DISRUPTIVE BEHAVIOR DISORDER (DBD) SYMPTOMS AMONG SCHOOL GOING CHILDREN (6-12YEARS)

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APPROVAL

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DECLARATION

I am **Munmun Akter**, want to declare that any single part of my research project will not be harmful to other. All data and literature in this study have been cited correctly. In that case all discussion of this research project is mine and I am only responsible for any mistake in the whole study.

Signature & Date

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DEDICATION

Dedicated to……

..…… My Beloved Parents, family members, teachers & friends.

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List of Acronyms

Abbreviation	Elaboration
ADHD	Attention-Deficit/Hyperactivity Disorder
APA	American Psychiatric Association
CBCL	Child Behavior Checklist
CD	Conduct Disorder
DBD	Disruptive Behavior Disorder
DBDs	Disruptive Behavior Disorders
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
ODD	Oppositional Defiant Disorder
SDQ	Strengths and Difficulties Questionnaire
SLT	Speech and Language Therapy
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization
LMI	Low- and Middle-Income Countries

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ABSTRACT

Childhood behavioral disorders represent a significant global concern, affecting children's emotional well-being, social relationships, and academic performance. Disruptive Behavior Disorders (DBDs), including Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), are among the most prevalent and challenging conditions in school-aged children. Early recognition and intervention are essential to mitigate long-term adverse effects and support healthy development.

In the selected primary schools in Savar, Bangladesh, prevalence rates of Disruptive Behavior Disorder (DBD) were found to be about 10.5% with 7.8% showing symptoms of Oppositional Defiant Disorder (ODD) and 5.5% showing symptoms of Conduct Disorder (CD). A cross-sectional study was carried out involving 256 parents or caregivers of the chosen schools, one madrasa and the primary sections of a few high schools and William and Marie Taylor School. Purposive sampling was used, and the data were gathered with the help of structured questionnaires, including sociodemographic data and Disruptive Behavior Disorder Rating Scale (DBD-RS). The questionnaire was clarified and feasible through a pilot study that involved 10 participants. The IBM SPSS Statistics (version 27) analysis showed that there were no significant associations between demographic variables and the presence of DBD symptoms. Parental reports were a source of comprehensive information regarding the behavioral pattern of the children at home and in their daily activities with the sample exhibiting mild/moderate behavioral issues.

These results highlight the need of early detection of Disruptive Behavior Disorders among school going children. Parental involvement is essential to proper assessment, and early detection of DBDs can enable interventions to enhance the behavioral, social, and academic performance of children.

Keywords: *DBD, ODD, CD*

CHAPTER 1 INTRODUCTION

1.1 Introduction

Many children have developmental and behavioral problems that may remain undetected because these issues could be short-lived and hard to differentiate between the normal developmental changes in childhood (Belcher et al., 2022). Among them, Disruptive Behavior Disorders (DBDs) are a group of disorders that involve problems with aggressive behavior regulation, impulse control and self-control manifested by behaviors that place others' safety at risk or violate normative social rules (Milone & Sesso, 2022). As per the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), DBDs including conduct disorder, ODD, and ADHD continue into adulthood in up to 60% of cases (Hawes, 2014). ODD and CD are the two primary disorders under the DSM-5 as categorized under DBDs and are characterized by an unusual behavior that is significantly beyond the norm of expected behavior of a person in his or her age group that it will impair social, emotional, and academic performance of a person; both conditions are more common in males, with sex ratios differing according to the specific disorder and age (American Psychiatric Association, 2013). ODD and CD are Disruptive Behaviour Disorders (DBDs), with the world prevalence rates of 3.3% and 3.2% of ODD and CD, respectively, and ODD being defined in the DSM-IV as a pattern of negativistic, defiant, disobedient, and hostile behaviour towards authority figures, and CD comprising a wider set of persistent behaviour that goes against family expectations, social norms, and the rights of others, including aggressive behaviours towards individuals or animals, property destruction, deceitful/theft related behaviour and serious deviance (Saleh et al., 2017). Attention-Deficit/Hyperactivity Disorder (ADHD) is an extremely common, impairing and chronic neurodevelopmental disorder, which is marked by lack of attention, impulsiveness as well as hyperactivity with very varying prevalence rates and subtype distributions across regions despite extensive research on the disorder; indeed studies among school-age children in Turkey have reported prevalence rates as low as 0.2% to as high as 27%, and subtype distributions have also been found to vary across regional samples (Gul et al., 2010).

According to Noordermeer et al. (2016) states empirical data indicate that up to 50% of children with ODD/CD have comorbid Disruptive Behaviour Disorders, and 25–35% are also diagnosed with ADHD. In Sub-Saharan Africa (SSA) DBDs are one of the most frequently seen forms of mental health difficulties in school-going children (Cortina, 2012). For instance, in Uganda, estimates of positive ODD scores range between 6-10%, those for CD were approximately 2%, and for ADHD they were about 3% (Kivumbi et al., 2019). Higher prevalence rates than those found here have been reported in neighbouring countries, for example externalizing and conduct-related issues that were identified in about 11.9 percent of adolescents (Hunduma et al., 2024). In Kenya, ODD (16.2%), CD (14.4%), and ADHD symptoms (9.0%), in combination have a prevalence of close to 40% in children aged between 6 and 12 years (Okoba, 2019). Not treated, the DBDs are associated with poor academic achievement (Sayal et al., 2015) and social relationships (Brennan et al., 2014), and follow to reach into adolescence and adulthood leading to dropout from school, delinquency, unemployment and substance use so that they account for a huge societal costs of (Savolainen et al., 2015). Recent results of a study undertaken in India stated that Disruptive Behavior Disorder is common among 21.4% of school-going children, 17.7% in Oppositional Defiant Disorder (ODD) and 3.7% in Conduct Disorder, where the disruptive behavior problem is significant in the population of school-going children (Sre Ridanya & Renuchitra, 2022). Disruptive behaviour disorders (DBDs), such as conduct disorder (CD), oppositional defiant disorder (ODD), and attention-deficit/hyperactivity disorder (ADHD), are serious mental health issues in children and adolescents across the world; where boys have been found to be about twice as likely as girls to have ADHD, utilising worldwide combined frequency of 8.0 (95% CI: 6.0-10.0%) in children and adolescents based on an umbrella review study starting reported above mentioned percentages(reported by) (Ayano et al., 2023c). Moreover, there is an increase study that show that ADHD (attention-deficit/hyperactivity disorder) and Disruptive Behavior disorders can co-exist with speech- and language-related problems, such as impairments in phonological processing, expressive and receptive language skills, and the use of pragmatic language (Mendez-Freije et al., 2023).

Regional studies present an enormous difference in the estimates of prevalence, largely owing to differences in diagnostic measures used and methods of sampling as well as socio-cultural contexts (Ayano et al., 2020). First, the prevalence of disruptive behavior

disorders (DBDs) has not been well-documented because of significant gaps in nationally representative prevalence data of child and adolescent mental health, especially in low- and middle-income countries, whereby few studies have been conducted with solid population estimates (Erskine et al., 2016). Second, the estimates of the prevalence of the disruptive behavior disorders are not consistent across studies because of a range of diagnostic criteria (DSM/ICD), methods of assessment, and age ranges, diminishing the potential of direct comparison and emphasizing the heterogeneity of methods (Solmi et al., 2023). Third, Turkish data show that Disruptive Behavior Disorders are socio-demographically different by age, gender, parental education, and family income, yet nationally representative data have not been represented well and are not consistently available, which reflects gaps in the knowledge of these correlates of disruptive behavior disorders in low- and middle-income countries (Senol et al., 2017). Fourth, much of the literature on disruptive behavior and associated comorbidity is based on clinical or other unusual samples, which tend to give higher and more uncertain prevalence rates than community samples, due to methodological differences and sample source effects, and not the actual prevalence rates in a general population (Chen et al., 2025). Fifth, the majority of epidemiological studies about childhood mental disorders have been conducted in high-income nations, which constrain the generalisability of the results to a wide range of cultural and socioeconomic contexts, including those in South Asia and Africa (Barican et al., 2021).

1.2 Significance of the study

Disruptive Behavior Disorders (DBDs) are childhood disorders that are marked by constant aggression, impulsivity, and violating behaviours, which are usually observed among children who are between the ages of 6 and 12 years (American Psychiatric Association, 2013). These behaviours have adverse impacts on academic achievement, relationship with peers, and classroom adaptation (Barican et al., 2021). ODD is noted to impact between 3- 5% of children, whereas conduct disorder impacts between 2-3%, a significant burden in the middle childhood period (Milone and Sesso, 2022). The behavioural disorders are listed by WHO as a major source of adolescent morbidity and disability and mentions the necessity of early detection and mental health approaches in schools (World Health Organization, 2025).The study will expect to increase the knowledge on the topic of disruptive behavior disorders in children engaged in school. The paper emphasizes the necessity of concentrating research and practical interventions to assist children in addressing their behavioral challenges at a critical point of their development.

For professionals development this prevalence study will be more encouraging. SLT professionals have great advantages to those who suffer Disruptive Behavior Disorders since they target the underlying causes of most of the difficult behaviors related to such disorders. Speech and Language Therapists can use this information for doing best practice by concerning the DBD symptoms among school going children. Speech and Language Therapy is a complementary and effective treatment for communication disorders, they also specialize in social communication, pragmatics, and emotional regulation, which is essential elements in finding solutions to the underlying causes of DBD. SLTs can address these behaviours by enhancing social skills, emotional expression and problem-solving, which results into more adaptive ways of managing their behaviors, resulting in improved social, emotional and academic outcomes. The study will hope to educate parents of children who meet the criteria for conduct disorder or oppositional defiant disorder about what is normal versus abnormal with regard to behaviors given their children's developmental stages while focusing on parenting approaches that acknowledge the child's abilities, employ positive reinforcement, create reasonable boundaries, and employ non-punitive discipline. Additionally, the study provide a context for future research in that field.

1.3 Research Question

What is the prevalence of Disruptive Behavior Disorders (DBDs) symptoms among school going children aged 6-12 years?

1.4 Objectives

The objectives of the study are given below-

1.4.1 General Objective

- The main objective of this research is to determine the prevalence of disruptive behaviour disorders occur among school-age children between the ages of 6 and 12.

1.4.2 Specific Objective

- To find out the prevalence of conduct disorder, oppositional defiant disorder, and non-specified disruptive behaviour disorders are among school-age children between the ages of six and twelve.
- To determine the sociodemographic characteristics of school-age children (6–12 years old) who have disruptive behaviour disorders.
- To determine if sociodemographic factors and the morbidity of disruptive behaviour disorders are correlated.

1.5 Literature Review

This chapter reviews literature on Disruptive Behavior Disorders (DBDs), including their prevalence, comorbidities, and conceptual framework.

DBDs, including conduct disorder and oppositional defiant disorder, can be found in the DSM-5 chapter on disruptive, impulse-control, and conduct disorders. These childhood conditions are characterized by chronic problems regulating emotions and behavior, which result in aggression, rule-breaking and poor social relationships. DBDs are more prevalent in boys and their frequency is modulated by developmental level, genetic susceptibility, and environmental factors. Early delay of gratification ability can forecast later behavior regulation and thus detection and intervention is critical (APA, 2013).

Rates of DBDs differ among regions and countries. Approximately 5% of the school-aged children in Puerto Rico exhibited behaviors that are adequately disruptive and consistent with diagnostic criteria to meet cutoff scores for diagnosis. It was found that ODD was more frequent than CD, indicating higher presentation of oppositional symptoms compared with conduct symptoms in children (Bird et al., 2006). A cross-sectional investigation in 2,434 school-aged children in Southwestern Uganda reported ODD in 6% of the sample, and CD was apparent in 2%, with about a quarter of subjects having impairment across several behavioral domains (Kivumbi et al., 2019). An umbrella review (Ayano et al., 2023) showed that the world prevalence of attention-deficit/hyperactivity disorder (ADHD) among children and adolescents is approximately 8%, with males being identified almost twice as often as females, showing a high degree of comorbidity between DBD and ADHD, and difficulty making differential diagnoses when the symptoms intersect.

Studies conducted in low-middle income countries show high prevalence and frequently poverty-related causes for DBD. In Nairobi, Kenya, cross-sectional study on school attending children reported high prevalence of DBD symptoms accompanied by gender differences in the pattern of behaviours. Standardized behavior measures were collected via teacher and/or caregiver report to assess disruptive and externalizing behavioral risk. Findings indicate significant behavioral problems associated with socio-demographic characteristics such as poverty and gender socialization practices (Okoba, 2019).

The prevalence of emotional, cognitive and behavioural problems among school-going children was found to be 22.7% in a study from Kanpur, India; where boys were more likely to have externalizing symptoms than girls. The research concluded that poverty and absence of outreached service determine the occurrence of these behavioral problems, hence supporting the importance for routine screening and early interventions (Gupta et al., 2017).

Neurobiological studies are of advantage for etiological issues in DBDs. Children with ODD and CD frequently show abnormalities in the brain areas associated with executive functioning, control of emotions, and decision-making (e.g., amygdala, insula, medial frontal), and these alterations have been repeatedly linked across both disorders. These are regions that are important for impulse control and social behavior, with alterations in their structure or function potentially associated with the behavioral problems seen in DBDs. It has been reported that the etiology of DBDs is multifaceted and results from intricate interplay between neural vulnerabilities and adverse environmental experiences (Noordermeer et al., 2016). The family-based approach has been highlighted in intervention research. Research from LMICs like Uganda suggest that structured parenting programs can improve child behavior and caregiver stress. From 2017 to 2023, such interventions showed reduced child behavioral problems and increased family functioning indicating the crucial role that parental support plays in improving DBDs, especially among low socioeconomic populations (Brathwaite et al., 2023).

Aetiologically, psychosocial and environmental causes play a major role in the occurrence of DBDs especially in LMICs. In Minia, Egypt, study reported conduct problems within a large percentage of 6–12 year old children. The study also found risk factors (low socioeconomic status, authoritarian/inconsistent parenting style, parent conflict and family history of neuropsychiatric disorder) that emphasized the role of a child's social context in modifying behavior (Elhamid et al., 2008b).

DBDs result from an interplay between psychosocial, environmental and personal vulnerabilities. Negative parenting, maltreatment, emotion processing difficulties, and neurocognitive deficits are all commonly linked with DBDs (Field, 2024). Studies from 2019 to 2024 encourage the roles of both individual risk along with environmental components of disruptive behavior. Effective interventions, therefore, need to cover a

range of domains (including parenting, family support and child-focused strategies), in order to mitigate risk and improve outcomes (Karwatowska et al., 2020). DBD are commonly comorbid with other psychiatric conditions, complicating the presentation and management. The prevalence of ODD among children with ADHD is estimated to be approximately one-third (34.7%) and that of CD nearly 10% (Nijardvik et al., 2025). Although DBD research is increasing across the world, evidence from LMICs is still woefully inadequate. In many areas, especially low income countries, there is limited recent and representative prevalence data. Worldwide, large swaths of the African, Latin American and other LMIC regions appear under-reported in global studies that could provide information on the extent of DBDs and for potential effective interventions (Erskine et al., 2016).

Polanczyk et al. (2015) found that methodological limitations prevent a clear understanding of DBDs, as a majority of research studies use screening tools not structured diagnostic interviews, which may be associated with over-inflated prevalence rates. Little is known about interventions in LMICs, where risk factors including family adversity, community violence, parenting behavior and school context are well described. These discrepancies point to the importance of local research input for early detection and school-based mental health programs.

Parental participation may also crucial for children's healthy development and behavioral adjustment, as increased caregiver involvement has been found to buffer against externalizing behaviors and promote positive emotional and academic engagement in youth (Goulet et al., 2024).

While the associations between DBDs and related risk factors have been investigated worldwide, information on local factors and solutions, including in LMICs is limited. In South Asia and Bangladesh particularly, studies available are old and not current. There are very few studies on the relationship between family, social and ecological factors and DBDs in school-age children. This is a timely study which seeks to address this gap by reporting the prevalence of DBDs in children from Bangladesh and factors associated with it, which can increase the possibility for early detection as well as provision of school-based mental health support.

1.6 Operational Definitions

1.6.1 Prevalence

The term prevalence, which is also known as the prevalence rate, is used to estimate the number of individuals with a specific disease in a given population at a given moment or at a given time during a specific time frame or period, and is often expressed as a percentage of the total population (Tenny & Hoffman, 2023).

In this study, prevalence was used to indicate the proportion of children in the selected population who were identified as having Disruptive Behavior Disorders (DBDs) during the data collection period.

1.6.2 Disruptive Behavior Disorder (DBD)

Disruptive Behavior Disorders (DBDs) are a set of psychiatric conditions that manifest themselves through constant patterns of defiant behavior and hostile and disruptive behavior that cause severe impairment of social and daily functioning, and the most common types- Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)- is determined by the intensity of defiant or antisocial behavior and are often initial manifestations in childhood or adolescence (Field, 2024b).

In this research, Disruptive Behavior Disorder (DBD) was used as an umbrella term to refer to children who fit the criteria of at least one of the DBDs, namely Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) as determined by parent and other caregiver reports on the Parent/Teacher DBD Rating Scale and a sociodemographic questionnaire.

1.6.3 Attention-Deficit/Hyperactivity Disorder (ADHD)

The neurodevelopmental disorder known as attention-deficit/hyperactivity disorder (ADHD) which conveys with continuously occurring inattentional patterns, hyperactivity or impulsivity which are more severe and frequent than is typical of the child's level of development, and whose symptoms appear in at least two settings (e.g., at home and in school) and is usually present before the age of 12 (Cabral et al., 2020).

In this study, ADHD was used to define a group of children who were diagnosed with the disorder using data provided by the parents or other caregivers using the

Parent/Teacher DBD Rating Scale and a sociodemographic questionnaire and was not directly evaluated in school.

1.6.4 Hyperactivity

A hyperactive person is too active and restless as a normal person may be, may be fidgety, highly energetic, or agitated, and generally a symptom of ADHD (Symptoms of ADHD, 2024).

In this study, hyperactivity was established to be the behaviors that could be observed and includes constant movements, inability to sit down, fidget and over-talking as indicated by the parents and caregivers and evaluated by the demographic and the parents /teachers DBD rating scale questionnaire.

1.6.5 Oppositional Defiant Disorder (ODD)

Oppositional Defiant Disorder (ODD) is a Disruptive Behavior Disorder characterized by an ongoing tendency of angry/irritable mood, argumentative or defiant behavior, or vindictiveness of at least six months and beyond normal concerning the level of child development (DSM-5 diagnostic criteria) (Kandola, 2025).

In this research, ODD was described as children who have developmental patterns of argumentativeness, non-compliance with rules, and purposeful irritation of others and was identified by the criteria of DSM-5 as corroborated by demographic data and questionnaire of parents/ teacher DBD rating scales.

1.6.6 Conduct Disorder (CD)

Conduct Disorder (CD) is a repetitive and continuing behavior where the fundamental rights of other persons or major age-related social regulations are breached, such as hostility towards others or animals, resources destruction, stealing or lying, and severe violations of the rules which is details foundation of severe impairment of social, academic, or family functioning (Substance Abuse and Mental Health Services Administration [US], 2016b).

During this research, Conduct Disorder (CD) was the term used on children and adolescents that exhibited consistent rule violations and aggressive actions, which were defined according to the DSM-5 criteria and were measured based on the data obtained via the parents/caregivers through the use of the DBD rating scale questionnaire.

CHAPTER 2 METHODOLOGY

This chapter describes the study's methodology, including the study design, location, population, sampling strategy, size, and process.

2.1 Study design

The researcher carried out this study to determine the prevalence of Disruptive Behavior Disorder (DBD) symptoms in school-going children aged between 6 and 12 years and to determine how they relate to selected sociodemographic factors. The quantitative cross-sectional survey design was employed because this design enables data to be gathered at one moment; it is suitable in estimating prevalence and analyzing relationships among variables (Setia, 2016). Cross-sectional research has been common across studies concerned with child and adolescent mental health to characterize the prevalence of symptoms and find association between variables in large samples (e.g., studies that report prevalence of psychiatric morbidity in children and adolescents) (Patil et al., 2013). Parents or primary caregivers were the source of the data, since it is possible that children at this age cannot self-report on their own behavioral symptoms. More recent cross-sectional studies in mental health have utilized parental perception and reporting of child mental health outcomes to determine the prevalence of the outcomes of the symptoms and their correlates (e.g., parental reports about the psychological state of children) (Lo Moro et al., 2024).

2.2 Study place

The study was carried in the chosen primary schools of Savar including one madrasa, the primary sections of a few high schools and William and Marie Taylor School.

2.3 Sample selection

2.3.1 Study population

The target population of people consisted of parents or guardians of children at the age of 6-12 years attending these schools.

2.3.2 Sampling procedure

Participants and schools were selected through random sampling in the study. Random sampling of schools was done to minimize selection bias in the target schools in Savar. Parents or caregivers of children between the ages of 6 and 12 years were selected to be take part in the research, by picking one or two children each out of the available number of schools; each school had between 2 and 27 participants. Qualitative data were obtained through the administration of structured forms such as Parents/Teacher DBD Rating Scale and a social demographic questionnaire that was given by the researcher to parents or the caregivers.

2.3.3 Sample size

Taherdoost (2016) states that a suitably large sample size is typically necessary for surveys to ensure that the sample is representative of this community. Results are more likely to accurately reflect the characteristics of the population when the sample size is higher. A sufficient sample size was thought to be required to improve the study's validity and reliability because the investigator employed a cross-sectional survey strategy. However, the population's characteristics and the study's goals may affect the necessary sample size (Etikan, 2016). The study aim is to find out the prevalence of Disruptive Behavior Disorder among school going children and it is a quantitative study so it is included large sample. In this study, investigator used a sampling equation to determine the sample size. The equation was according to sample size-

We know that –

Sample size, $n = \frac{z^2 p(1-q)}{d^2}$

$= \frac{(1.96)^2 \times 0.5\ (1 - 0.5)}{(0.05)^2}$

$=384$

Where,

n = required sample size

z = confidence level at 95%

(standard value of 1.96)

p = estimated prevalence of subject (0.5)

d = 5% margin of error

(0.05 as the standard value)

So, the size of the sample was 384 participants.

The investigator attempted to collect as much data feasible due to time constraints. Within two month, investigator gathered 256 data.

2.3.4 Inclusion criteria

- Male and female respondents.
- The guardians or parents of children between the age of 6 to12 years.
- Had lived with and taken care of the child since age 5 years or above.
- Gave an informed consent to take part.

2.3.5 Exclusion criteria

- Parents/guardians who had not lived or raised the child.
- Participants who refused to take part in the study.

2.4 Data collection

2.4.1 Data collection Instrument

Data were collected through two instruments, sociodemographic questionnaire and the Disruptive Behavior Disorder Rating Scale (DBD-RS) developed by Pelham, Gnagy, Greenslade and Milich in 1992.

DBD-RS has 45 items with a response options that range from 0 = Not at all to 3 = Very much and utilises 10 mins to be filled. The DSM diagnostic criteria (APA, 1994) aligns with DBD-RS. The scale was proven reliable and valid in multiple studies by Silva et al. (2005) and Friedman-Weieneth et al. (2009).

In the study, parents filled out the DBD-RS and provided details on the child's behavior. The reason for this is that those who know the child best were asked.

2.4.2 Data collection Procedure

The relevant ethical authority approved data collection before it was conducted. Prior approval from the selected schools was obtained for the collection of data. Parents or guardians of students between the age of 6-12 years were approached and made aware of purpose, procedures and voluntary nature.

After taking written consent from the parents or guardians, data was collected using a pre-structured questionnaire with two sections. The initial part consisted of social and demographic information of the child and parents, age, sex, educational level other relevant background characteristics as per objective of the study. Making use of the

Disruptive Behavior Disorder (DBD) Rating Scale, assessment of disorder of disruptive behaviour symptoms among children was given in the second part of the scale.

The parents (or caregivers) were asked to complete the questionnaire because they know the child's behavior at home and in daily life best. The responses of the participants were kept confidential and anonymous, and the child and parent's identity was not recorded.

Data collection was carried out over a designated period of time and completed questionnaires were checked for completeness and consistency before data entry check. The researchers encoded and entered the data into IBM SPSS Statistics (version 27) in accordance with the objectives for analysis.

2.4.3 Pilot study

The investigator conducted a pilot study prior to the main data collection to ensure the clarity and feasibility of the questionnaire. The questionnaire was administered to 10 parents or guardians of children between the ages of 6 and 12, who completed it without difficulty. The pilot study helped the investigator identify any ambiguous or unclear items and refine the wording and instructions of the questionnaire as necessary. Based on the feedback from the pilot study, minor modifications were made to improve clarity, thereby ensuring that the final questionnaire would be easily understood by the target population.

2.4.4 Data analysis procedure

Data analysis is the process of organizing, summarizing and presenting the collected data to meet the research objectives. The study's data were examined with the help of 27^{th} version of IBM SPSS Statistics (IBM Corp., 2020).

Frequencies and percentages had been computed in the case of categorical variables, including sex, age group, and education level. In the case of continuous variables, the means and standard deviation were suitable measures of summary (Pallant, 2020).

In order to attain the study objectives, the analysis involved:

(i) The Prevalence of Disruptive Behavior Disorders (DBDs) on the whole and of each type, in particular.

(ii) Conducting social-demographic analysis of the participants.

(iii) Analysing the association between DBDs and socio-demographic variables through relevant bivariate statistical tests, including the Chi-square test of categorical variables. The statistical significance was established at $p < 0.05$ (Field, 2018).

2.4.5 Ethical Consideration

The study has been conducted according to the declaration of the Institutional Review Board of the Bangladesh Health Professions Institute. The selected schools were also given permission to ensure that institutional policies were adhered to. Voluntary nature and the purpose of participation in the study were well informed to parents or guardians of children aged between 6-12 years. All participants were informed about the study through a written informed consent and the questionnaires were administered. The participants were assured that their answers were confidential and anonymous and neither the names of children nor parents or guardians were documented. The research followed the principles of beneficence and non-maleficence, as no harm was inflicted on the study participants. Participation was entirely voluntary, and participants were free to withdraw from the study at any point without any negative consequences.

CHAPTER 3 RESULTS

3.1 Demographic information of the respondents

3.1.1 Gender of the respondents

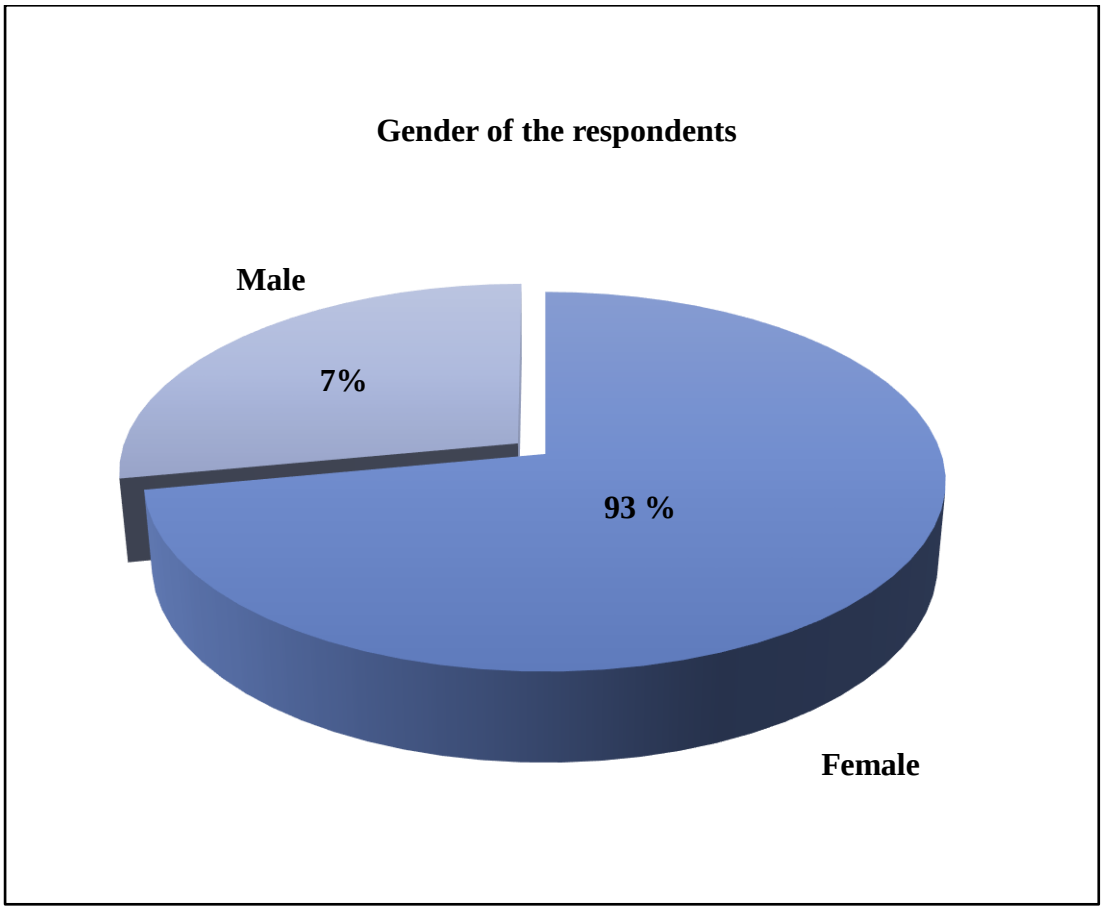


Figure no-1: Gender of the respondents

The pie chart shows the gender ratio of all respondents (256) of the study. In this study the prevalence of female is highest 93% (238) than male 7% (18).

3.1.2 Age of the respondents

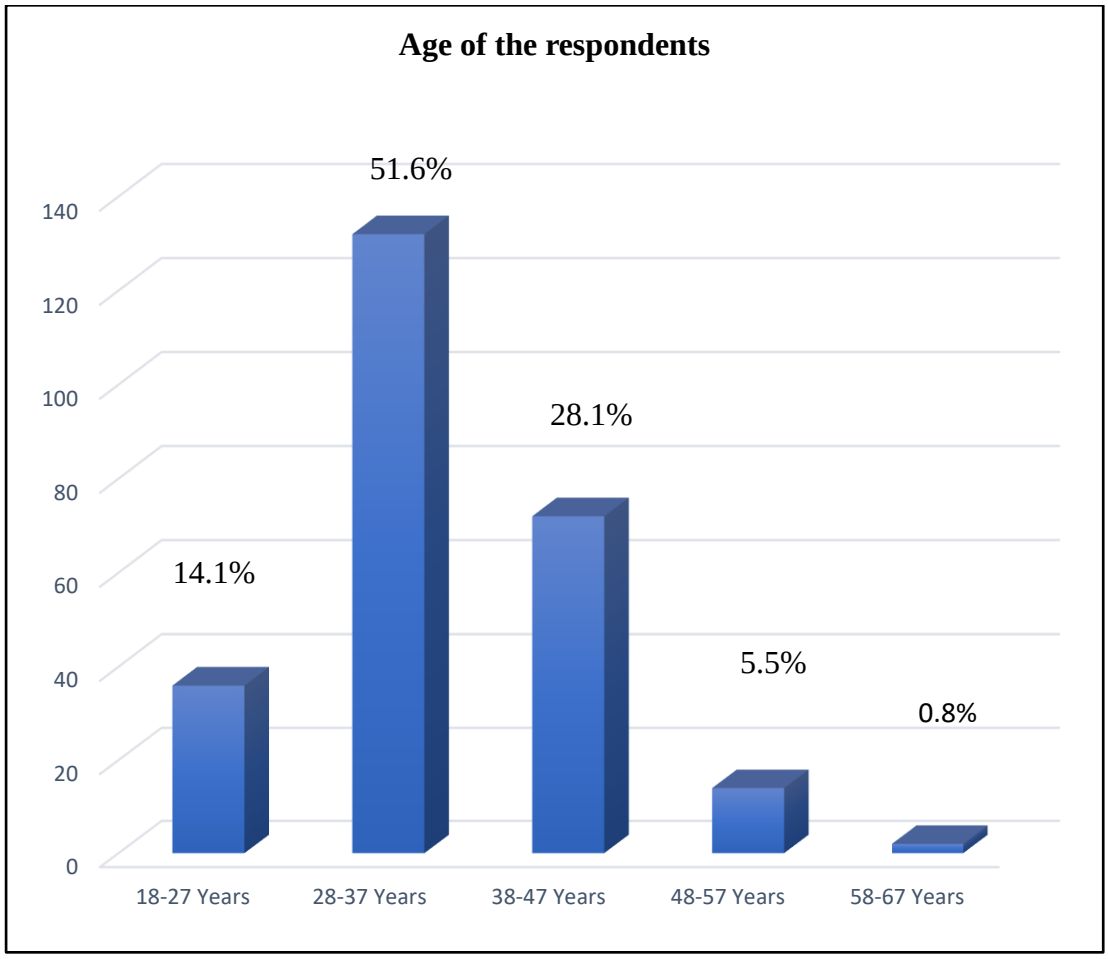


Figure no- 2: Age of the respondents

The bar graph demonstrates the ages of the respondents. Majority of participant's age range was between 28 to 37 years. The ages with the next highest frequency were 38-47 years and 18-27 years. A total of 5.5% of the respondents belonged to the age group of 48-57 years. On the other hand, the least proportion was of the age group of 58-67 years, at just 0.8%.

3.1.3 Marital status of the respondents

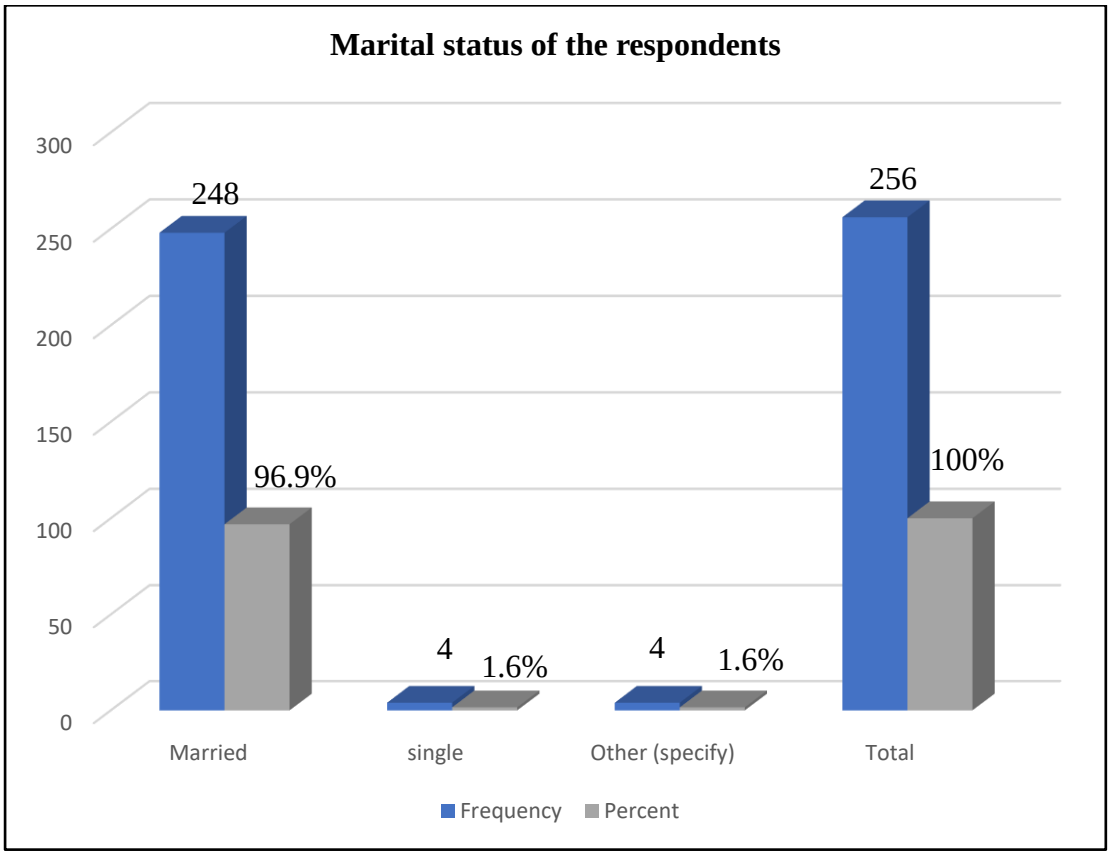


Figure no- 3: Marital status of the respondents

Among this total respondents, most of the respondents 96.6% (248) were got married, 1.6% (4) were single, and rest of the respondents 1.6% (4) were other relatives.

3.1.4 Educational level of the respondents

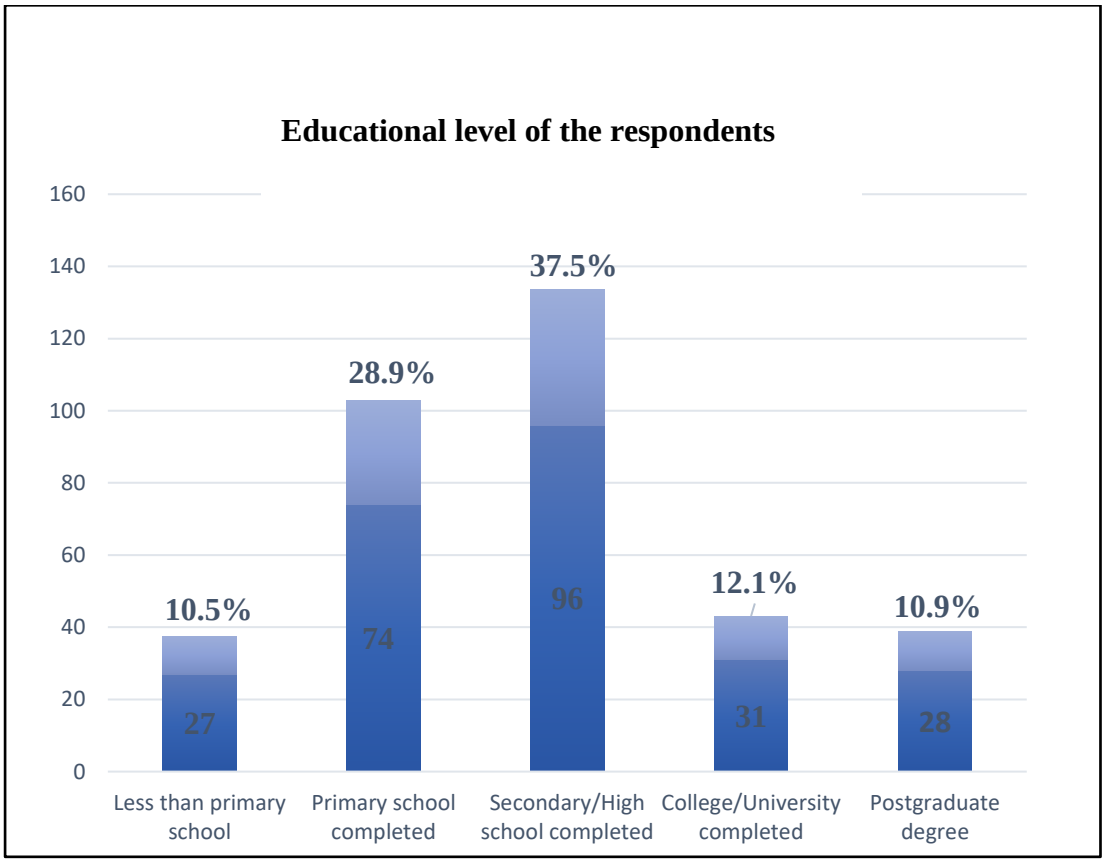


Figure no-4: Educational level of the respondents

Distribution of respondents by educational level. Among the respondents, 10.5% (27) had less than primary school education, 28.9% (74) had completed primary school, 37.5% (96) had completed secondary/high school, 12.1% (31) had completed college or university, and 10.9% (28) had attained a postgraduate degree.

3.1.5 Educational level of the respondent's partner

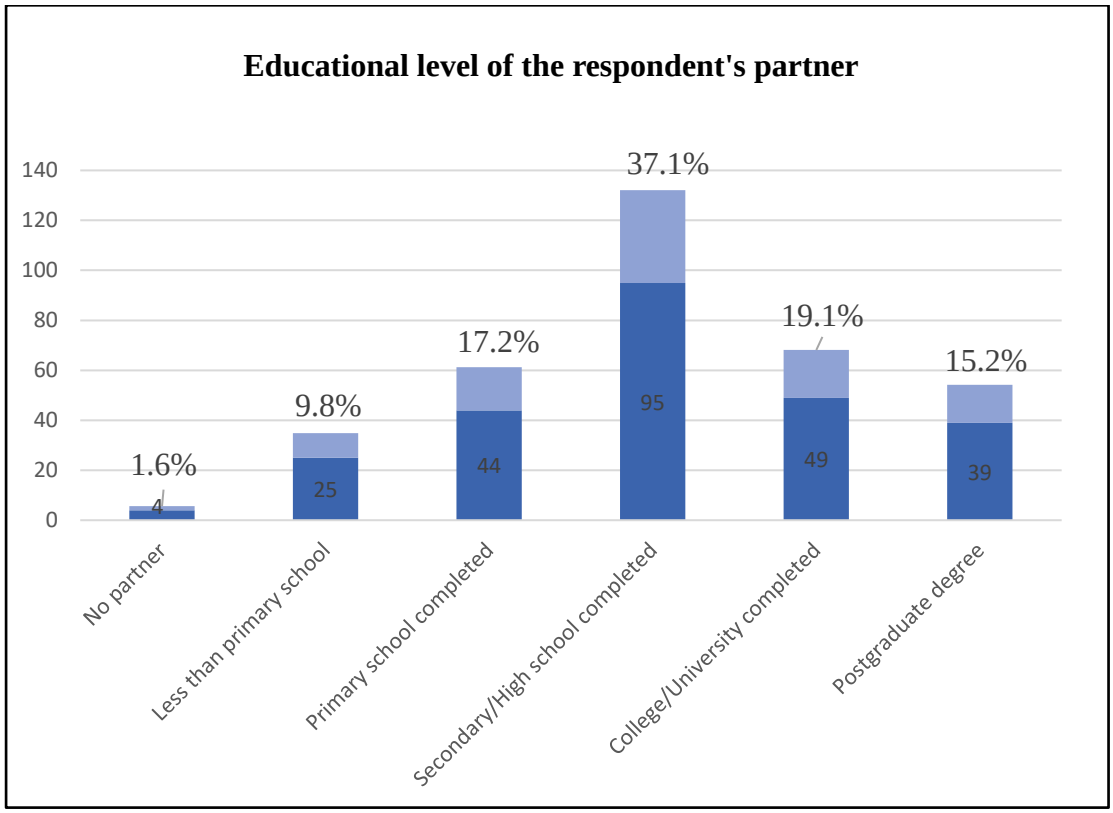


Figure no- 5: Educational level of the respondent's partner

Distribution of respondent's partner by educational level. Among all the respondents partner educational level, 1.6% (4) reported having no partner, 9.8% (25) had less than primary school education, 17.2% (44) had completed primary school, 37.1% (95) had completed secondary or high school, 19.1% (49) had completed college or university, and 15.2% (39) had attained a postgraduate degree.

3.1.6 Religion of the respondents

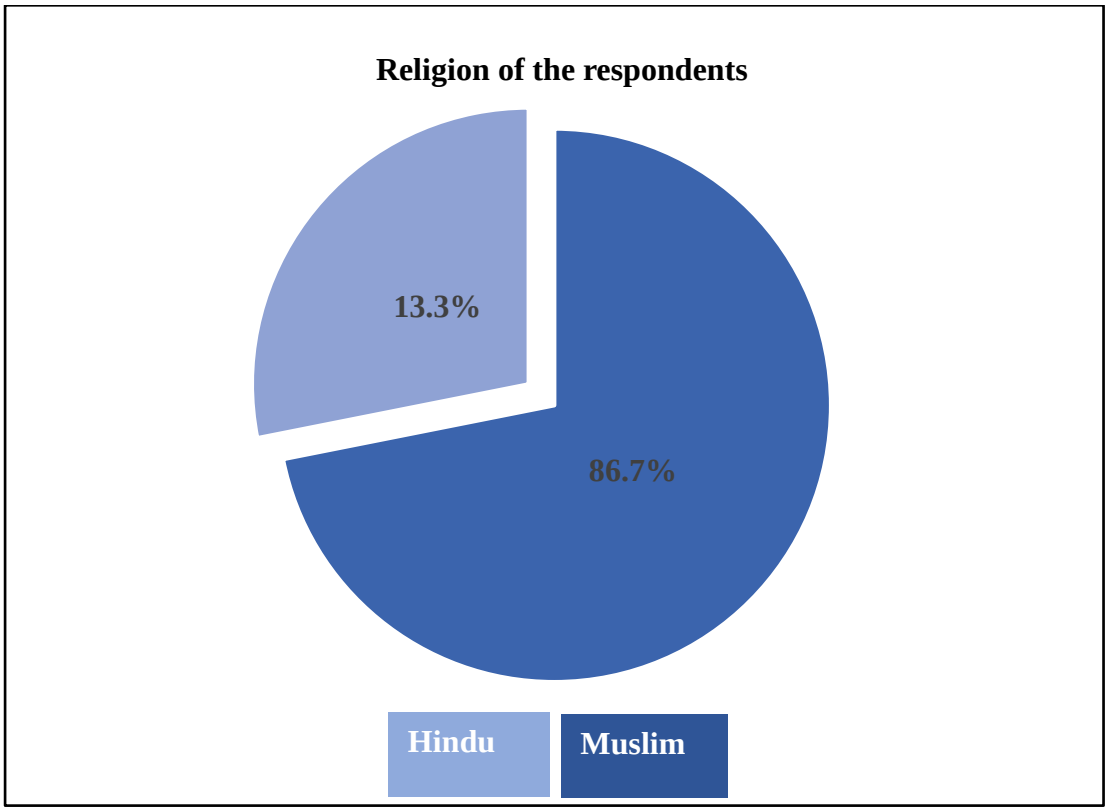


Figure no- 6: Religion of the respondents

The pie chart indicates the religion of the respondents. Most of the respondents were Muslim (86.7%, n=222), with a smaller proportion being Hindu (13.3%, n=34).

3.1.7 Gender of the study child

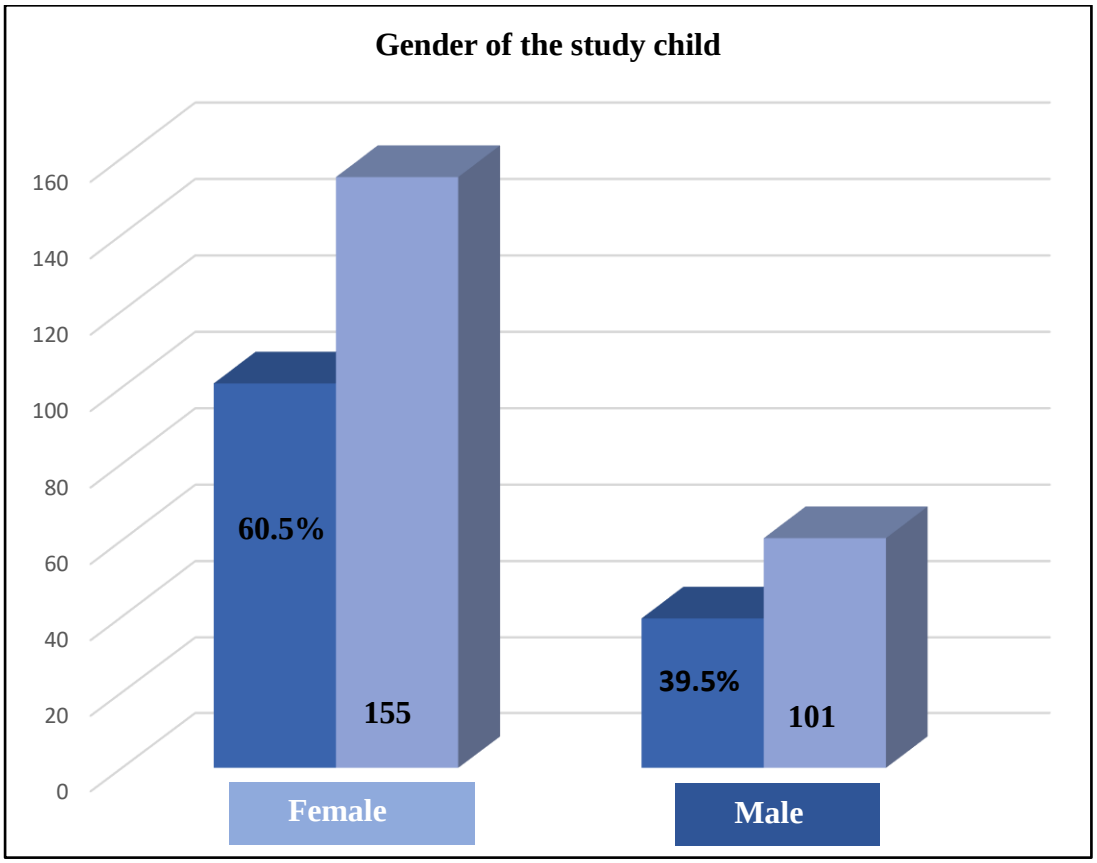


Figure no- 7: Gender of the study child

In this study the graph chart showing the gender of the study children. More than half of the children were female 60.5%, (n = 155), while 39.5% (n = 101) were male.

3.1.8 Age of the study child

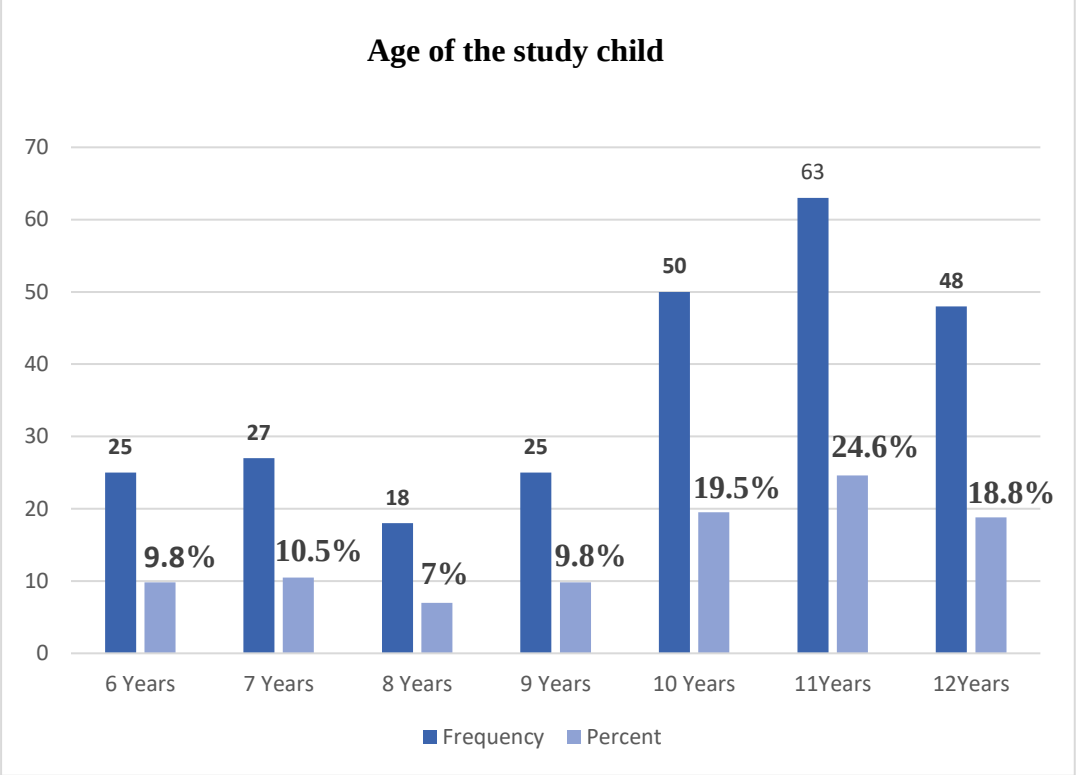


Figure no- 8: Age of the study child

The chart gives the age distribution of the children in the study. Children's age averaged between 6 and 12 years. The largest share of participants were aged 11 years (24.6% n = 63), followed by 10 years (19.5%, n = 50) and 12 years (18.8%, n = 48). The ages of the children decreased when the age reached 6 to 9 years with frequency of them around 10.0% or nearly 25 children. However, the smallest frequencies are 8 years (7.0%; n = 18).

3.2 Prevalence of Disruptive Behavior Disorders in School-Aged Children (6–12 Years) (N = 256)

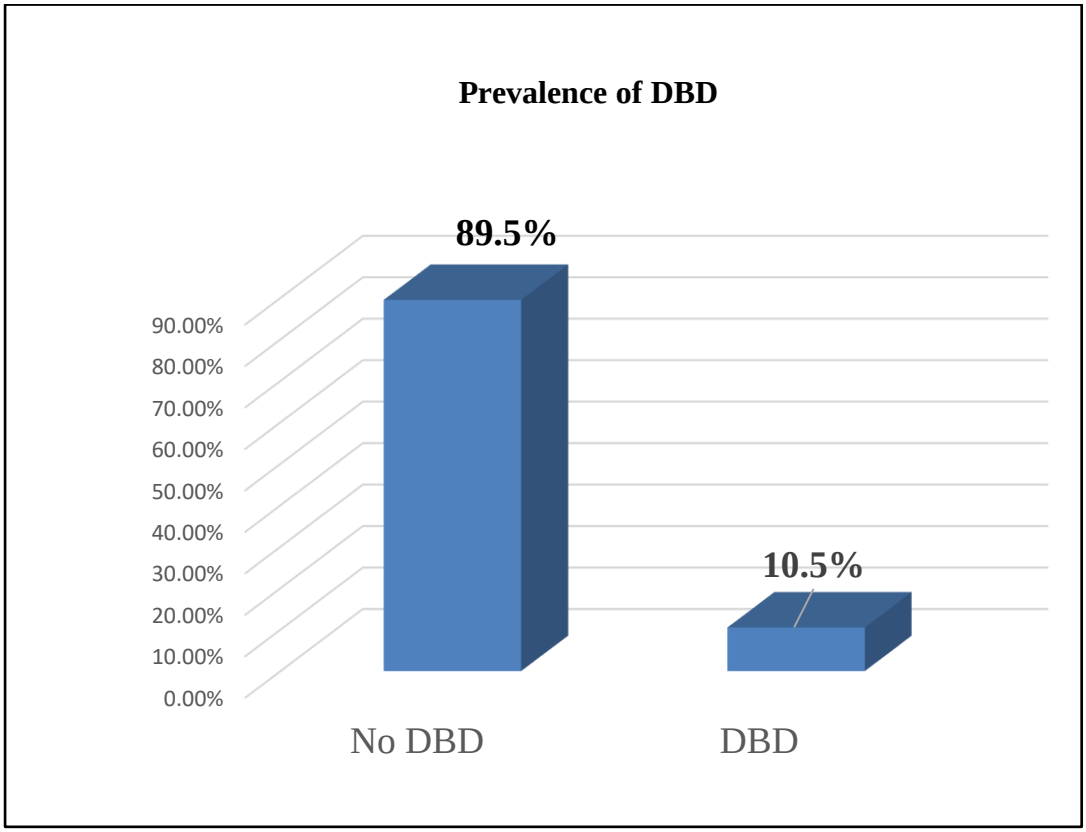


Figure no- 9: Prevalence of Disruptive Behavior Disorders in School-Aged Children (6–12 Years) (N = 256)

This Figure illustrates disruptive behaviour disorders' prevalence. Among 256 children in school, ages 6 to 12, 10.5% were found to have Disruptive Behavior Disorders, while 89.5% did not have any Disruptive Behavior Disorder.

3.3 Prevalence of Conduct disorder, oppositional defiant disorder, and non-specific disruptive behaviour disorders (N = 256)

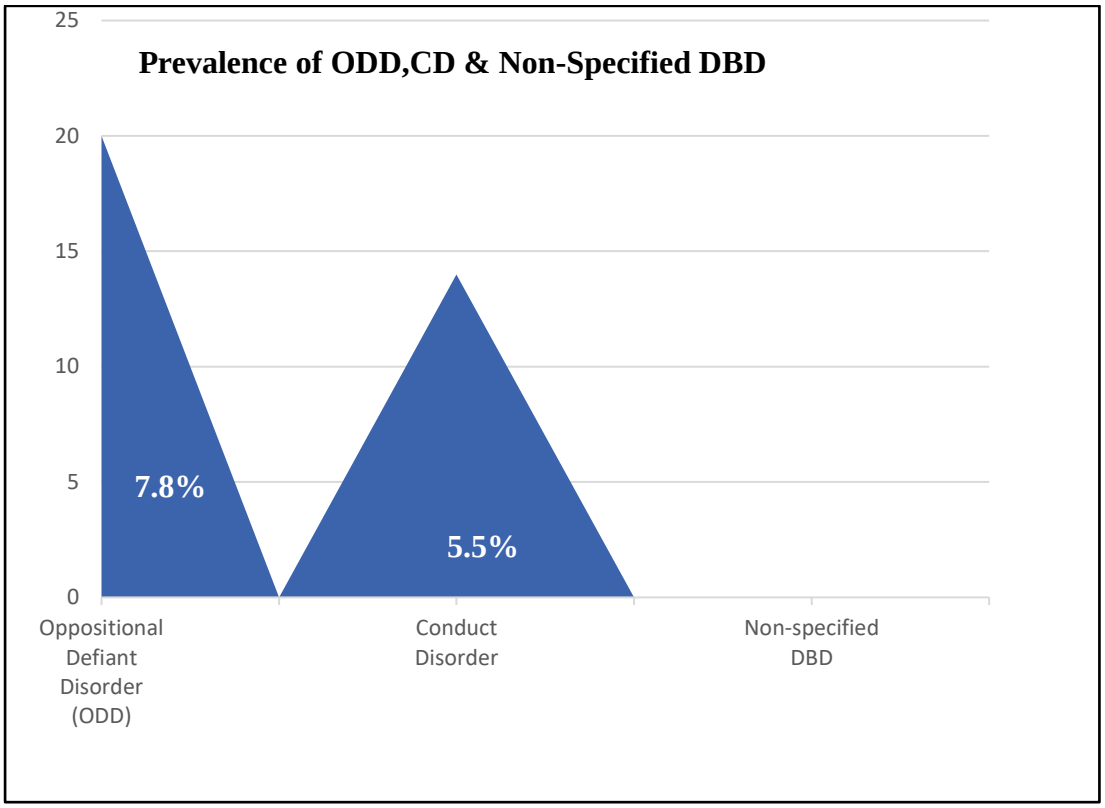


Figure no- 10: Prevalence of Conduct disorder, oppositional defiant disorder, and non-specific disruptive behaviour disorders (N = 256)

In this study this graph chart showing the ODD, CD and Disorders of Non-Specified Disruptive Behaviour prevalence among school-age children aged 6 to12. Out of 256 children, ODD was diagnosed among 7.8 (n = 20) while 5.5% (n = 14) met CD with the remaining cases being non-specified disruptive disorder. None of the participants were found to have Non-specified Disruptive Behavior Disorder (0.0%, n = 0).

3.4 Socio-demographic characteristics of the study participants (N = 256)

Variable	Category	n	%
Child age (years)	6-8	70	27.3
	9-10	75	29.3
	11-12	111	43.4
Child gender	Male	101	39.5
	Female	155	60.5
Education level of respondent	Less than primary	27	10.5
	Primary completed	74	28.9
	Secondary/High school	96	37.5
	College/University	31	12.1
	Postgraduate	28	10.9
Education level of partner	Less than primary	25	9.8
	Primary completed	44	17.2
	Secondary/High school	95	37.1
	College/University	49	19.1
	Postgraduate	39	15.2
Marital status	Married	248	96.9
	Single	4	1.6
	Other	4	1.6
Religion	Muslim	222	86.7
	Hindu	34	13.3

Number of children (<18 years)	0-1	214	83.6
	≥2	42	16.4
Number of habitable rooms	One	41	16.0
	Two	89	34.8
	Three	79	30.9
	Four or more	47	18.4

Table 1: Socio-demographic characteristics of the study participants (N = 256)

Table 1 presents the socioeconomic profile of the respondents. The sample of 256 participants, children aged between 6 and 12 years, was considered. The majority of the children fell within the range of eleven to twelve years. Some of the children were of age group between 9 and10 years. Among the children, the age group of between the ages of six to eight years constituted the quarter of the number of children. The proportion of girls children was greater than the proportion of boys among the children that were studied. The father and mother of the respondent have not achieved much education, as most of them only finished their secondary school. The second one was the principal one at 28.90%. Similarly, the respondents were informed. The majority of participants (96.90%) are married and the majority of the participants (86.709) are Muslims. Findings indicate that about 83.6% of all households had no children or 1 child below 18 years. In a residential scenario, the number of rooms that can be occupied is two. It is near 34.8 %.

3.5 Socio-demographic characteristics of children with Disruptive Behavior Disorders (N = 27)

Variable	Category	n	%
Child age (years)	6	6	22.3
	7	2	7.4
	8	3	11.1
	9	3	11.1
	10	3	11.1
	11	7	25.9
	12	3	11.1
Child gender	Male	13	48.1
	Female	14	51.9
Education level of respondent	Less than primary	2	7.4
	Primary completed	8	29.6
	Secondary/High school	8	29.6
	College/University	5	18.5
	Postgraduate	4	14.8
Education level of partner	Less than primary	3	11.1
	Primary completed	5	18.5
	Secondary/High school	6	22.2
	College/University	6	22.2
	Postgraduate	7	25.9
Marital status	Married	26	96.3

	Other	1	3.7
Religion	Muslim	24	88.9
	Hindu	3	11.1
Number of children (<18 yrs)	0	12	44.4
	1	13	48.1
	2	1	3.7
	3	1	3.7
Habitable rooms	One	5	18.5
	Two	11	40.7
	Three	4	14.8
	Four or more	7	25.9
Relationship with child	Mother	22	81.5
	Father	4	14.8
	Other	1	3.7

Table 2: Socio-demographic characteristics of children with Disruptive Behavior Disorders (N = 27)

Table 2 presents the socio-demographic features of children with Disruption Behaviour Disorders. Of the affected children (N= 27), the majority were aged 11 years old (25.9%). Females slightly predominated (51.9%). Muslim and married most respondents. Most respondents were in primary and secondary school. Around half the families had one child aged 18 years or older. Many families were accommodated by a household of two or more usable rooms.

3.6 Association between variables

3.6.1 Association between Demographic and DBD Symptoms

3.6.1.1 Association between Gender and DBD Symptoms

Gender	DBD Present n (%)	DBD Absent n (%)	Total
Male	13 (48.1%)	88 (38.4%)	101
Female	14 (51.9%)	141 (61.6%)	155
Total	**27 (100%)**	**229 (100%)**	**256**

Table 3: Association between Gender and DBD Symptoms

There was no statistically significant association between gender and DBD symptoms ($\chi^2 = 0.955$, $p = 0.328$).

3.6.1.2 Association between age of the child and presence of Disruptive Behaviour Disorder

Age of the child (years)	DBD absent n (%)	DBD present n (%)	Total n (%)
6 years	19 (8.3)	6 (22.2)	25 (9.8)
7 years	25 (10.9)	2 (7.4)	27 (10.5)
8 years	15 (6.6)	3 (11.1)	18 (7.0)
9 years	22 (9.6)	3 (11.1)	25 (9.8)
10 years	47 (20.5)	3 (11.1)	50 (19.5)
11 years	56 (24.5)	7 (25.9)	63 (24.6)
12 years	45 (19.7)	3 (11.1)	48 (18.8)
Total	**229 (89.5)**	**27 (10.5)**	**256 (100.0)**

Table 4: Association between age of the child and presence of Disruptive Behaviour Disorder

The association between age of the study child and presence of Disruptive Behavior Disorders is presented in Table 4. Chi-square test showed that there was no statistically significant association between age of the child and Disruptive Behavior Disorder (χ^2= 7.905, df = 6, p = 0.245).

3.6.1.3 Association between DBDs and educational level of the respondents

Education level of the respondent	DBD present n (%)	DBD absent n (%)	Total n (%)
Less than primary school	2 (7.4)	25 (10.9)	27 (10.5)
Primary school completed	8 (29.6)	66 (28.8)	74 (28.9)
Secondary/High school completed	8 (29.6)	88 (38.4)	96 (37.5)
College/ University completed	5 (18.5)	26 (11.4)	31 (12.1)
Postgraduate degree	4 (14.8)	24 (10.4)	28 (10.9)
Total	**27 (100.0)**	**229 (100.0)**	**256 (100.0)**

Table 5: Association between DBDs and educational level of the respondents

No statistically significant association between Disruptive Behavior Disorders and education level of the respondent ($\chi^2 = 2.225$, df = 4, p = 0.694). The distribution of Disruptive Behavior Disorders was similar across different levels of parental education, indicating that education level of the respondent was not significantly related to the presence of disruptive behavior disorders among the study children.

3.6.1.4 Association between DBDs and educational level of the respondent's partner

Education level of respondent's partner	DBD present n (%)	DBD absent n (%)	Total n (%)
Less than Primary school	3 (11.1)	4 (1.7)	7 (1.6)
Primary school completed	5 (18.5)	22 (9.6)	27 (9.8)
Secondary/High school completed	6 (22.2)	39 (17.0)	45 (17.2)
College/University Completed	6 (22.2)	89 (38.9)	95 (37.1)
Postgraduate degree	7 (25.9)	43 (18.8)	50 (19.1)
Total	**27 (100.0)**	**229 (100.0)**	**256 (100.0)**

Table 6: Association between DBDs and educational level of the respondent's partner

No statistically significant correlation between Disruptive Behavior Disorders and the educational level of the respondent's partner ($\chi^2 = 4.776$, df = 5, p = 0.444). The distribution of disruptive behavior disorders was similar across different categories of partner's educational level, indicating that partner's education was not significantly related to the presence of disruptive behavior disorders among the study children.

3.6.1.5 Association between DBDs and marital status of the respondent

Marital status of the respondent	DBD present n (%)	DBD absent n (%)	Total n (%)
Married	26 (96.3)	222 (96.6)	248 (96.9)
Single	0 (0.0)	4 (1.7)	4 (1.6)
Other (specify)	1 (3.7)	3 (1.3)	4 (1.6)
Total	**27 (100.0)**	**229 (100.0)**	**256 (100.0)**

Table 7: Association between DBDs and marital status of the respondent

There was no statistically significant association between disruptive behavior disorders and marital status of the respondent ($\chi^2 = 1.358$, df = 2, p = 0.507). The distribution of disruptive behavior disorders was similar across different marital status categories of the respondents.

3.6.1.6 Association between Disruptive Behavior Disorders (DBDs) and Religion of the Respondent

Religion of the respondent	DBD present n (%)	DBD absent n (%)	Total n (%)
Muslim	24 (88.9)	198 (86.5)	222 (86.7)
Hindu	3 (11.1)	31 (13.5)	34 (13.3)
Total	**27 (100.0)**	**229 (100.0)**	**256 (100.0)**

Table 8: Association between Disruptive Behavior Disorders (DBDs) and Religion of the Respondent

There was no statistically significant association between Disruptive Behavior Disorders and religion of the respondent ($\chi^2 = 0.123$, df = 1, p = 0.725). This indicates that the frequency of disruptive behavior disorders in the study child did not differ significantly by the religion of the respondent.

3.6.1.7 Association between DBDs and number of children in the house under the age of 18

The number of children under 18 years	DBD present n (%)	DBD absent n (%)	Total n (%)
0	12 (44.4)	76 (33.2)	88 (34.4)
1	13 (48.1)	113 (49.3)	126 (49.2)
2	1 (3.7)	28 (12.2)	29 (11.3)
3	1 (3.7)	10 (4.4)	11 (4.3)
4	0 (0.0)	2 (0.9)	2 (0.8)
Total	**27 (100.0)**	**229 (100.0)**	**256 (100.0)**

Table 9: Association between DBDs and number of children in the house under the age of 18

No association was found between disruptive behavior disorders (DBDs) and the number of household children under 18 years ($\chi^2 = 2.707$, df = 4, p = 0.608). The distribution of DBDs was alike in households having different number of children. There was a slight association (Cramer's V = 0.103).

3.6.1.8 Association between DBDs and number of habitable rooms in the household

Number of habitable rooms	DBD present n (%)	DBD absent n (%)	Total n (%)
One	5 (18.5)	36 (15.7)	41 (16.0)
Two	11 (40.7)	78 (34.1)	89 (34.8)
Three	4 (14.8)	75 (32.8)	79 (30.9)
Four or more	7 (25.9)	40 (17.5)	47 (18.4)
Total	**27 (100.0)**	**229 (100.0)**	**256 (100.0)**

Table 10: Association between DBDs and number of habitable rooms in the household

According to the results, there was no statistically significant association between having any form of disruptive behaviour disorders (DBD_any) and number of habitable rooms in the house (Pearson $\chi^2 = 3.887$, df = 3, p = 0.274). The impact measure was marginal, Cramer's V = 0.123. The household's number of habitable rooms was not related with the disruptive behaviour disorder of the study children (N = 256).

CHAPTER 4 DISCUSSION

A Questionnaire on Sociodemographics and Parent/Teacher DBD Rating Scale were used to be evaluate the prevalence of Disruptive Behaviour Disorder (DBD) symptoms among 6-12years old school going children in Savar, Bangladesh. The rate of DBD was 10.5% among the 256 children. ODD (7.8%) was the most common disorder followed by CD (5.5%, n = 14). These results indicate that a substantial proportion of Bangladeshi school children may have symptoms of disruptive behaviour, and the importance of early detection to minimize psychosocial and academic problems.

Our results were less than the ones reported from Kenya among Kyeva et al. (2021) who included 1,200 school-aged (6–12 years) children using Child Behavior Checklist (CBCL) filled out by both parents and teachers, in which ODD and CD were found to be prevalent at 12% and 8%, respectively. Disparities may be related to situational stressors (such as exposure to a contaminated environment or poverty) and methodological variations. Use of multi-informant methods may find a more diverse group of behaviors than use of only parents, perhaps leading to greater detection rates. Moreover, the bigger and more heterogenous Kenyan sample might result in prevalence estimates being more robust across settings.

In Egypt, Elhamid et al. (2008) reported ODD and CD prevalence of 10% and 6% among 800 children, which is broadly comparable to our results. The use of similar rating approaches supports comparability, although minor differences may arise from cultural variations in the expression, perception, and reporting of disruptive behaviours.

In Turkey, Senol et al., (2017b) reported an ODD prevalence of 9% and CD prevalence of 5% among 500 children aged 6–12 years. Variations across countries may partly relate to the screening instruments used (e.g., DBD scales vs. SDQ), which differ in symptom coverage and sensitivity. Overall, oppositional behaviours tend to be most commonly identified in middle childhood, consistent with the observed pattern across studies.

Studies from India which have used validated measures such as CBCL for assessing ODD and CD have also found similar estimates (e.g., ODD 7.73% and CD 5.48% in a sample of 900 children) for these disorders indicating that the burden is comparable across geographies of South Asian region when similar age-groups and

instrumentation strategy are employed. Nonetheless, cultural influences may well still play a role in the process of knowledge and symptom reporting that might then influence prevalence estimates (Bhardwaj et al., 2019).

On the other hand, prevalence of ODD and CD was higher (ODD 14%, CD 10%) in nearly 1000 children reported by Okoba (2019) from Nairobi. This discrepancy may be due urban contextual stressors and methodology issues such as the use of the SDQ from multiple raters (parents and teachers) that may result in an over-identification of behaviour problems. These findings emphasize the need for enhanced school-based identification, referral pathways and early behavioural interventions.

In conclusion, both the current study and existing literature propose that Bangladesh should have community and school-based programs for mental health to deal about ODD and CD. While the prevalence seems to be moderate, there is a need for timely prevention and early interventions to minimize long term psychosocial and school effects.

CHAPTER 5 LIMITATIONS & RECOMMENDATIONS

5.1 Limitations

Investigator found that there were some limitations in the study. During this study the investigator always tried to minimize these limitations with the help of supervisor's suggestion. The major limitation are given follow:

- Due to restrictions on time, the study could not be conducted on a larger sample size.
- Due to the limitation of the study being conducted in Savar, the findings cannot generalizable.
- Many social and demographical factors were not related to DBD. Using larger samples in research can bring about differences.

5.2 Recommendations

Moreover, further investigation is needed for better result of this study.

- In future research, using a wider and bigger sample from a variety of locations and schools will reduce bias and make estimates more acceptable and realistic.
- The study found that 10.5% of at-risk children showed DBD symptoms, suggesting school screenings.
- Schools must improve their behavior management as rates of ODD and CD are very high.
- Future studies should include other factors, besides socio-demographic ones. Various environment, parenting practices, peer-influence etc. are factors of DBD. The better explanation of DBD morbidity can be achieved through this study.
- Parents and teachers need to develop adequate support and awareness programs to identify DBD symptoms early and take timely action.

CHAPTER 6 CONCLUSION

According to a study, the presence of Disruptive Behavior Disorder (DBD) symptoms were assessed among school-aged children (6-12 years old) in Savar. Overall, 10.5% (n = 27) of the participants were found to have DBD and 89.5% (n = 229) did not have DBD. 7.8% of the children with DBD met criteria for ODD while 5.5% of the children suffering from DBD confirmed to CD according to the DSM. According to the socio-demographic profile of the study participants and any children who had DBDs, the situation of both parents and Person with Disabilities (PWDs) was beneficial. However, statistical tests do not show a significant association between DBD presence and the gender, age, parental education, partner's education, marital status, religion, number of children aged under 18 years in the household and number of habitable rooms ($p > 0.05$). The results showed that a great deal of children had DBD symptoms, however, in this sample, socio-demographic characteristics alone did not explain the morbidity of the disruptive behaviors.

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ANNEXURES

Annexure-1 (A)

Socio-Demographic Questionnaire

Q. No	Question	Response	Code
1	Language of the interview?		
2	Your relationship with the targeted child?	Mother Father Other relative(Specify) Other(specify)	1 2 3 4
3	Your gender	Male Female	1 2
4	What is your date of birth?	Day____Month____Year____ Your Age?	1 2
5	What is your marital status?	Married Divorced or separated Single Other(Specify)	1 2 3 4
6	What is the highest level of education you have completed?	Less than primary school Primary school completed Secondary/High school completed	1 2 3

		College/University completed Post graduate degree	4
7	What is the highest level of education your partner have completed?	Less than primary school Primary school completed Secondary/High school completed College/University completed Post graduate degree	1 2 3 4
8	How many habitable rooms does your household occupy in its main dwelling?(don't count bathrooms, toilets, storerooms, or garage)	One Two Three Four or more	1 2 3 4
9	What is the main source of lighting in the household?		
10	Total number of household members		
11	Total number of children under 18 years old in your household		
12	Religion	Muslim Hindu Others(specify)	1 2 3

13	Study Child date of birth	--/--/--(day/month/year) Estimated Age_____	1 2
14	Child's gender	Male Female	1 2

Annexure-1 (B)

সামাজিক ও জনসংখ্যাভিত্তিক প্রশ্নাবলী

তারিখ: _____

নাম: _____

মোবাইল: _____

বিদ্যালয়ের নাম: _____

আপনার বয়স: _____

১. সাক্ষাৎকারের ভাষা?

☐ বাংলা ☐ ইংরেজি

২. শিশুর সাথে আপনার সম্পর্ক?

☐ মা ☐ বাবা ☐ অন্যান্য আত্মীয়
☐ অন্যান্য

৩. আপনার লিঙ্গ?

☐ পুরুষ ☐ মহিলা

৪. আপনার জন্ম তারিখ?_____

৫. আপনার বৈবাহিক অবস্থা?

☐ বিবাহিত ☐ তালাকপ্রাপ্ত বা বিচ্ছিন্ন ☐ অবিবাহিত
☐ অন্যান্য

৬. আপনি শিক্ষার সর্বোচ্চ কোন স্তর সম্পন্ন করেছেন?

☐ প্রাথমিক বিদ্যালয়ের চেয়ে কম

☐ প্রাথমিক বিদ্যালয় সম্পন্ন

□ মাধ্যমিক/উচ্চ বিদ্যালয় সম্পন্ন

□ কলেজ/বিশ্ববিদ্যালয় সম্পন্ন

□ স্নাতকোত্তর ডিগ্রি

৭. আপনার সঙ্গী শিক্ষার সর্বোচ্চ কোন স্তর সম্পন্ন করেছেন?

□ প্রাথমিক বিদ্যালয়ের চেয়ে কম

□ প্রাথমিক বিদ্যালয় সম্পন্ন

□ মাধ্যমিক/উচ্চ বিদ্যালয় সম্পন্ন

□ কলেজ/বিশ্ববিদ্যালয় সম্পন্ন

□ স্নাতকোত্তর ডিগ্রি

৮. আপনার প্রধান বাসস্থানে কতটি বাসযোগ্য কক্ষ রয়েছে? (বাথরুম, টয়লেট, স্টোররুম বা গ্যারেজ গণনা করবেন না)

□ একটি □ দুটি □ তিনটি □ চার বা তার বেশি

৯. পরিবারের প্রধান আলোর উৎস কী?_____

১০. পরিবারের মোট সদস্য সংখ্যা?_____

১১. আপনার পরিবারের ১৮ বছরের কম বয়সী শিশুদের মোট সংখ্যা?_____

১২. ধর্ম?

□ মুসলিম □ হিন্দু □ অন্যান্য

১৩. শিশুর জন্ম তারিখ? _____

বয়স _____

১৪. শিশুর লিঙ্গ?

□ পুরুষ □ মহিলা

Annexure-2 (A)

Parent/Teacher DBD Rating Scale

Child's Name……

Class…… Sex…….

Date ……

Check the column that best describes your /this child. Please write DK next to any items for which you don't know the answer.

	Not at All	Just a Little	Pretty Much	Very Much
1. often interrupts or intrudes on others (e.g., butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
3. often argues with adults				
4. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talks excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)				

9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking)e.g.runs into				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms in seat				
13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				
20. often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in the neighborhood)				

21. often shifts from one uncompleted activity to another				
22. often has difficulty playing or engaging in leisure activities quietly				
23. often fails to give close attention to details or makes careless mistakes				
24. is often angry and resentful				
25. often leaves seat in classroom or in other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				
29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens, or intimidates others				
33. is often "on the go" or often acts as if "driven by a motor"				

34. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g., mugging, purse snatching)				
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42. often has difficulty organizing tasks and activities				
43. has broken into someone else's house, building, or car				
44. is often forgetful in daily activities				

45. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)				

Annexure-2 (B)

শিক্ষক/অভিভাবক ডিবিডি(DBD) রেটিং স্কেল

শিশুর নামঃ _____ ফর্ম পূরণ করেছেনঃ _____

শ্রেণি:_____ জন্ম তারিখঃ _____ লিঙ্গঃ_____ ফরম পূরণের তারিখঃ_____

নিচের লক্ষণগুলো থেকে যে কলামটি আপনার/ এই শিশুর জন্য যেটি উপযুক্ত মনে হয় সেটি টিক (✓) দিন। যে বিষয়গুলির উত্তর আপনি জানেন না, অনুগ্রহ করে তার পাশে **"জানিনা"** লিখুন।

	মোটেও না	খুবই অল্প	মোটামুটি	অনেক বেশি
১। প্রায়শই অন্যদের বাধা দেয় বা হস্তক্ষেপ করে (যেমন, কথোপকথন বা খেলাধুলায় বাধা দেয়া)				
২। পিতামাতার বা অভিভাবকের উপস্থিতি বাড়িতে থাকা সত্ত্বেও কমপক্ষে দুবার রাতে বাড়ি থেকে পালিয়ে গিয়েছে (অথবা একবার পালিয়ে দীর্ঘ সময়ের জন্য বাড়িতে ফিরে আসে নাই)				
৩। প্রায়শই বড়দের সাথে তর্ক করে				
৪। প্রায়শই ভালো কিছু বা অনুগ্রহ পেতে অথবা বাধ্যবাধকতা এড়াতে মিথ্যা বলে (যেমন "অপরাধ" এড়াতে)				
৫। প্রায়ই তার পরিবারের অন্যান্য সদস্যদের সাথে নিজে থেকে মারামারি শুরু করে				
৬। মানুষের প্রতি শারীরিকভাবে রাগান্বিত হয়ে থাকে				
৭। প্রায়ই অতিরিক্ত কথা বলে				
৮। ভুক্তভোগীর মুখোমুখি না হয়ে তুচ্ছ মূল্যের জিনিসপত্র চুরি করে (যেমন ভাঙচুর এবং প্রবেশ না করে দোকান থেকে চুরি করা; জালিয়াতি)				
৯। প্রায়শই বাইরের উদ্দীপনায় সহজেই মনোযোগ হারিয়ে ফেলে				
১০। সম্ভাব্য পরিণতি বা দুর্ঘটনা বিবেচনা না করে বিপজ্জনক কার্যকলাপে লিপ্ত হয় (রোমাঞ্চ-অনুসন্ধানের উদ্দেশ্যে নয়), যেমন, না তাকিয়ে রাস্তায় ছুটে যায় /না দেখে রাস্তা পার হওয়া				
১১। প্রায়শই স্কুল থেকে পালিয়ে যায় , বিশেষ করে ১৩ বছর বয়সের আগেই				
১২। প্রায়শই হাত বা পায়ে অস্থিরতা দেখায় অথবা সিটে বসেই নড়াচড়া করে				
১৩। প্রায়শই হিংসাত্মক বা প্রতিশোধপরায়ণ আচরণ করে				
১৪। প্রায়শই গালাগালি বা অশ্লীল ভাষা ব্যবহার করে				
১৫। প্রায়শই নিজের ভুল বা খারাপ আচরণের জন্য অন্যদের দোষারোপ করে				
১৬। ইচ্ছাকৃতভাবে অন্যের জিনিসপত্র নষ্ট করে থাকে (আগুন লাগানো ছাড়া)				

১৭। প্রায়শই বড়দের অনুরোধ বা নিয়ম মেনে চলতে অস্বীকৃতি জানায় বা অস্বীকার করে				
১৮। যখন কেউ তার সাথে সরাসরি কথা বলে, তখন প্রায়ই মনে হয় সে ঠিকমতো শুনছে না				
১৯। প্রশ্ন শেষ হওয়ার আগেই প্রায়শই উত্তর দেয়				
২০। প্রায়শই নিজের পরিবারের বাইরে যারা থাকে তাদের সঙ্গে মারামারি শুরু করে (স্কুলের বন্ধু বা প্রতিবেশীদের সঙ্গে)				
২১। সে প্রায়ই একটি কাজ শেষ না করে মাঝপথে ছেড়ে দিয়ে অন্য কাজে লেগে যায়				
২২। প্রায়শই সে খেলার সময় বা অবসরে চুপচাপ ও শান্তভাবে থাকতে পারে না				
২৩। প্রায়শই গভীর মনোযোগ দিতে ব্যর্থ হয় অথবা স্কুলের কাজ, কাজ, বা অন্যান্য কার্যকলাপে অসাবধানতাবশত ভুল করে।				
২৪। প্রায়শই রাগান্বিত এবং বিরক্ত হয়				
২৫। প্রায়ই শ্রেণীকক্ষে বা অন্যান্য পরিস্থিতিতে আসন ছেড়ে চলে যায় যেখানে বসে থাকার কথা				
২৬। প্রায়শই অন্যের সামান্য কথা বা আচরণের সেই সহজে রেগে যায় বা কষ্ট পায়				
২৭। প্রায়শই নির্দেশাবলী অনুসরণ করে না যেমন স্কুল হতে বাড়ির কাজ, নিজ বাসার কাজকর্ম সম্পন্ন করতে ব্যর্থ হয় (তবে বিরোধী আচরণ বা নির্দেশাবলী বুঝতে ব্যর্থতার কারণে নয়)				
২৮। প্রায়ই রেগে যায়। হঠাৎ মেজাজ হারিয়ে ফেলে				
২৯। প্রায়শই কাজ বা খেলার মধ্যে মনোযোগ ধরে রাখতে অসুবিধা হয়				
৩০। প্রায়ই নিজের পালার বা সুযোগের জন্য অপেক্ষা করতে অসুবিধা হয়				
৩১। কাউকে যৌন কার্যকলাপে বাধ্য করেছে				
৩২। প্রায়শই অন্যদের ধমক দেয়, হুমকি দেয়, অথবা ভয় দেখায়				
৩৩। প্রায়ই অতিরিক্ত চঞ্চল থাকে, যেন কেউ তাকে থামাতে পারছে না				
৩৪। প্রায়ই প্রয়োজনীয় জিনিস হারিয়ে ফেলে (যেমন খেলনা, স্কুলের কাজ, পেন্সিল, বই, বা অন্যান্য সরঞ্জাম)				
৩৫। প্রায়ই এমন পরিস্থিতিতে দৌড়ে বেড়ায় বা ওঠানামা করে, যেখানে তা অনুচিত (কিশোর-কিশোরী বা প্রাপ্তবয়স্কদের ক্ষেত্রে এটি অস্থিরতা অনুভব করার মধ্যেই সীমাবদ্ধ থাকতে পারে)				
৩৬। প্রায়ই পশুদের প্রতি নিষ্ঠুর আচরণ করে				
৩৭। প্রায়ই এমন কাজ এড়িয়ে চলে, অপছন্দ করে, বা অনীহা প্রকাশ করে যেগুলোর জন্য দীর্ঘ সময় ধরে মনোযোগ ধরে রাখা লাগে (যেমন স্কুলের কাজ বা বাড়ির কাজ)				
৩৮। প্রায়ই বাবা-মার নিষেধ থাকা সত্ত্বেও রাতে বাইরে থাকে, যা ১৩ বছর বয়সের আগেই শুরু হয়েছে				
৩৯। প্রায়ই ইচ্ছাকৃতভাবে অন্যদের বিরক্ত করে				

৪০। কোনো ভুক্তভোগীর মুখোমুখি হয়ে চুরি করেছে (যেমন ছিনতাই, ব্যাগ ছিনিয়ে নেওয়া, জোর করে টাকা আদায়, অস্ত্র দেখিয়ে ডাকাতি)				
৪১। ইচ্ছাকৃতভাবে বড় ধরনের ক্ষতি করার উদ্দেশ্যে আগুন লাগিয়েছে				
৪২। প্রায়ই কাজ বা কার্যক্রম গুছিয়ে / সংগঠিত করতে সমস্যা হয়				
৪৩। অন্য কারো বাড়ি, ভবন বা গাড়িতে জোরপূর্বক প্রবেশ করেছে				
৪৪। প্রায়ই দৈনন্দিন কার্যক্রম ভুলে যায়				
৪৫। এমন কোনো অস্ত্র ব্যবহার করেছে যা অন্যদের গুরুতর শারীরিক ক্ষতি করতে পারে (যেমন ব্যাট, ইট, ভাঙা বোতল, ছুরি, বন্দুক)				

Annexure-3 (A)

CONSENT FORM

Assalamualaikum/ Namaskar, My name is Munmun Akter, I am conducting this study for a Bachelor project study titled "Disruptive Behavior Disorder (DBD) symptoms among school going children (6-12years)" from Bangladesh Health Professions Institute (BHPI), University of Dhaka. I would like to know about the prevalence of Disruptive Behavior Disorder symptoms among school going children with some questions asked to their parents/caregiver. This will take approximately 15-20 minutes.

I would like to inform you that this is a purely academic study and will not be used for any other purpose. The researcher is not directly related to Centre for the Rehabilitation of the Paralyzed (CRP), so your participation in the research will have no impact on your present or future treatment in this area. All information provided by you will be treated as confidential and in the event of any report or publication it will be ensured that the source of information remains anonymous.

Your participation in this study is voluntary and you may withdraw yourself at any time during this study without any negative consequences. You also have the right not to answer a particular question that you don't like or do not want to answer during the interview.

If you have any query about the study or your right as a participant, you may contact with Munmun Akter, Speech & Language Therapy department, Bangladesh Health Professions Institute (BHPI).

Do you have any questions before I start ?

So, may I have your consent to proceed with the interview? YES/ NO

Signature/Fingerprint of the Participant: Date:

Signature of the Investigator: Date:

Signature/Fingerprint of the witness: Date:

Annexure-3 (B)

সম্মতি পত্র

প্রিয় অংশগ্রহণকারী,

আসসালামু আলাইকুম,আমি মুনমুন আক্তার, ঢাকা বিশ্ববিদ্যালয়, চিকিৎসা অনুষদের অধীনে বাংলাদেশ হেলথ প্রফেশন্স ইনষ্টিটিউট এর বি, এস, সি ইন স্পিচ এন্ড ল্যাংগুয়েজ থেরাপি বিভাগের ১ জন ছাত্রী। আমার ডিগ্রির অংশ হিসেবে আমি একটি গবেষণা পরিচালনা করছি, যার শিরোনাম হলো: " **৬-১২ বছর বয়সী স্কুলগামী শিশুদের মধ্যে বিঘ্নিত আচরণগত ব্যাধি (DBD)-এর লক্ষণসমূহ** "। এই গবেষণার উদ্দেশ্য হলো ৬-১২ বছর বয়সী স্কুলগামী শিশুদের মধ্যে বিঘ্নিত আচরণগত ব্যাধির প্রাদুর্ভাব খুঁজে বের করা। এই গবেষণার জন্য আমি আপনার কাছ থেকে কিছু তথ্য সংগ্রহ করতে চাই এবং আশা করি আপনি স্বতঃস্ফূর্তভাবে এই সাক্ষাৎকারে অংশগ্রহণ করবেন। আপনার সঠিক উত্তর আমার গবেষণায় অনেক সাহায্য করবে। আমি নিশ্চিত করছি যে, আপনার পরিচয় এবং প্রদানকৃত সকল তথ্য সম্পূর্ণ গোপন রাখা হবে এবং শুধুমাত্র গবেষণার উদ্দেশ্যেই ব্যবহার করা হবে। আপনি ইচ্ছা করলে যেকোনো সময় এই গবেষণা থেকে নিজেকে সরিয়ে নিতে পারবেন। যদি আপনার কোনো প্রশ্ন থাকে, আপনি সরাসরি আমাকে জিজ্ঞাসা করতে পারেন।

আপনার অংশগ্রহণের জন্য আপনাকে আন্তরিক ধন্যবাদ।

অংশগ্রহনকারীর স্বাক্ষরঃ	তারিখঃ
গবেষণাকারীর স্বাক্ষরঃ	তারিখঃ
সাক্ষীর স্বাক্ষরঃ	তারিখঃ

Annexure-4

1. Association between Gender and DBD Symptoms

Chi-Square Tests					
	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.955[a]	1	.328		
Continuity Correction[b]	.592	1	.442		
Likelihood Ratio	.939	1	.333		
Fisher's Exact Test				.406	.220
Linear-by-Linear Association	.952	1	.329		
N of Valid Cases	256				
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 10.65.					
b. Computed only for a 2x2 table					

Table 3

The association between Gender and DBD symptoms was statistically non-significant ($p>0.05$)

2. Association between age of the child and presence of Disruptive Behaviour Disorder (N = 256)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	7.905[a]	6	.245
Likelihood Ratio	7.038	6	.317
Linear-by-Linear Association	3.244	1	.072
N of Valid Cases	256		
a. 4 cells (28.6%) have expected count less than 5. The minimum expected count is 1.90.			

Table 4

The association between age of the child and presence of Disruptive Behaviour Disorder was statistically non-significant ($p>0.05$)

3. Association between DBDs and educational level of the respondents (N = 256)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	2.225[a]	4	.694
Likelihood Ratio	2.125	4	.713
Linear-by-Linear Association	.940	1	.332
N of Valid Cases	256		
a. 3 cells (30.0%) have expected count less than 5. The minimum expected count is 2.85.			

Table 5

The association between DBDs and educational level of the respondent was statistically non-significant ($p>0.05$)

4. Association between DBDs and educational level of the respondent's partner (N=256)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	4.776[a]	5	.444
Likelihood Ratio	5.108	5	.403
Linear-by-Linear Association	1.268	1	.260
N of Valid Cases	256		
a. 5 cells (41.7%) have expected count less than 5. The minimum expected count is .42.			

Table 6

The association between DBDs and educational level of the respondent's partner was statistically non-significant ($p>0.05$)

5. Association between DBDs and marital status of the respondent (N = 256)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	1.358[a]	2	.507
Likelihood Ratio	1.561	2	.458
Linear-by-Linear Association	.166	1	.684
N of Valid Cases	256		
a. 4 cells (66.7%) have expected count less than 5. The minimum expected count is .42.			

Table 7

The association between DBDs and marital status of the respondent was statistically non-significant ($p>0.05$)

6. Association between Disruptive Behavior Disorders (DBDs) and Religion of the Respondent (N = 256)

Chi-Square Tests					
	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.123[a]	1	.725		
Continuity Correction[b]	.003	1	.959		
Likelihood Ratio	.129	1	.720		
Fisher's Exact Test				1.000	.504
Linear-by-Linear Association	.123	1	.726		
N of Valid Cases	256				
a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.59.					
b. Computed only for a 2x2 table					

Table 8

The association between DBDs and Religion of the Respondent was statistically non-significant ($p>0.05$)

7. Association between DBDs and number of children in the house under the age of 18 (N = 256)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	2.707[a]	4	.608
Likelihood Ratio	3.343	4	.502
Linear-by-Linear Association	1.978	1	.160
N of Valid Cases	256		
a. 4 cells (40.0%) have expected count less than 5. The minimum expected count is .21.			

Table 9

The association between DBDs and number of children under 18 years in the household was statistically non-significant ($p>0.05$)

8. Association between DBDs and number of habitable rooms in the household (N=256)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.887[a]	3	.274
Likelihood Ratio	4.309	3	.230
Linear-by-Linear Association	.037	1	.847
N of Valid Cases	256		
a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 4.32.			

Table 10

The association between DBDs and number of habitable rooms in the household was statistically non-significant ($p>0.05$)

Anneure-5 (A)

IRB Approval Letter

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

Ref: CRP-BHPI/IRB/09/2025/1155 Date: 15.09.2025

To
Munmun Akter
4th Year Student
B.Sc. in Speech & Language Therapy
Session: 2020-21, DU Reg. No.: 14304, Student ID:132000275
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal "Disruptive Behavior Disorder (DBD) symptoms among school going children (6-12years)"- by the ethics committee.

Dear Munmun Akter,
Congratulations.
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above-mentioned dissertation, with yourself, as the principal investigator and Nure Naznin, Assistant Professor of Speech and Language Therapy Department, BHPI as thesis supervisor. The Following documents have been reviewed and approved:

Sl. No.	Name of the Documents
1	Thesis proposal
2	Questionnaire (English & Bangla version)
3	Information sheet & consent form.

The purpose of this study is to determine the prevalence of disruptive behavior disorders among school-going children aged 6-12 years. The study involves answering Parent / Teacher DBD Rating Scale questionnaire that may take fifteen to twenty minutes. There is no likelihood of any harm to the participants, and the findings may benefit in identifying and addressing behavioral issues in early childhood development. The members of the Ethics committee has approved the study to be conducted in the presented form at the meeting held at 08:30 AM on May 21, 2025 (49th IRB meeting) at BHPI.

The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulation.

Best regards,

Muhammad Millat Hossain
Associate Professor, Project and Course Coordinator, MRS
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
CRP-Chapain, Savar, Dhaka-1343, Bangladesh. Tel: +88 02 224445464-5, +88 02 224441404, Mobile: +88 01730059647
E-mail : principal-bhpi@crp-bangladesh.org, Web: bhpi.edu.bd

Annexure-5 (B)

Permission to Conduct the Research

Date: 14.07.2025

To

The Head

Department of Speech & Language Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343, Bangladesh

Subject: **Prayer for Seeking Permission to conduct the Research Project.**

Sir,

With due respect, I state that I am a 4th year student of B.Sc. in Speech & Language Therapy Department, Session: 2020-21 at Bangladesh Health Professions Institute (BHPI), the academic institute of Centre for the Rehabilitation of the Paralysed (CRP). I am sincerely seeking your permission to conduct my research project as the partial fulfillment of the requirement for the degree of B.Sc in Speech and Language Therapy. The title of research project is "**Disruptive Behavior Disorder (DBD) symptoms among school going children (6-12years)**".The main aim of the study is to find out the prevalence of disruptive behavior disorders among school-going children aged 6-12 years.

Now I am seeking your kindness to approve me to conduct the research project and I would like to ensure that anything of my research project will not be harmful to the participants.

So, I therefore pray and hope that you would be kind enough to grant me the permission to conduct the research project.

Your obediently

Munmun Akter

Munmun Akter

4th year student of B.Sc. in Speech & Language Therapy Department

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka

Head of the Department	Comment
Md. Sazzad Hossain Assistant Professor & Head Department of Speech and Language Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka	Permission has been granted. 17/7/2025

Md. Sazzad Hossain
Asst. Professor & Head
Department of Speech and Language Therapy
Bangladesh Health Professions Institute (BHPI), CRP

Annexure-5 (C)

Permission to Conduct the Data Collection

Date: 14.07.2025

To

The Head

Department of Speech & Language Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343, Bangladesh

Subject: **Prayer for Seeking Permission for Data Collection as part of Research Project conduction.**

Sir,

With due respect, I state that I am a 4th year student of B.Sc. in Speech & Language Therapy Department, Session: 2020-21 at Bangladesh Health Professions Institute (BHPI), the academic institute of Centre for the Rehabilitation of the Paralysed (CRP). I am sincerely seeking your permission for data collection to conduct my research project as the partial fulfillment of the requirements for the degree of B.Sc. in Speech & Language Therapy. The title of my research project is "Disruptive Behavior Disorder (DBD) symptoms among school going children (6-12years)". The aim of my study is "To determine the prevalence of disruptive behavior disorders among school-going children aged 6-12 years.

Now I am seeking your kindness to approve me to start the data collection as part of the research project conduction and I would like to assure that anything of my research project will not be harmful for the participants.

So, I therefore pray and hope that you would be kind enough to grant me the permission of data collection and this permission will help me to conduct a successful study as a part of my course.

Your obediently

Munmun Akter

Munmun Akter

4th year student of B.Sc. in Speech & Language Therapy Department

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka

Head of the Department	Comment
Md. Sazzad Hossain Assistant Professor & Head Department of Speech and Language Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka	Permission has been granted. 14/7/2025

Md. Sazzad Hossain
Asst Professor & Head
Department of Speech and Language Therapy
Bangladesh Health Professions Institute (BHPI), CRP

Annexure-5 (D)

Permission from William and Marie Taylor School

Date: 21.09.2025

Principal

William and Marie Taylor School (WMTS)

The Inclusive School of CRP

CRP, Chapain, Savar, Dhaka-1343

Subject: Prayer for seeking permission to conduct data collection for the research project.

Sir,

With due respect, I state that I am a 4th year student of B.Sc. in Speech & Language Therapy Department, Session: 2020-21 at Bangladesh Health Professions Institute (BHPI), an academic institute of Centre for the Rehabilitation of the Paralysed (CRP) affiliated with the Faculty of Medicine, University of Dhaka. I am sincerely seeking permission to conduct data collection from William and Marie Taylor School for my research project as the partial fulfillment of the requirement for the degree of B.Sc. in Speech and Language Therapy. The title of research project is **''Disruptive Behavior Disorder (DBD) symptoms among school going children (6-12)''** under honorable Supervisor, Nure Naznin, Assistant Professor, Department of Speech &Language Therapy, BHPI,CRP, Savar, Dhaka-1343. The purpose of the study is to determine the prevalence of disruptive behavior disorders among school-going children aged 6-12 years. I would like to collect data from September to November. All information which I collect from participants will be treated as confidential.

Now I am seeking your kindness to approve my application to collect data for the research project and I would like to ensure that anything of my research project will not be harmful to the participants.

So, I therefore pray and hope that you would be kind enough to grant me the permission of conducting data collection for the research project.

Yours obediently,

Munmun

Munmun Akter

4th year, B.Sc. in Speech & Language Therapy

Session: 2020-21

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Principal	Comment
Md. Abdullah Al Zubayer Principal William and Marie Taylor School (WMTS) CRP, Savar, Dhaka-1343	Permitted for data collection from WMTS. 23-9-25

MD. ABDULLAH AL ZUBAYER
Principal
William and Marie Taylor School
CRP-Savar, Dhaka-1343

Forwarded
23/09/25

Md. Sazzad Hossain
Asst. Professor & Head
Department of Speech

Annexure-5 (E)

Permission from Selected Schools

বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464, 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Radio Colony Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) ★ CRP, SAVAR, DHAKA ★ Date:

বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464, 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Dairy Farm Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) ★ CRP, SAVAR, DHAKA ★ Date:

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Jamsing Hazi Abdul Gani Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP SAVAR, DHAKA * Date:.....

মোহাম্মদ মমতাজ উদ্দিন
ভারপ্রাপ্ত প্রধান শিক্ষক
হাজি আব্দুল গনি সরকারি প্রাথমিক বিদ্যালয়
বিপিএটিসি, সাভার, ঢাকা

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Savar Model Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP SAVAR, DHAKA * Date:.....

24.09.25

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster

Badda Govt. Primary School

Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) Date: CRP, SAVAR, DHAKA

নাসিমা আজাদ
প্রধান শিক্ষক
বাড্ডা সরকারি প্রাথমিক বিদ্যালয়
সাভার, ঢাকা।

নাসিমা আক্তার
সহঃ শিক্ষক
তারিখঃ ২৪/০৯/২৫

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster

Savar Manik Chandra Govt. Primary School

Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) Date: CRP, SAVAR, DHAKA

বিদ্যুৎ কুমার ঘোষ
সহ: শিক্ষক
তা: ০৮/০৯/২০২৫

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Rajashon Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

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We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP, SAVAR, DHAKA * Date:

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Emandipure Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP, SAVAR, DHAKA * Date:

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Gerda Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) Date: CRP, SAVAR, DHAKA

২৪/০৮/২৫
লাকী আহমেদ
প্রধান শিক্ষক
গেন্ডা সরকারী প্রাথমিক বিদ্যালয়
সাভার, ঢাকা।

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Rajabari Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) Date: CRP, SAVAR, DHAKA

২৪/০৮/২০২৫
(শিপ্রা চৌধুরী)
প্রধান শিক্ষক
রাজাবাড়ী সর প্রাঃ বিদ্যালয়
সাভার, ঢাকা।

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)

(The Academic Institute of CRP)

CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To

Headmaster

Birulia Govt. Primary School

Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Munmun Akter would like to collect data in your organization from 31.08.2025 to 30.11.2025. Her title: "Disruptive Behavior Disorder (DBD) Symptom among School going Children (6-12 years)".

We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP, SAVAR, DHAKA * Date:

আকলিমা আক্তার ২৯/৮/২০২৫
আকলিমা আক্তার
সাবেক প্রধান শিক্ষক
বিরুলিয়া সরকারি প্রাথমিক বিদ্যালয়
সাভার, ঢাকা।

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)

(The Academic Institute of CRP)

CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To

Headmaster

Akrain Govt. Primary School

Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B. Sc in Speech and Language Therapy Course, under Faculty of Medicine, University of Dhaka.

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We shall remain grateful to you if you could kindly allow her to collect data in your Organization

With regards

Md. Sazzad Hossain
Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP, SAVAR, DHAKA * Date:

হোসনে আরা বেগম ২৯.০৮.২০২৫ইং
হোসনে আরা বেগম
প্রধান শিক্ষক
১০ নং আকরান সরকারি প্রাথমিক বিদ্যালয়
বিরুলিয়া, সাভার, ঢাকা।

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Kolma Govt. Primary School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

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Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP, SAVAR, DHAKA * Date:

২৯/৮/২৫
ভারপ্রাপ্ত প্রধান শিক্ষক
কলমা সরকারি প্রাথমিক বিদ্যালয়
সাভার, ঢাকা।

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BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP, SAVAR, DHAKA * Date:

২৯/৮/২৫
মীর মোঃ লুৎফর রহমান
প্রধান শিক্ষক (ভারপ্রাপ্ত)
দোগাইর সরকারি প্রাথমিক বিদ্যালয়
আওলিয়া, সাভার, ঢাকা।

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
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(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Chapain New Model High School
Savar, Dhaka.

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Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP SAVAR, DHAKA * Date:

28.10.2025
মোঃ আশ্রুর রহমান
এম.এ.এম.এস (১ম শ্রেণী)
প্রধান শিক্ষক/সদস্য সচিব
চাপাইন নিউ মডেল হাইস্কুল
সাভার, ঢাকা।

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
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(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Lion Dr. Alamgir Moti ~~Sir~~ High School
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

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Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP SAVAR, DHAKA * Date:

29.10.25
ফারহানা সাজনীন (আনি)
প্রধান শিক্ষক
লায়ন ডা. আলমগীর মতি উচ্চ বিদ্যালয়
চাপাইন, সাভার, ঢাকা।

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CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 30.08.2025

To
Headmaster
Hanada Scholars School.
Savar, Dhaka.

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Asst. Prof. & Head
Dept. of Speech & Language Therapy
BHPI, CRP, Savar, Dhaka.

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI) * CRP, SAVAR, DHAKA * Date:

Harunur Rashid
Head Teacher
Hanada Scholars School
Savar, Dhaka.

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
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Date: 30.08.2025

To
Headmaster

Savar Public School & College
Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

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মোঃ আঃ জলিল
প্রধান শিক্ষক
আবার পাবলিক স্কুল
এন্ড কলেজ

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New S.R. High School

Savar, Dhaka.

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Md. Ekramul Haque
Principal
New S.R High School