? was thetriggering factor of their sad emotion. They were not mingling with friend and family. Tried to be isolated from others.
17	29.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Prognosis of the child's condition.	The rational responding was used to make parent understandable about the thought they were having related to the Future. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. It

				was also quoted to the parents that the present actions will decides the future. They were asked to make new schedule for their routine to be followed.
18	3.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to watch videos on success stories.
19	6.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of Prognosis of the child's condition. It was also asked any other thing which bothers them related to the child's condition.
20	10.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors.
21	13.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social Isolations.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like their presence. They expressed that running after the child make them exhausted and frustrated also.They have become more irritable and short tempered, due to this they will ruintheir relationship with the friends and family. Now they avoid meeting friends and family
22	17.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are

				problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	20.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	24.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do deep breathing exercises on regular basis.
25	27.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	2.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Personal Space.	Parents were further interviewed on personal space. Idiosyncratic technique was used to understand the literally meaning of personal space for both the parents. It was observed that mother was over occupied in her daily routine and father was overburdened due to work life imbalance.
27	10.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Red defined the meaning of their personal space through rational responding technique. Asked both parents to create a schedule for work life

				balance. It was also asked parents that following a schedule for balance in life very important, scheduling of the day will help them understand the gaps for personal spaces.
28	18.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	General follow up was done on the tasked asked to do. It was also found there was scope to correct their schedule for personal spaces. Helped parent to create spaces in schedule for their self. Asked to follow the schedule on daily basis.
29	24.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups on previous task asked i.e.schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	1.9.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups for previous Stressors. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They were observed to be more positive in this perspective also.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	7.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.

32	14.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.
33	21.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	28.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	5.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	14.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master. 7 E. H	FATHER'S NAME- Mr. 7 E. H	MOTHER'S NAME- Mrs. 7 E. H

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	4.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	8.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	11.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Mother hadInsecurities forother child in family. Both parents were worried on the Social Stigma, Social Segregation, Future Worrisome, child's Life with the Condition in future.
4	15.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	18.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of child's Life with the Condition in future.	Parents were very worried about the child's future with limited Intellectual condition. They prejudiced that the child can't live life independently. Will he be burdened on other child in family? The thought of who will look after him after us? Will he manage himself after us? Interrogative questions about the future with parents were the triggering factor of their sad emotion and anxiety.

6	22.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of child's Life with the Condition in future.	The rational responding was used to make parent understandable about the thought they were having related to the Future of the child with the condition. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. Motivation were reinforced with positive quotations for life and future. They were asked to make new schedule for their routine to be followed. Asked to be focus on today & mindfulness to be practiced on regular basis.
7	25.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of child's Life with the Condition in future.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to practice mindfulness on regular basis.
8	29.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of child's Life with the Condition in future. It was also asked, if any else bothering them related to the child's condition.
9	1.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors. Practice mindfulness & focus on today technique. They were found to be more looking forward for the life now, in compression with the past sessions on the same stressor.

10	5.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social Stigma& Emotions aligned with ANT of Social Stigma.	ANT on Insecurities of thesituation when other judge the child in social situation. They use to feel sad in social gatherings. To prevent judgments they were resistiveto take the child out in social gatherings.
11	8.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multiple quotes and real life stories. It was asked form the parent to write down incidences, they were encounter with. Asked awkward situation where they felt judgment of the people on their ward's condition.
12	12.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have no incidents to share about social stigmatic situations. They shared casual situation but that is also not linked with the child's condition. Asked parent to do Deep Breathing at home for at least 30 Minutes on daily basis.
13	15.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation and feel like he'll be ignored or bullied in social situations .
14	19.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They were asked to make a list of evidences they had previously related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges

				will come with Limited Intelligence, but we need to modify our thoughts to think positive to see other perspective of the life.
15	22.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Very few incidents they discussed in the sessions and found that they were assuming it very much. Asked them to take child out in all gatherings and help him accommodate with the situations. Asked to do deep breathings also on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	26.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Future worrisome & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
17	29.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
18	3.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous session about Future.
19	6.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.

20	10.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they insecure about the future. After Session they were observed More Relaxed about Future Insecurities.
21	13.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social Isolations.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like if they around them. They expressed that running after the child made them exhausted and frustrated. Now they get irritated easily. This is ruined their relationship with the friends and family. Now they avoid meeting friends and family
22	17.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	20.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	24.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do

				deep breathing exercises on regular basis.
25	27.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	2.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Insecurities of other child in family.	Parents were further interviewed on Insecurities of other child in family. Rational Responding technique was used to make parent understandable about the relationship between 1st child and 2nd child. They were made reminded about the fact that family always stay together and take care of each other in good or bad times. Nurturing offspring's in a way where they do not feel burdened. The planning of future should be done in very practical grounds is important. Parents were asked to make list of their insecurities and solution for the same.
27	10.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities of other child in family.	Follow up was taken on the previous discussion. It was found that parent made the list of the insecurities and the best solution of the problems. After discussion and guidance on the same. Parent felt more relaxed and relived. They were also suggested to practice mindfulness and deep breathing exercised on regular basis.
28	18.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities of other child in family.	General follow up was done on the tasked asked to do. They were also asked to watch videos on the success stories of the families having children with special

				needs. They were also suggested to spend time with both children through scheduling of their routine. Practice mindfulness technique on regular basis.
29	24.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities of other child in family.	Follow ups on previous task asked i.e.schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	1.9.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT Insecurities of other child in family.	Follow ups for previous Stressors. It was found that parent incorporated mindfulness in their schedule on daily basis. They also felt more relaxed on the insecurities of next pregnancy. Asked to practice suggested recommendation on regular basis.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	7.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.
32	14.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic

				solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.
33	21.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	28.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	5.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	14.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master. 8 E.J FATHER'S NAME- Mr. 8 E.J MOTHER'S NAME- Mrs. 8 E.J

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	3.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	7.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	10.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Rapport. Mother has Insecurities for next conception. Both parents were worried on these Social Stigma, Social Segregation, Future Worrisome, child's Life with the Condition in future.
4	14.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	17.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of child's Life with the Condition in future.	Parents were very worried about the child's future with limited Intellectual condition. They prejudiced that the child can't live life independently. The thought of who will look after him after us? Will he manage himself after us? Interrogative questions about the future with parents were the triggering factor of their sad emotion and anxiety.

6	21.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of child's Life with the Condition in future.	The rational responding was used to make parent understandable about the thought they were having related to the Future of the child with the condition. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. Motivation were reinforced with positive quotations for life and future. They were asked to make new schedule for their routine to be followed. Asked to be focus on today & mindfulness to be practiced on regular basis.
7	24.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of child's Life with the Condition in future.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to practice mindfulness on regular basis.
8	28.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of child's Life with the Condition in future. It was also asked, if any else bothering them related to the child's condition.
9	31.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors. Practice mindfulness & focus on today technique. They were found to be more looking forward for the life now, in compression with the past sessions on the same stressor.

10	4.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social Stigma& Emotions aligned with ANT of Social Stigma.	ANT on Insecurities of thesituation when other judge the child in social situation. They use to feel sad in social gatherings. To prevent judgments they were resistiveto take the child out in social gatherings.
11	7.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multiple quotes and real life stories. It was asked form the parent to write down incidences, they were encounter with. Asked awkward situation where they felt judgment of the people on their ward's condition.
12	11.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have no incidents to share about social stigmatic situations. They shared casual situation but that is also not linked with the child's condition. Asked parent to do Deep Breathing at home for at least 30 Minutes on daily basis.
13	14.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation and feel like he'll be ignored or bullied in social situations .
14	18.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They were asked to make a list of evidences they had previously related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges

				will come with Limited Intelligence, but we need to modify our thoughts to think positive to see other perspective of the life.
15	21.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Very few incidents they discussed in the sessions and found that they were assuming it very much. Asked them to take child out in all gatherings and help him accommodate with the situations. Asked to do deep breathings also on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	25.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Future worrisome & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
17	28.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
18	2.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous session about Future.
19	5.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.

20	9.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they insecure about the future. After Session they were observed More Relaxed about Future Insecurities.
21	12.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social Isolations.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like if they around them. They expressed that running after the child made them exhausted and frustrated. Now they get irritated easily. This is ruined their relationship with the friends and family. Now they avoid meeting friends and family
22	16.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	19.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	23.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do

				deep breathing exercises on regular basis.
25	26.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	3.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Insecurities for next conception.	Parents were further interviewed on Insecurities for next conception. Rational Responding technique was used to make parent understandable about the relationship between previous & upcoming pregnancy. It was also explained that genetic probability of the next conception to be happen to be like previous condition of the child.Even they suggested to have consultation with Gynae for the same.
27	9.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities for next conception.	Follow up was taken on the previous discussion. It was also suggested that they should consult a gynae for detailed discussion on the same and as per parents the gynae also guided the likelihood of the next conception. They got clarity on the same by reinforced by the 2 professional on their insecurity. After generalization their insecurity they felt more relaxed.
28	17.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities for next conception.	General follow up was done on the tasked asked to do. It was also asked if they any insecurities related to the same. They were suggested to have a consultation with the concerned expert of the fraternity rather than just browsing

				their enquiry on internet. They were also suggested to practice mindfulness technique on regular basis.
29	28.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT Insecurities for next conception.	Follow ups on previous task asked i.e.schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	31.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT Insecurities for next conception.	Follow ups for previous Stressors. It was found that parent incorporated mindfulness in their schedule on daily basis. They also felt more relaxed on the insecurities of next pregnancy. Asked to practice suggested recommendation on regular basis.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	6.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.
32	13.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.

33	20.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	27.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	4.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	13.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Miss. 9 E.J	FATHER'S NAME- Mr. 9 E.J	MOTHER'S NAME- Mrs. 9 E.J

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	3.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	7.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	10.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Identified ANT of the family.Disturbed Family Dynamics, Future Insecurities, Social Stigma, prognosis of the condition&child's life in future.
4	14.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	17.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT & Emotions of the Parents on Family Dynamics.	Parents were further interviewed on Family Dynamics. It was found that father of the child was elder son in the family and had 2 more young unmarried siblings. Mother need to take care of every individual in family with child, whereas father need to help family in terms of finance in family to support the family. It was observed that mother was over occupied in house hold chores and father was overburdened due to responsibilities.
6	21.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S	Focusing on ANT & Emotions of the Parents linked with Family Dynamics.	Carefully understood the family dynamics and responsibilities. The

		STRESSOR.		parents were train for assertive training. It was asked form parents that sometimes we have to say “no” to the person and in situations where you do not agree. It was also asked that practice saying “NO” when your personal scheduled time is compromising. Scheduling of the routeing was also asked to restructure.
7	24.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION’S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Family Dynamics.	Assertive training was reinforced and general follow up was done on the task asked. It was also found there was scope to correct the schedule for personal spaces. Helped parent to create spaces in schedule for their self. Asked to follow the schedule on daily basis.
8	28.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION’S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT & Emotions of the Parents linked with Family Dynamics.	Follow ups on previous task asked i.e. schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
9	31.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION’S STRESSOR.	Follow up on previous session objective i.e. Family Dynamics.	Reinforced & Follow ups of assertive training was done. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They found more space in their daily schedule for their self and were observed to be more positive in this perspective.
10	4.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Insecure of Awkward questions about the child. They use to feel sad in social gatherings. To prevent so they were in denial of taking child out in social gatherings.

11	7.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multiple and it was asked form the parent to write down few incidences where they were asked awkward question regarding their ward's condition.
12	11.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have 1 incidents to share about social stigmatic situations, but that is also not linked with the questions asked related to child's condition. Asked parent to do Deep Breathing at home for at least 30 Minutes on daily basis.
13	14.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to her Intellectual limitation and feel like she'll be ignored or bullied in social situations.
14	18.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They were asked to make a list of evidences they had previously related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges will come with Limited Intelligence, but we need to modify our thoughts to think positive to see other perspective of the life.
15	21.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Very few incidents they discussed in the sessions and found that they were assuming it very much. Asked them to

				take child out in all gatherings and help him accommodate with the situations. Asked to do deep breathings also on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	25.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Prognosis of the child's condition.	Parents were very worried about the child's future with limited Intellectual condition. They assumed that she won't be able to live life independently and will never take care of himself in future. Their thought of What will happen after us ? was the triggering factor of their sad emotion. They were not mingling with friend and family. Tried to be isolated from others.
17	28.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Prognosis of the child's condition.	The rational responding was used to make parent understandable about the thought they were having related to the Future. Stories were narrated to generalized that the children having intellectual disabilities are living independent life with dignity and pride. It was also quoted to the parents that the present actions will decides the future. They were asked to make new schedule for their routine to be followed.
18	2.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to watch videos on success stories.
19	5.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S	Focusing on previous ANT & Emotions of the Parents to modify their	Follow up were taken from both the parents on their ANT of Prognosis of the

		STRESSOR.	behaviours.	child's condition. It was also asked any other thing which bothers them related to the child's condition.
20	9.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors.
21	12.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Social Isolations.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like their presence. They expressed that running after the child make them exhausted and frustrated also. This ruined their relationship with the friends and family. Now they avoid meeting friends and family.
22	16.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and family said that their presence are problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	19.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	23.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life

				and child. They were also asked to do deep breathing exercises on regular basis.
25	26.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	3.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
27	9.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
28	17.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous session about Future.
29	28.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.
30	31.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they feel insecure about the future. After Session they were observed More Relaxed about Future Insecurities in comparison to the previously done sessions.

	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	6.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every situation is also very important.
32	13.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.
33	20.9.21	PREVENTION OF RELAPSING ASSESSMENT & EVALUATION	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	27.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	4.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.

36	13.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

CHILD'S NAME- Master. 10 E.J	FATHER'S NAME- Mr. 10 E.J	MOTHER'S NAME- Mrs. 10 E.J

SESSION NO	DATE	CBT OBJECTIVES	SESSION HIGHLIGHTS	REMARKS/HOMEWORKS
	ASSESSMENT & RAPPORT BUILDING SESSIONS			
1	3.5.21	RAPPORT BUILDING	Making Rapport and understanding the Antecedent.	Initiated with child's History and condition he is in. Rapport Sessions only.
2	7.5.21	RAPPORT BUILDING	Making Rapport, understanding the Antecedent.	Had detailed discussion on child life journey and parenting during the child's development.
3	10.5.21	RAPPORT BUILDING, FINDING STRESSORS AND ASSESSMENTS.	Making Rapport, understanding the Antecedent and initiating Assessment	Good Rapport, Mother has Future Insecurities, Social Stigma. Father is more concerned about prognosis &child's life in future. Both shared that they do not have any personal spaces now.
4	14.5.21	RAPPORT BUILDING, FINDING STRESSORS AND EVALUATION	Making Rapport, understanding the Antecedent and initiating Assessment	Initiated with previous session inputs and reconfirmed Stressors expressed previously. Creating Baseline with Antecedents using Stress Scale.
	CBT INTERVETION SESSIONS WITH TARGATED GOAL ON ANTECEDENTS SESSIONS			
5	17.5.21	CBT INTEREVTION-ADDRESSING STRESSORS	Understanding ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Rational Responding used to explained the parents ANT they are having. Helped to modified Behaviour by explaining that Future is still yet to come and we need to work today to make future better.
6	21.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Gave New Perspective of Future and narrated Success stories of Children having Intellectual Disabilities. Asked Parent to watch videos of parents having Success Stories
7	24.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Follow ups was taken on the home work asked. Parents watched Videos and found more positive compared to previous

				session about Future.
8	28.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to set yearly goals for their self and break those yearly goals in Months goals and month goals in weeks and so on.
9	31.5.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT of Parents on Future Insecurities & Emotions they aligned with ANT.	Asked parents to use Relaxation tech whenever they insecure about the future. After Session they were observed More Relaxed about Future Insecurities.
10	4.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT of Parents on Social Stigma& Emotions aligned with ANT of Social Stigma.	ANT (Insecure of Awkward questions about the child). They use to feel sad in social gatherings. To prevent so they were in denial of taking child out in social gatherings.
11	7.6.21	CBT INTEREVTION- ADDRESSING STRESSORS	Focusing on ANT of Parents on Social Stigma & Emotions aligned with ANT of Social Stigma.	Asked Multiple Questions for the evidences of their dysfunctional thought. They quoted multiple and it was asked form the parent to write down few incidences where they were asked awkward question regarding their ward's condition.
12	11.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Follow up was done the tasked asked and it was observed that the parents have 2 incidents to share about social stigmatic situations, but that is also not linked with the questions asked related to child's condition. Asked parent to do Deep Breathing at home for at least 30 Minutes on daily basis.
13	14.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Evaluation of previous ANT and Understanding other ANT of Parents on Social Stigma.	Parents were more relaxed about the question asked by others on Child's condition ANT. They also express their insecurity about the activities child performs due to his Intellectual limitation and feel like he'll be ignored or bullied in

				social situations (2nd ANT
14	18.6.21	CBT INTEREVTION ON NEW ANT OF PREVIOUS STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Again asked parents to have evidences of the situations they are assuming. They were asked to make a list of evidences they had previously related to this ANT. The generalization of parents in the same situation was also be briefed to the parents. It was also shared that challenges will come with Limited Intelligence, but we need to modify our thoughts to think positive to see other perspective of the life.
15	21.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT of Parents on Social Stigma.	Very few incidents they discussed in the sessions and found that they were assuming it very much. Asked them to take child out in all gatherings and help him accommodate with the situations. Asked to do deep breathings also on regular basis.
SESSION NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
16	25.6.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Prognosis of the child's condition.	Parents were very worried about the child's future withlimitedIntellectual condition. They assumed that he won't be able to live life independently and will never take care of himself in future. Their thought of What will happen after us ? was thetriggering factor of their sad emotion. They were not mingling with friend and family. Tried to be isolated from others.
17	28.6.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Prognosis of the child's condition.	The rational responding was used to make parent understandable about the thought they were having related to the Future. Stories were narrated to

				generalized that the children having intellectual disabilities are living independent life with dignity and pride. It was also quoted to the parents that the present actions will decides the future. They were asked to make new schedule for their routine to be followed.
18	2.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow ups were taken on the task asked. It was found that parents were more positive on child's future in comparison to the previous session. They were taught to schedule their routine for best engagement of their day. They were asked to watch videos on success stories.
19	5.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on previous ANT & Emotions of the Parents to modify their behaviours.	Follow up were taken from both the parents on their ANT of Prognosis of the child's condition. It was also asked any other thing which bothers them related to the child's condition.
20	9.7.21	CBT INTEREVTION - FOLLOWING UP THE PREVIOUS SESSIONs ON ALL STRESSORS ADDRESSED.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed and tried to help parents to follow the guidelines asked to be followed on all stressors.
21	12.7.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS. ASSESSMENT & EVALUATION	Understanding ANT & Emotions of the Parents on Social Isolations.	Parents felt like they are isolated with their friends and families due to the condition of the child. Friend and family now don't like their presence. They expressed that running after the child make them exhausted and frustrated also. This is ruined their relationship with the friends and family. Now they avoid meeting friends and family
22	16.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents on Social Isolation.	The rational responding was used to make parent understandable about the meeting people and family. Asked to share the incident where their friends and

				family said that their presence are problem for them. Not valid incident were shared. Asked them to make list of Friends & relatives.
23	19.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on tasks asked to do at home and follow for prevention of relapsing.	General discussion was done on the previous stressors addressed. It was also asked to the parents to prioritize the names mentioned in the list. They were also asked to make a call to their friends and relative.
24	23.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous stressors addressed. It was found that parents were happy after talking to their friends and relatives and no one made them feel bad, even they were concerned about their health, life and child. They were also asked to do deep breathing exercises on regular basis.
25	26.7.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Follow up on the tasks asked to do at home and prevention of relapsing.	General discussion was done on the previous task asked for homework and explored the experience they had. They were also asked to meet their friends and relatives frequently. It was observed that they were more positive about meeting friends and family now.
26	3.8.21	CBT INTEREVTION- ADDRESSING NEW STRESSORS.	Understanding ANT & Emotions of the Parents on Personal Space.	Parents were further interviewed on personal space. Idiosyncratic technique was used to understand the literally meaning of personal space for both the parents. It was observed that mother was over occupied in her daily routine and father was overburdened due to work life imbalance.
27	9.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Red defined the meaning of their personal space through rational responding technique. Asked both

				parents to create a schedule for work life balance. It was also asked parents that following a schedule for balance in life very important, scheduling of the day will help them understand the gaps for personal spaces.
28	17.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	General follow up was done on the tasked asked to do. It was also found there was scope to correct their schedule for personal spaces. Helped parent to create spaces in schedule for their self. Asked to follow the schedule on daily basis.
29	28.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR.	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups on previous task asked i.e.schedule follow ups. It was found that parents were following the schedule, but both the parents were not regular in following up the schedule. It was asked to the parent that regular follow up of the schedule is important to have positive impact in their life.
30	31.8.21	CBT INTEREVTION- FOLLOWING UP THE PREVIOUS SESSION'S STRESSOR. ASSESSMENT & EVALUATION	Focusing on ANT & Emotions of the Parents linked with Personal Spaces.	Follow ups for previous Stressors. It was found that parent incorporated the schedule on daily basis. They also observed few changes in work life balance. They were observed to be more positive in this perspective also.
	RELAPSE PREVENTION & TERMINATION PROCESS SESSIONS			
S.NO	**DATE**	**CBT OBJECTIVES**	**SESSION HIGHLIGHTS**	**REMARKS/HOMEWORKS**
31	6.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to if any negative thoughts comes. They were asked that negative thoughts are natural process. No one can get rid of these, just we need to believe on ourself. That go through the challenges. Staying positive in every

				situation is also very important.
32	13.9.21	PREVENTION OF RELAPSING	Addressing the Thought that can lead to Relapsing	Asked parents to change the thought process if negative thoughts comes. Asked parents to practice realistic solutions of the challenges. They were motivated to write down the challenges on paper. Then frame the severity they can cause and solutions we can implement.
33	20.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Taught the parents to practice relaxation techniques, problem-solving mindfulness, or positive distraction to manage stress or negative emotions.
34	27.9.21	PREVENTION OF RELAPSING	Developing copying strategy	Follow up on practices of relaxation techniques, problem-solving mindfulness.
35	4.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT	Strengthening Social Support	Asked parents to maintain connections with supportive friends, family, or peer groups. It was also asked that reaching out for help when needed can increase resilience against relapsing and make them feel good.
36	13.10.21	PREVENTION OF RELAPSING & TERMINATION OF CBT ASSESSMENT & EVALUATION	Healthy Life Style Practicing	Promote habits that contribute to well-being, such as regular exercise, healthy eating, adequate sleep, and engaging in enjoyable activities.

LIST OF PUBLICATIONS

S.No	LOG ID	Type of Paper	Name of the Journal//Book	Jounal indexing	Title of the Paper	Published Date	Volume & Issue Number	ISSN/ISBN Number	Impact Factor	Web link of journal indexing
1	76864	Journal	African Journal of Bio Medical Research	Scopus	Pre-Post study on the impact of CBT Intervention on Parental Stress of Children with Intellectual Disability	6th Dec 2024	Vol 27 (4s) (Dec 2024); 5322-5325	1119-5091	0.132	NA
2	74289	Journal	Man and Development	UGC Care	Impact of CBT on Parental Stress having Children with Intellectual Disability	Sep 2024	Vol XL VI, Issue No-3	0258-0438 Print Only	6.3	NA
2	74059	Journal	Urban India	UGC Care	An Empirical Study on Parental Stress and Behavioural Problems of Intellectual Disabled Children	Jul- Dec 2024	Vol 44, Issue No-2	0970-9045	6.7	NA

LIST OF CONFERENCES

S.No	Name of the Conference	Jounal indexing	Title of the Paper	Published Date	Type of paper	This is thesis work
1	Recent Trends in Research on Multidisciplinary Educational Aspects in Psychology	Organised on IJMER, India & Blue Hora University, Ethiopia	The relationship between parental stress and behaviour development of children with intellectual disability	2 & 5 April 2024	Research	YES
2	Two days Interdisciplinary National Seminar Sponsored by ICSSR		Sexual Harassment in Men: A Crime	16 & 17 March 2024	Review Paper	NO