IMPACT OF FAMILY FUNCTIONING AND FRUSTRATION DISCOMFORT ON COMMON MENTAL DISORDERS AMONG JUVENILE DELINQUENTS: EFFICACY OF DIALECTICAL BEHAVIOR THERAPY

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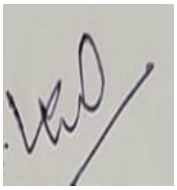

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Dedication

To

*My **Father***

Behind every success of mine is my father

*"Someone once said that every person is trying to live up to his/her father's expectations**....** "*

This achievement of mine is little effort to meet his expectations which is not yet enough……

My late mother

No words to explain her struggles for my achievements at this stages she is no more with me but definitely happy there in heaven

My dearest and precious family members
Dr. Wasif Khurshid (brother), Dr. Misbah Khurshid (sister),

Hammad Zia (husband) (he is beyond every imagination)
And my redefined strength and joy of my life my son Yousuf Hammad

And my supervisor and my friend

Throughout my PhD journey she was the person who proved a safety wall for me in front of every obstacles during the completion of this journey I have never seen such a promising person in my life

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List of Abbreviations

APA	American Psychological Association
DSM	Diagnostic and Statistical Manual of Mental Disorders
SPSS	Statistical Package for Social Sciences
BFRS	Brief Family Relationship Scale
FDS	The Frustration Discomfort Scale
CMDQ	Common Mental Disorders Questionnaire
DBT	Dialectical Behavior therapy

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Abstract

The present study was aimed to explore the Impact of Family Functioning and Frustration Discomfort on Common Mental Disorders among Juvenile Delinquents: Efficacy of Dialectical Behavior Therapy. For this purpose present research was divided into 3 studies phases Study I focused on Translation, Adaptation and Validation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ), Study II included Main Study, Translation, Adaptation, Validation and intervention of Dialectical Behavior Therapy (DBT) Adolescence Manual was carried out in Study III. The purpose of the study I was to translate the scales BFRS, FDS and CMDQ into Urdu language. The data was collected from male juveniles of different jails of Punjab, Pakistan. Sample was drawn by purposive sampling technique from juveniles (n=177). Their age range from 13-18 years and belonged to different socioeconomic class and have different types of crimes. Results of pilot study showed that Urdu translation of the scales were reliable and validity for the present study. Confirmatory factor analysis was carried out with help of AMOS, which showed model fit for the translated scales. Cross language validation was also satisfactory on these scales.

Study II: Main Study of the present research sample of (N=454) included convicted male juvenile delinquents with purposive sampling from Bahawalpur, Punjab (n=247), & Haripur, Khyber Pakhtunkhwa (n=207) jails. The age range of the sample was between 13 to 18 years. The categories of crimes were murder, dacoits and theft. Non convicted male juvenile were not part of this study. Urdu translation version of BFRS, FDS and CMDQ scales were used for convicted male juvenile delinquents. The objective of the main study was to investigate the relationship of BFRS, FDS and CMDQ among Juvenile Delinquents.

Frustration discomfort moderated between Family Functioning and Common Mental Disorders among Juvenile Delinquents. Juveniles having single parent scored high on Common Mental Disorders and Frustration Discomfort as compared to juveniles Delinquents having both parents. Juveniles having single parent reported low on Family Functioning as compared to juveniles Delinquents having both parents scored significant (p>.01). Juveniles showed no differences on BFRS, FDS and CMDQ on the basis of severity of crime. Study III: Translation, Adaptation, Validation and intervention of Dialectical Behavior Therapy (DBT) Adolescence Manual. DBT was translated and validated it accordingly. DBT (Urdu version) were administrated on juveniles (n=14), who scored moderate to high on BFRS, FDS and CMDQ. The aim of the intervention was to assess effectiveness of DBT intervention on the juveniles of Pakistan. It was hypothesized that Post scores of Juvenile Delinquents would be high on Family Functioning as compared to their pre scores. Post scores of Juvenile Delinquents would be low on FDS and CMDQ as compared to their pre scores. The results were discussed in the context of prevailing values of Pakistani jail environment among juveniles. After one week of the post assessment on FDS and CMDQ was carried out. Results showed that post intervention scores were significant through paired sample t-test. Previously no intervention study was conducted on juvenile in Pakistan and DBT manual was not translated into Urdu especially for the juvenile delinquents in Pakistan.

Keywords: Family Functioning, Frustration Discomfort, Common Mental Disorders, Dialectical Behavior Therapy and Juvenile Delinquents

Chapter-I

INTRODUCTION

Juvenile delinquency and its implications in Pakistan have emerged as pressing concerns, affecting individuals, families, and society at large. The delinquent behaviors among young individuals are on the rise, as evidenced by alarming day by day in all over the world. These behaviors encompass a wide range of activities, including theft, substance abuse, aggression, and involvement in criminal acts. The consequences of juvenile delinquency extend beyond the individuals involved, contributing to social instability and undermining the overall well-being of communities (Elliott, 2015).

Juby and Farrington (2006) found that impact of mental disorders among juvenile delinquents cannot be ignored. Researchers consistently demonstrate a higher prevalence of mental health issues among this population compared to non-delinquent individuals. When left untreated, these mental disorders can exacerbate delinquent behaviors and increase the risk of reoffending. Adolescents with mental health challenges often struggle with managing their emotions, controlling impulses, and making sound decisions, all of which further contribute to their engagement in juvenile delinquent activities.

To effectively address juvenile delinquency, it is crucial to understand the interrelationships between family functioning, frustration discomfort, and mental disorders. The family environment plays a pivotal role in shaping the behavior and psychological well- being of adolescents. Dysfunctional family dynamics characterized by poor communication, neglect, abuse, and lack of emotional support can contribute to the development of mental health problems and delinquent behaviors. By studying the interplay between family functioning, frustration discomfort, and mental disorders, researchers and practitioners can gain insights into the underlying mechanisms and develop targeted interventions to address these issues (Steinberg, 2007).

According to Cicourel (2017) the urgency of addressing juvenile delinquency and associated mental health problems cannot be overstated. It has been demonstrated that delinquency rises during the developmental stage of adolescence. Age and criminal behavior are associated, according to numerous studies (Loeber & Farrington, 2014; Tremblay & Nagin, 2005). In general, we are aware that delinquent activity gradually rises from childhood to adolescence, with a distinct peak of delinquent engagement occurring between the ages of 15 and 19. Similar trends emerged from a study that examined the trajectories of delinquent behavior throughout childhood, adolescence, and the beginning of adulthood. According to their findings, delinquent behavior increased starting at age 10 and continued until the teenagers were 17 years old.

The term "juvenile delinquency" describes criminal behavior done by young people under the age of 18. The majority of juvenile crime is committed by a subset of chronic juvenile. These young people are the result of interactions between people and their environments, and additional issues including drug use, mental health issues, and academic failure are frequently a part of their daily existence (Hockenberry, 2020).

Juvenile delinquency has always been a significant legal and social problem, particularly during the period of changing systems like radical upheaval and societal crises lead to an increase in juvenile delinquency, which is a component of overall criminality. It is thought that teenagers frequently push the boundaries imposed by their parents and other adults. Teenagers are known for being somewhat rebellious and trying new things. Few of them, though, engage in harmful activities on a regular basis that harm their social, academic, familial, and personal functioning. Parents and the community at large have serious concerns about this young person (Shoemaker, 2000).

Delinquent behavior is split into two categories in juvenile justice: "status" offenses and "delinquency" offenses. Status offenses are actions that would not be punishable by law if performed by an adult; examples include running away from home, violating curfew, possessing or using alcohol, and truancy (skipping school). According to the Federal Bureau of Investigation in Washington in 2019, delinquency offenses include the destruction or theft of property, the commission of violent crimes against people, the possession of illegal weapons, and the possession or sale of illegal substances.

Adolescent offenders fall into two categories: those with early onset and those with late onset. According to Steinberg (2006), delinquency's early onset occurs when a boy is still a young child, and it typically affects males. Ineffective socializing skills, bad peer relationships, and unstable households are causal factors. Such juvenile criminals typically go on to commit more violent and dangerous crimes as adults. He claims that the term "late onset" refers to delinquent symptoms that appear early in childhood and affect both boys and girls, show a greater understanding of norms and standards, have a powerful peer group, have struggling families, tend to commit less serious crimes, and are less likely to break the law as adults.

Delinquent Behavior

The emergence of behavioral issues or troublesome behavior is thought to be detectable as early as age two. Toddlers' natural growth routes include becoming hostile to their parents and acting violently toward other kids. Between the ages of 3 and 6, children often experience a drop in these oppositional behaviors as they learn how to utilize proper speech, which makes it easier for them to express their wants and feelings and resolve conflicts. This troublesome behavior, which ranges from Passive Aggressive Behavior to Oppositional Defiant Disorder, may continue throughout one's life and may develop into Psychopathic Personality Disorder (DSM-V-TR, 2022). However, failing to cultivate positive

traits like honesty, non-aggression, and respect for authoritative figures may result in negative traits like the following.

Juvenile Delinquency Theories

The development of preventative measures to address the issue aided by society's understanding of the reasons of juvenile delinquency; accordingly, the treatment of the offender must be founded on an understanding of the causes that contributed to adolescent growth, learning is a continuous reciprocal interaction of cognitive, behavioral, and environmental factors. The social learning hypothesis, commonly referred to as observational learning, places a strong emphasis on behavior modeling, in which a youngster observes adults or other children around and imitates their behavior.

The theoretical background of the concept of juvenile delinquency and the factors that contribute to its development and maintenance. It draws upon various psychological, sociological, and environmental theories to provide a comprehensive understanding of the phenomenon. Psychological theories play a crucial role in explaining the individual factors that contribute to delinquent behavior.

Psychodynamic theory: One such theory is the psychodynamic theory, which suggests that delinquent behavior stems from unresolved unconscious conflicts and the influence of early childhood experiences. It places emphasis on how defense mechanisms, personality development, and the effects of internal conflicts affect a person's predisposition for crime. According to Bongers et al. (2003), adolescent years were characterized by a rise in delinquent behavior.

Social learning theory: A psychological theory relevant to juvenile delinquency is the social learning theory. This theory posits that individuals learn behavior through observation, imitation, and reinforcement. According to this perspective, delinquent behavior

can be acquired through exposure to deviant models, such as family members, peers, or media influences (Akers 1998).

Strain theory: Agnew's general strain theory (2005) also emphasizes the importance of rewards and punishments in shaping behavior. Strain theory, for example, suggests that individuals engage in delinquent behavior as a result of experiencing strain or frustration caused by the discrepancy between socially accepted goals and the means available to achieve them. When individuals are unable to attain legitimate goals, they may resort to deviant means, such as engaging in delinquent acts, as a way to cope with their frustration.

He offers a paradigm that could be helpful in understanding juvenile delinquency. His general strain hypothesis states that one of the main types of strain is being exposed to unpleasant events or circumstances, including aversive circumstances at home, such as fights and violence. The idea is that adolescents are pushed into delinquency by adverse emotional reactions brought on by being trapped in a bad environment. This obstacle is frustrating the teen, which may resort to frantic avoidance or criminal activity out of wrath.

Strain theory in criminology posits that societal pressure to achieve goals, especially through legitimate means, can create strain or frustration, leading some individuals to commit crimes as a way to cope or seek relief. This theory suggests that blocked opportunities and negative social interactions can generate negative emotions like anger and frustration, which may then be channeled into criminal behavior.

Labeling theory: Another sociological viewpoint pertinent to adolescent delinquency is labeling theory. This theory places a strong emphasis on how social stigma and labeling affect people's behavior and self-concept. This hypothesis contends that when people are branded as delinquents, they may internalize this label and participate in more delinquent behavior as a result of societal expectations and self-fulfilling prophecies (Henry, Tolan, & Gorman-Smith, 2001).

The theoretical background also includes an exploration of the interplay between these psychological, sociological, and environmental factors. It recognizes that delinquent behavior

is influenced by multiple interacting factors, and a comprehensive understanding requires considering the complex interplay between individual, social, and environmental influences. By drawing upon these theoretical perspectives, the article provides a framework for understanding the development and maintenance of juvenile delinquency. It acknowledges the importance of considering individual factors, such as personality and psychological processes, as well as social and environmental factors when examining delinquent behavior. This theoretical background serves as a foundation for the subsequent sections of the article, which delve into specific aspects of family functioning, frustration discomfort, and mental health in relation to juvenile delinquency.

Bandura (1977) examined how the representation of violence in the media might have a profoundly negative effect on the conduct of particular sorts of children who watch violent television programs as part of his research on the social learning theory. He made the observation that some kids will watch the actions of the characters on television and then emulate them. These findings lead us to the conclusion that aggressive behavior is imitated in juvenile criminality. He came to the conclusion that some kids pick up violent and aggressive behaviors by watching others and then imitating what they observe. He referred to this as direct learning because the observed behavior and the modeled behavior were instantly matched (Wiesner et al., 2003). So, in accordance with the social learning hypothesis, learning can take place by the straightforward process of first seeing, and then copying, the behaviors of others.

An individual must be placed in a supportive atmosphere where he or she would be less likely to be enticed to copy violent behavior as part of preventive programs based on the social learning theory. It can be difficult to assess how modern religion actually contributes to the fight against crime. It has a huge potential role, but whether it will play that role depends on how active a religion is in the lives of its adherent ants. Although not all religious beliefs and practices are accepted in the United States, those that are usually fall under small, minority groups. The development of a common morality through religion that complies with

the law offers a system of societal control that includes both substantive legal norms and those that crosses over with those norms (Asetline, Gore, & Gordon, 2001).

Labeling theory, a sociological perspective, suggests that societal reactions to deviance can amplify an individual's deviant behavior, particularly in the context of juvenile delinquency. In Pakistan, this theory has implications for how juveniles are processed within the legal system and how they are perceived by their communities. The theory posits that negative labels, applied by institutions like the justice system or even significant others like parents and peers, can become internalized by the juvenile, leading to a self-fulfilling prophecy of further deviance. In the context of Pakistani culture, this theory can be examined through the lens of family influence, peer interactions, and societal perceptions of deviance.

In Pakistani culture, strong family ties and close-knit communities play a significant role. This can be both a positive and negative influence. While strong family support can help individuals reintegrate after minor offenses, negative labeling from family members can exacerbate deviant behavior. Similarly, peer influence, particularly within youth groups, can either encourage or discourage deviant actions, and the labeling of individuals by their peers can have a significant impact on their self-concept and future behavior. Collectivist cultures, like those found in Pakistan, may have unique dynamics in terms of labeling and deviance, as family and community play a more significant role in shaping individual behavior.

Wardak (2018) from University of South Wales did a study on Social Control and Deviance: A South Asian Community, in his cross sectional study, emphasis that labeling theory layouts are very close ties with the Asian culture in regard to negative and offending behavior in the society. In conclusion, labeling theory offers a valuable framework for understanding the dynamics of deviance in Pakistani culture. By examining the social processes that lead to labeling and the consequences of such labeling, researchers can gain a deeper understanding of the complex relationship between social reactions and individual behavior in this context.

Family Functioning and Delinquency

Family functioning plays a serious role in the development of delinquent behavior among juveniles. This subsection explores the influence of family dynamics, communication patterns, and parenting styles on the likelihood of engaging in delinquent activities.

Understanding these factors is essential for developing effective interventions that address the root causes of delinquency and promote healthy family environments. Family dynamics significantly impact the behavior and well-being of children and adolescents. A dysfunctional family environment characterized by conflict, poor communication, and inadequate parental involvement can contribute to the development of delinquent behavior. Research has shown that juveniles who experience family dysfunction, such as parental conflict, violence, or substance abuse, are at a higher risk of engaging in delinquent activities. The instability and inconsistency within the family unit can disrupt the child's sense of security, leading to emotional distress and an increased susceptibility to juvenile delinquency. Some academics contend that the opposite is also true, that good parenting can have a favorable impact on children.

Parents that act in an illegal or criminal manner exhibit a more extreme form of dysfunctional parenting. Children of substance abusers display more behavioral and emotional issues, less socially adaptable behavior, higher rates of psychiatric disease, and higher use of illicit drugs in research comparing them to demographically matched controls (Keller et al., 2002).

Communication patterns within the family also play a crucial role in the development of delinquent behavior. Open and effective communication between parents and children promotes trust, understanding, and emotional support. In contrast, a lack of communication or negative communication patterns, such as frequent arguments, criticism, or neglect, can contribute to feelings of frustration and isolation among juveniles. Inadequate communication

within the family hinders the development of healthy coping mechanisms, increasing the likelihood of resorting to delinquent behaviors as a means of expression or escape (Houchins et al., 2001).

Communication between parents and young adolescents is associated with family closeness, which in turn guards against teenagers engaging in risky behaviours for their health. Children and adolescents benefit from improved communication because it reduces the impacts of risk factors and increases the benefits of protective factors. Child and adolescent engagement in health risk behaviours, such as tobacco, alcohol, and other drug use, sexual behaviour, and unintentional and purposeful injuries, is influenced by risk and protective variables (Kann et al., 2000). The ability to resolve conflict is a crucial component of communication that drives research into parent-adolescent communication.

Parenting styles have a significant impact on a child's behavior and likelihood of engaging in delinquency. Authoritative parenting, characterized by a balance of warmth, support, and consistent discipline, has been associated with lower levels of delinquent behavior. In contrast, authoritarian parenting, which emphasizes strict rules and harsh discipline without emotional support, and permissive parenting, characterized by a lack of structure and boundaries, has been linked to an increased risk of delinquency. Authoritative parenting promotes healthy emotional development, effective problem-solving skills, and a sense of responsibility, which serve as protective factors against delinquent behaviors.

Children of divorcing parents frequently experience emotional problems over whether they should be loyal to one or both of their parents. When their biological parents remarry, they will likewise struggle to find time for their parents and adjust to new influences. According to the authors, kids and teenagers who suffer family strife as a result of divorce and remarriage frequently act more aggressively, defiantly, and delinquently. One argument is that divorce results in circumstances and effects that are harmful to children (Keller et al., 2002).

The quality of the parent-child relationship influences the child's behavior and susceptibility to delinquency. A warm and nurturing relationship fosters a sense of belonging and

connectedness, reducing the likelihood of engaging in delinquent activities. On the other hand, a strained or distant parent-child relationship can contribute to feelings of rejection and emotional distress, increasing the risk of delinquency as a means of seeking validation or attention (Colvin, Cullen, & Vander, 2002).

Parents and children have different perspectives on what conflict means (Steinberg & Cauffman, 1996). Young, middle, and late adolescents may have different conflict issues and intensities, and the genders of the kid and parent may also have an impact (Coleman, 1997; Jory, Rainbolt, Karns, Freeborn, & Greer, 1996; Vangelisti, 1992). According to Noller and Callan (1991) and Riesch et al. (2000), disagreements usually revolve around commonplace, seemingly trivial topics that haven't changed much throughout the years.

Divorce, parental depression (or other major illnesses), inconsistent parenting, frequent moves, and at least one parent committing a felony are just a few examples of the disruptions that might occur. This leads to the conclusion that youngsters are very susceptible to engaging in antisocial behavior when there is a lack of stability and regularity in their life. The influence of family functioning on delinquency is essential for developing interventions that promote positive family environments. By targeting family dynamics, communication patterns, and parenting styles, interventions can strengthen family relationships, improve communication skills, and enhance parenting strategies. This can include parent training programs that teach effective discipline techniques, conflict resolution skills, and communication strategies. Additionally, family therapy can help address underlying issues and improve overall family functioning (Haggerty, & Fleming, 2002).

Juvenile’s likelihood of developing adjustment issues has long been associated with family conflict (Cummings & Davies, 2010). However, rather than taking into account the effects of conflict in the family as a whole, research has concentrated on the relationships between conflicts in particular family systems, such as interparental or parent-child hostility, and children's adjustment. In order to limit the conceptualization of family conflict as a risk factor, researchers have compartmentalized concerns about the role of conflict in the family

by concentrating only on particular family systems (such as parent-child or interparental conflict). This has led to the development of isolated areas of study of family conflict (such as only parent-child conflict or interparental conflict, respectively).

Family relationship quality has reportedly been used to explain individual differences in the onset of delinquency participation during adolescence, according to Pardini et al. (2015). According to interactional theory (Thornberry, 2014) and social control theory, weak social ties with other family members enhance the probability of juvenile misbehavior. As evidenced by low levels of support and large levels of negativity, this would suggest a link between greater delinquent activity and weaker family connection quality. By boosting daily family contact and fostering or mending family ties, intervention studies have shown the efficacy of family-based therapy in reducing juvenile delinquency. For instance, studies indicate that functional family therapy and multisystem therapy can help teenagers engage in less antisocial and criminal behavior (Henggeler, 2015). For instance, Windle (2000) investigated latent growth models of juvenile delinquency among adolescent boys and females, using family support as a predictor of change in teenage delinquent conduct. Family support was not a significant predictor of change in juvenile delinquency over time, despite lower levels of family support being linked to higher levels of juvenile delinquency at the beginning of the relationship. With a somewhat different perspective, Keijsers et al. (2012) discovered that patterns of adolescent delinquency were linked to changes in parent-child relationships across time. However, the sample they used only included males. Having a single parent dramatically raises the chance of boys acting out, according to another fact. Demuth and Brown (2004) found that single- father led homes had much higher rates of juvenile criminality than single-mother headed households, despite the fact that having a single parent is a significant risk factor for juvenile delinquency.

The relationship between family transitions and adolescent offending is partially explained by changes in economic resources and parental closeness, according to Brown (2006), but the relationship is still statistically significant and no further justification or analysis of the mediating roles of these factors is given. In addition, Rebellon (2002) explores the interaction

between social control, direct control, strain, and social learning variables in the relationship between family structure and juvenile delinquency, concluding that social learning variables appear to be the most crucial elements tying family structure and juvenile delinquency.

Ineffective parenting is more common among moms who lack self-control than among those who possess it, according to a study (Nofziger, 2008). According to Lomanowska et al. (2017), parenting abilities are transmitted from one generation to the next, maintaining a consistent degree of self-control throughout generations. Families with poor self-control therefore find themselves in a vicious cycle. Unfortunately, there is a socially selected mating tendency in which people who lack self-control choose spouses who share their lack of self-control (Boutwell and Beaver, 2010). Crime is also passed down from generation to generation as a result of this. This phenomenon may be caused by family variables, such as the diffusion of parenting techniques over generations (Farrington et al., 2009).

Frustration Discomfort and Juvenile delinquency

Frustration is less intense and immediate (due to a high degree of tolerance).

However, they may be more serious and durable. The frustrating situation may trigger responses lying on the edge of both normality and pathology among juvenile delinquents (Pantelie, 2001). Frustration discomfort refers to the experience of emotional distress, unease, or dissatisfaction when faced with frustrating or challenging situations. In the context of juvenile delinquents, frustration discomfort is closely linked to various mental health issues. The severity of the effects depends on a number of variables, including the type of barrier, the nature and level of motivation, and the structural-dynamic features of the frustrated person.

A youngster will therefore react to little, quick disputes like offenders do. They can manifest in a variety of ways, such as aggression toward objects when a child is unable to vent their frustration on an adult, jealousy, isolation, and sometimes hostility and stubbornness.

Research has shown links between parent-child attachment frustration (DeKlyen & Greenberg, 2008) and juvenile adjustment and emotional insecurity regarding interparental

conflict. However, EST suggests that youth's emotional security is an important goal in regard to numerous family interactions and broadens the study of emotional security beyond particular dyadic relationships (Cummings & Davies, 1996). Youth's symptoms of various specific disorders and problems, such as depression, anxiety, and conduct and peer problems, will be mediated by emotional insecurity in the family system. It can be challenging to limit conflict to a single dyad, though, as it can encompass several family members and systems (parents and children, for example). Additionally, rather than predicting particular symptoms or issues (such as depression or peer problems), previous research has usually looked at relationships with rather broad-band indicators of adjustment problems, i.e., internalising and/or externalising problems. The potential for applicability to child clinical psychology theory and practice is increased by concentrating on the prediction of the symptoms of certain disorders or issues (Cummings & Davies, 2010).

Discomfort intolerance refers to the inability to tolerate or effectively cope with distressing emotions. Juvenile delinquents who struggle with discomfort intolerance may engage in impulsive and maladaptive behaviors as a way to avoid or alleviate emotional discomfort. This can manifest as aggression, substance abuse, self-harm, or other forms of delinquent behavior. The inability to regulate emotions and cope with frustration can contribute to the development of mental health disorders such as anxiety, depression, and conduct disorder (Deković et al, 2004).

Entitlement, on the other hand, involves a sense of deserving special treatment or privileges without putting in the necessary effort. Juvenile delinquents who exhibit a sense of entitlement may engage in delinquent behaviors as a means of asserting their perceived rights or entitlements. This entitlement-driven behavior can contribute to conflicts with authority figures, a disregard for rules and societal norms, and an increased risk of engaging in criminal activities (Harrington, 2005).

Emotional intolerance refers to a limited capacity to tolerate and effectively manage intense emotions. Juvenile delinquents with emotional intolerance may experience difficulties in

regulating anger, frustration, sadness, or anxiety. This emotional dysregulation can lead to impulsive and aggressive behaviors, as well as difficulties in forming and maintaining healthy relationships. The presence of emotional intolerance among delinquent youth is often associated with comorbid mental health disorders, such as borderline personality disorder or oppositional defiant disorder (Pychyl et al, 2000).

Achievement frustration refers to the experience of persistent dissatisfaction and distress resulting from perceived failures or setbacks in achieving personal goals or expectations. Juvenile delinquents who face chronic achievement frustration may engage in delinquent behaviors as a way to gain a sense of control, power, or recognition. This can include acts of vandalism, theft, or aggression to compensate for feelings of inadequacy or to seek validation through antisocial activities (DiGiuseppe et al., 2016).

In the Pakistani context, cultural factors and contextual nuances need to be considered when implementing interventions targeting frustration discomfort and mental health issues among juvenile delinquents. It is essential to tailor interventions to align with cultural values, beliefs, and practices. Collaborating with local communities, religious leaders, and mental health professionals can help ensure the interventions are culturally sensitive and relevant.

Recognizing the impact of frustration discomfort on mental health among juvenile delinquents and implementing evidence-based interventions, such as DBT, can contribute to improved mental health outcomes and a reduction in delinquent behaviors.

Common Mental Disorders

Numerous children with mental health problems are seen by the juvenile justice system. Up to 70% of young persons at juvenile justice interaction points have a diagnosable

mental health disorder, per a meta-analysis by Vincent (2008). This is consistent with recent research that demonstrates an overrepresentation of young persons with mental/behavioral

health disorders in the juvenile justice system (Shufelt & Cocozza, 2006; Meservey & Skowyra, 2015; Teplin et al. 2015). But prevalence varies depending on where in the legal system young people are evaluated. A national survey found that the risk of diagnosed illnesses increased as children were processed farther through the juvenile justice system (Wasserman et al. 2016). The relationship between mental health problems and system involvement is complicated, and it can be difficult to distinguish between correlational and causal relationships between the two, even though there appears to be a high proportion of young people with mental health issues in the juvenile justice system.

This literature review will focus on disparities in mental health treatment within the juvenile justice system, the extent of mental health issues among youths who are at risk and involved with the justice system, the relationship between mental health and justice involvement, and evidence-based initiatives that have been proven to improve outcomes for youths with mental health issues. Many mental health practitioners in the United States classify mental disorders using the Diagnostic and Statistical Manual of Mental Disorders, 5th (American Psychiatric Association, 2013). The mental health problems that prisoners face may vary from country to country, but the high prevalence of mental illness among prisoners nevertheless remains a common factor. The treatment of mental illnesses, as well as planning, budgeting, and policy creation by the departments of correctional services and health depend heavily on data on the prevalence of mental illness in penitentiary service institutions.

According to the literature that is currently accessible, risk factors like social marginalization and insufficient healthcare in correctional facilities have a significant role in the development of mental disorders in convicted offenders (López, et al. 2016).

Common Mental Disorders and Juvenile Delinquency

Due to the rising reliance on it to handle such issues, the juvenile justice (detention, probation, adolescent correctional institutions, etc.) system is now responsible for offering mental health exams and treatment services for its young people. The juvenile justice system, according to Garascia (2005), was initially both a preventative and rehabilitative method,

putting more of an emphasis on the needs and rights of children than the requirement to punish them.

Young people have committed violent and nonviolent crimes at a decreased rate during the past few decades, but according to Tørmoen et al, (2020).), more young people are being handled by the juvenile justice system. Approximately 1,100 delinquent cases were processed daily in 1960, 4000 delinquency cases were treated daily in juvenile courts in 2009, and 2900 delinquency cases were processed daily in juvenile courts in 2013. According to the National Juvenile Justice Council (NJJC), there was a 9% decline in juvenile delinquent cases between 1985 and 2013 but a 30% spike in delinquency cases between 1985 and 2009. More particular, between 1985 and 2013, the number of delinquent cases involving drug offenses, person offenses, and public order offenses increased while the number of cases involving property violations fell. Detention-related delinquency cases reached their peak in 2002, and then fell by 44% through 2013 to reach their lowest point since 1985. Despite a drop in the number of delinquent cases involving incarceration, the NJJC reports that the proportion of cases involving detention was higher in 2013 (21%) than it was in 1985 (19%).The likelihood that a delinquent case will be handled formally (without a petition for adjudication) fell between 1985 and 2013. Despite a brief uptick, 31% of all delinquent cases in 2013 ended with either an adjudication or a waiver to criminal court, which is very similar to the 30%. It seems that some efforts have been made in the most recent years to decrease the number of youth cases processed in the juvenile justice system; however, this may be done by processing cases more informally or transferring cases to adult court.

Greenwood (2008) argues that it would be more economically prudent to make more of an effort to prevent children from becoming criminals as adults. While incarceration and detention are occasionally necessary for young people, it has become increasingly evident in recent years that they frequently have detrimental consequences that frequently lead to recidivism and persistent criminal conduct. On the other hand, community-based approaches have been found to lower re-offending, especially in young people who commit serious and severe crimes. Due to the decrease in resources, numerous communities began turning to the

juvenile justice system in an effort to fill the gap. Furthermore, public opinion of the US juvenile justice system has been shifting once more, this time from a punitive to a rehabilitative approach in the jails.

To care for the mental health or other specific requirements of young offenders, however, a greater dependence on youth detention systems has emerged, as opposed to a concentration on community-based provision of services (Brown, et al. 2015). In the context of juvenile delinquency, it is crucial to understand the prevalence and impact of common mental disorders among delinquent youth. This subsection explores several common mental disorders, including depression, anxiety, stress and alcohol use, drug abuse, and emotional distress, and their significance in relation to delinquent behavior. Depression is a mood disorder characterized by persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities. Among juvenile delinquents, depression is a prevalent mental health issue and can significantly contribute to delinquent behaviors. Depressive symptoms can impair a young person's ability to function effectively, leading to academic difficulties, social withdrawal, and an increased likelihood of engaging in delinquent acts as a means of self-medication or escape from emotional pain.

Excessive and ongoing concern or fear that interferes with daily functioning is a symptom of anxiety disorders. Generalized anxiety disorder, social anxiety disorder, and post-traumatic stress disorder (PTSD) are among the anxiety disorders that delinquent juveniles frequently experience. According to Medrano et al. (2018), these illnesses can increase emotional reactivity, impair decision-making, and increase the propensity for impulsive and violent actions.

Stress and alcohol use often co-occur and can have a significant impact on delinquent behavior. Delinquent youth may turn to alcohol as a way to cope with stressors or alleviate emotional distress. The misuse of alcohol can further exacerbate behavioral problems, impair judgment, and increase the risk of engaging in delinquent acts. Drug abuse is another common issue among juvenile delinquents. Substance abuse, including the use of illicit

drugs, can contribute to delinquent behaviors as individuals may engage in criminal activities to obtain drugs or support their addiction. Drug abuse can have detrimental effects on cognitive function, decision-making, and overall mental health, further increasing the risk of engaging in delinquent acts. Emotional distress is a broad term encompassing a range of negative emotional states experienced by delinquent youth. It includes feelings of anger, frustration, fear, and sadness. Emotional distress can be both a cause and a consequence of delinquent behavior. Delinquent youth often experience high levels of emotional distress due to various environmental, psychological, and social factors. This distress can contribute to impulsive and maladaptive coping mechanisms, resulting in a perpetuation of juvenile delinquent behaviors (Gross, 2002). Understanding the prevalence and impact of these common mental disorders in the context of juvenile delinquency is essential for effective intervention strategies. It highlights the need for comprehensive mental health assessments and tailored treatment approaches that address both the underlying mental health issues and the delinquent behaviors.

Before addressing Dialectical Behavior Therapy (DBT), as a researcher there is some explanation of using DBT instead of other therapies like CBT. CBT mainly helps clients identify and change problematic ways of thinking and behaving, while DBT also helps clients regulate extreme emotions to improve relationships through validation and behavior change.

DBT (Dialectical Behavior Therapy) is often preferred over CBT (Cognitive Behavioral Therapy) for individuals with borderline personality disorder, severe emotion dysregulation, or those struggling with self-harm or suicidal behaviors. DBT's focus on emotional regulation, acceptance, and interpersonal skills makes it particularly well-suited for these challenges, while CBT is often favored for anxiety, depression, and other conditions.

DBT is so effective because it is taught in engaging, interactive, memorable, and fun ways that are catered to the individual's learning style. Clients are able to practice these skills in sessions as well as in the real world, and then process how it went with supportive, professional help.

Here's a more detailed breakdown:

DBT is often preferred when:

Emotion dysregulation is a core issue: DBT directly addresses the difficulty in managing intense emotions, which is a hallmark of conditions like borderline personality disorder.

Interpersonal problems are significant: DBT includes skills training to improve communication, build healthy relationships, and manage conflict.

Self-harm or suicidal behaviors are present: DBT is designed to help individuals develop coping mechanisms to manage urges and reduce harmful behaviors.

A more comprehensive, longer-term approach is needed: DBT typically involves individual therapy, group skills training, and phone coaching, making it a more intensive treatment.

Acceptance and change are both important: DBT emphasizes the importance of accepting oneself while also working towards change, which can be crucial for individuals struggling with self-esteem and self-acceptance issues.

CBT is often preferred when:

Anxiety and depression are the primary concerns: CBT's focus on identifying and changing negative thought patterns is effective in treating these conditions.

A more focused and time-limited approach is desired: CBT sessions are often shorter and more goal-oriented, making it a good fit for individuals who prefer a structured and less intensive treatment.

The individual is motivated to change their thinking and behavior: CBT requires active participation and a willingness to challenge one's own thoughts and behaviors.

In essence, the choice between DBT and CBT depends on the individual's specific needs and challenges. While CBT is a powerful tool for addressing a wide range of mental health conditions, DBT offers a more specialized approach for individuals who struggle with intense emotions, interpersonal difficulties, and self-destructive behaviors.

Interventions for Juvenile Delinquents: Importance of DBT

Dialectical Behavior Therapy (DBT) has shown significant promise as an intervention for

addressing mental health concerns among juvenile delinquents. This subsection explores the importance of DBT and its potential effectiveness in promoting positive outcomes in this population. DBT was initially developed by Marsha (2017) to treat individuals with borderline personality disorder. However, its principles and techniques have since been adapted and applied to various populations facing emotional dysregulation and maladaptive behaviors, including delinquent youth. DBT is rooted in the biosocial theory, which posits that the interplay between biological vulnerabilities and invalidating social environments contributes to emotional dysregulation and problematic behaviors.

The Massachusetts Department of Youth Services (DYS) approach, however, differs from the traditional application of DBT for adolescent in that the adaptations are made for teenagers who are in juvenile justice settings; the skill modules are pertinent to the problems and difficulties that the youth encounter, such as waiting for court dates, attempting to earn privileges within the program, and dealing with frustrations associated with being away from family. Due to time constraints and the probable ability of the children in various settings to employ each module, the state uses a distinct DBT module for each of its five forms of care *(*Kuehn, 2020).

One of the key principles of DBT is the focus on balancing acceptance and change. It promotes acceptance of the individual's current experiences while simultaneously encouraging efforts to change maladaptive behaviors. This approach is particularly relevant for delinquent youth who may have experienced invalidation and rejection in their social environments, leading to emotional dysregulation and a lack of adaptive coping skills. DBT treatment emphasizes the validation of the client’s thoughts and behaviors as legitimate and understandable. Individual counseling sessions make up the treatment, where the most detrimental issues such as suicide and self-harm are addressed first in a hierarchy of importance (Koerner, 2012). In addition, clients are taught new coping mechanisms through the use of skills groups.

DBT incorporates a range of techniques that target specific areas of concern. These

techniques include mindfulness practices, distress tolerance skills, emotion regulation strategies, and interpersonal effectiveness training. Mindfulness helps individuals develop awareness of their emotions, thoughts, and bodily sensations without judgment, allowing them to respond more effectively to challenging situations. Distress tolerance skills equip youth with strategies to tolerate and manage distressing emotions without resorting to impulsive and harmful behaviors (Groves et al., 2012). Emotion regulation techniques focus on identifying and modulating intense emotions to promote emotional stability. Interpersonal effectiveness training teaches effective communication and relationship skills to navigate social interactions more skillfully. DBT's effectiveness lies in its comprehensive approach, addressing both the underlying emotional dysregulation and the maladaptive behaviors associated with delinquency. By providing individuals with coping skills and promoting emotion regulation, DBT empowers delinquent youth to make healthier choices and engage in pro-social behaviors. Moreover, DBT's emphasis on acceptance and validation fosters a therapeutic environment where youth feel understood, supported, and motivated to change (McCauley et al., 2016).

DBT's efficacy for young people living in residential facilities and its effectiveness for adolescents in the forensic setting has been examined researches that have yielded five articles (Ivanoff & Marotta, 2018). The majority of evaluations for this demographic use meager sample sizes and lack sound methodology. However, DBT is frequently shown to be a successful therapy for people with serious emotional and behavioral issues. It is significant to note that there is a need to pinpoint the precise DBT elements that are most closely associated with behavioral issues so that institutions can order treatment modalities in accordance with demand and resources (Banks & Gibbons, 2016).

Research has demonstrated the potential effectiveness of DBT in reducing recidivism rates and improving mental health outcomes among juvenile delinquent youth. Studies have shown that DBT can lead to decreases in impulsive behaviors, aggression, self-harm, and substance

abuse. It has also been found to enhance emotion regulation, distress tolerance, and interpersonal functioning. These positive outcomes contribute to the overall well-being and rehabilitation of delinquent youth, increasing their chances of successful reintegration into society (Miller et al., 2007).

The adaptability of DBT makes it particularly suitable for addressing the needs of delinquent youth in the Pakistani community. Cultural factors play a significant role in shaping the experiences and behaviors of individuals, and interventions must be sensitive to these cultural nuances. DBT's core principles align with many cultural values, such as respect for authority, familial bonds, and social harmony. Additionally, DBT's emphasis on mindfulness can integrate well with Eastern contemplative traditions already present in the Pakistani culture.

Mindfulness is important by educating adolescent to recognize and describe their feelings as well as the accompanying action urges (such as self-harm, suicide thoughts, substance use, etc.), mindfulness reduces emotional dysregulation. Youth are encouraged to practice mindfulness as a life skill through DBT activities (Follette, 2006; Trupin et al., 2002). Skills in mindfulness directly contribute to the development of distress tolerance (Wagner et al., 2006). Distress tolerance techniques help adolescent offenders resist impulsive choices by addressing their propensity for high-risk, risky activities.

These abilities educate teenagers how to divert their attention and calm down on their own in order to stop making snap judgments and acting recklessly. In addition, developing distress tolerance skills enables teenagers to accept themselves and their thoughts, feelings, and actions without passing judgment. By learning how to recognize and categorize emotions, cultivate positive feelings, and lessen vulnerability to negative emotions, individuals with excessive emotional sensitivity can learn to regulate their emotions.

Due to their emphasis on teaching impartial observation of one's current feeling, these techniques enhance mindfulness. The interpersonal effectiveness skills also address the challenges that teenagers face in establishing reliable and satisfying relationships. The art of

"walking the middle path" deals with skewed thinking and dialectical conundrums among family members. By demonstrating how to objectively observe one's own thoughts and emotions, interpersonal effectiveness skills build on mindfulness skills (Wagner et al., 2006). Furthermore, according to Vidal et al. (2017), administrators and policy makers require precise information regarding the costs associated with offering evidence-based therapies. In order to convince government organizations and administrators to fund the treatment, information about the cost savings and efficacy data for DBT can be helpful. For multi-problem suicidal adolescents, the costs of not using DBT (such as hospitalization) are frequently higher than the costs of using DBT. Evidence-based techniques like DBT may be encouraged to be implemented and maintained if federal, state, and local organizations in charge of funding mental health care collaborate more and plan better. Internal administrative support is also crucial for a DBT program to be successful. Because of the perception that DBT programs involve a lot of time and money in terms of staffing and training (e.g., therapist consultation teams and phone consultations), some administrators may be hesitant to support them (Miller et al., 2007). Administrators should be educated on how a DBT program might fit into the objectives of their own organizations.

Juvenile delinquency and the associated mental health problems are imperative for the well-being of individuals and society. Understanding the prevalence and significance of juvenile delinquency in Pakistan, along with the impact of untreated mental disorders, highlights the urgency of intervention. Exploring the relationship between family functioning, frustration discomfort and mental disorders provides insights into the underlying factors contributing to delinquent behaviors. Justifying the selection of Dialectical Behavior Therapy (DBT) as an intervention underscores its evidence-based effectiveness and adaptability to diverse populations. By integrating DBT into the Pakistani context, tailored interventions can be developed to address the unique needs of juvenile delinquents and promote positive mental health.

Pakistani researches on Juvenile delinquency

The causes of juvenile delinquency are an endeavor to identify the many factors that exist, contribute to delinquent behavior, and show how these activities violate the law of Pakistan. Therefore, immediate steps should be done to eliminate this grave threat and pandemic signal from society. This research was carried out in the juvenile barracks of Punjab Province's Adyala jail in Rawalpindi District, Pakistan. The study can considerably contribute to Pakistani societal norms and will be helpful to policy makers, law enforcement agencies, and civil society. There are significant risks to Pakistani citizens' health, social growth, and morality (Mahmood & Cheema, 2004).

Juvenile delinquency is caused by a number of causes, according to Auolakh (1999), including dysfunctional families, a troubled neighborhood, bad company among classmates, poverty, and unemployment. These variables display a variety of elements, including social, psychological, and economic facets. Other causes of juvenile delinquency include the environment inside and outside the home, unchecked population growth, poverty, the negative effects of media, computers, and mobile phones, an unfriendly school climate, a lack of moral education, and various life circumstances. The literature mentioned above provides a clear mirror to better comprehend the reasons of delinquency in society and a request to implement certain preventive measures for the improvement of society in Pakistan.

According to Khan et al. (2022), the size of the family, the gender of the siblings, and IQ all had a significant effect on adolescent criminality, problems including broken homes, poverty, unemployment; relatives who are criminals, dysfunctional families, and parent deaths or divorce have a substantial impact on juvenile delinquency. According to studies (Ali, 2006), parental supervision, good family relationships, and religious teaching all contribute to a reduction in juvenile criminal behavior. Studies have also demonstrated a link between mundane conduct and religion. In the three provinces of Punjab, Sindh, and Khyber

Pakhtunkhwa where the survey was done, the majority of the juveniles were found guilty of thefts, mobile phone snatching, drugs trafficking, rape, kidnapping, murder, and one wheeling, claim Khan et al (2023). According to a different study's findings, criminals chose to steal and rob because they thought it was the simplest method to get money.

The 2018 juvenile justice system legislation, the spirit of the United Nations Convention on the Rights of the Child (UNCRC), and other international rules and regulations such as the Beijing and Riyadh Rules will also be explained and clarified (Shah, Balasingam, Salman, Dhanapal, & Ansari, 2020). This legislative framework should prioritise the reintegration of a child in conflict with the law and the encouraging of that youngster to play a constructive role in society. Pakistan regrettably lacks the spirit and foundation of these international treaties. Therefore, in order to rehabilitate, resocialise, and reintegrate juveniles in Pakistan, the problems and their effects as well as corrective solutions will be examined for optimal execution through the stakeholders in Pakistan. This phenomenon could be caused by the transmission of parenting methods across generations (Farrington et al., 2009).

The social issue of juvenile delinquency affects every nation, including Pakistan. As children are greatly influenced by the exposure to inappropriate environments, disputes typically emerge owing to significant degrees of discrimination among social classes, which becomes a push or pull component of indulgence in delinquency. The goal of the current study is to investigate the variables influencing adolescent delinquency in Pakistan's Punjab province. This study is significant because socioeconomic and psychological factors have a significant impact on Pakistani children and adolescents, particularly those between the ages of seven and eighteen. This generation is the future of our country, and as such, they must be a major factor in its development. Unfortunately, due to unsuitable socialization environments and other psychological factors that had a negative impact on their cognitive and psychological development, some of these kids and teens went on to become criminals in the future. The

goal of the study is to identify the elements that influence young people to deviate from sociocultural norms and values and commit crimes. This study's findings may help determine the causes and effects of adolescent delinquency with confidence. The outcome may also be beneficial for the juveniles' behavior improvement in order to aid in their social reintegration, and they will undoubtedly develop a feeling of commitment and duty as a result of understanding their role in the development of the nation. The study will offer better recommendations for safeguarding children against various forms of abuse (Munir, 2014, Sadruddin, 2011).

Rationale

Juvenile Delinquency has become a global epidemic and is spreading in developing and developed societies in organized and semi-organized manners. In any civilized society, the criminal justice system has the highest premium as it guarantees the rule of law and fair play to its citizens. In fact, economic growth is unthinkable in a country where there is civil strife and fear for one's life and property (Khan, 2023). In

Pakistan money, land, sexual assault, illiteracy, honor killings, old enmity, and drug addiction are the main factors causing increase juvenile delinquency. The recent emergence of militancy deeni madrisas (religious education institutions) has further exacerbated the situation. These institutions impart instruction in militancy and sectarian hatred to young persons below eighteen years (Nadeem, 2002).

There are ever increasing incidents related with delinquent behavior either it is firing in the school or shoplifting or run away from school etc. Among other factors, most important etiological factors are psycho-social ones, including the environment of delinquent in which he was reared up. There are many explanations of this behavior, like conflict, frustration and poor relationship with family and aggression and low level of self-esteem (Branden, 1994; Grove & Crutehfield, 2002; Paetsch & Bertrand, 1997; Perpler & Craig, 2008). In our Pakistani culture, delinquent behavior is manifested in a wide verity of behavior; fewer researches are conducted to explore the psycho-social causes of

such behavior (Altaf, 1988; Tariq, 1991, Khurshid, 2003).

The high prevalence of mental disorders not only necessitates a need for treatment, but also emphasizes the need for different levels of mental health care with varying treatment options. Some youth who meet criteria for a disorder experience their disorder permanently and need emergency services immediately soon after imprisoned. Others, approximately 10%, represent a group of youth with chronic mental health needs who will likely need clinical care well into adulthood. Some youth function well despite their symptoms, while others present limited functionality. Regardless of the diagnosis, youth will present within the juvenile justice system differently, with different mental health needs requiring differing levels of care. This task is weighty for one system of care to provide fully (Shelton, 2005).

Rural juvenile delinquency in Pakistan is attributed to illiteracy, poverty, water theft, factions and feuds, land disputes, terrorism, child trafficking, extortion, money grab. The juvenile delinquency in big cities of Pakistan include trial under murder, attempt murder, hurt, dacoity, robbery, burglary, drugs and motor vehicle thefts, in Karachi, Lahore, Rawalpindi Islamabad, Peshawar and Quetta (Khan, 2023).

The main focus of the research was to assessment of the Juvenile delinquents family functioning and frustration discomfort, on common mental disorders. Along with assessment of FDS and CMDQ on juveniles and another was provision of DBT focused intervention of juveniles in jail environment. During the last few decades, one of the most widely studied topics in criminology is the relationship between family system and the criminal behavior which strengthens crime and delinquent behavior. The crimes committed by adolescents and young adults of the society who are less than 18years of age qualify for juvenile delinquency. Some of the responsible factors which make teenagers to go for such criminal behavior include school failure, substance use, environmental or individual factors and psychological disorders. The present study is concerned to explore the Impact of Family Functioning and

Frustration Discomfort on Common Mental Disorders among Delinquents in the Punjab, Pakistan. This study is important as the concern for Pakistani children adolescents, especially the age from thirteen to eighteen years old are highly affected by socioeconomic and psychological factors.

This research added a new dimension in the field of forensic Psychology in Pakistan because previously no research and work has been done on the rehabilitation of juveniles regarding common mental disorders, minimizing their frustration discomfort and enhancing the family functioning. The study provided better suggestions for the protection of juveniles from various abuses in the jails. These juveniles are the product of interaction between individuals and unhealthy psychological as well as environmental factors, and their lives often are characterized by the presence of other problems, including interfamily problems, peer pressure, drug use, mental health problems and school failure. Juvenile delinquency has also many other reasons. For example, the environment in and outside the home, un-controlled population, poverty, bad impact of media: TV, computer and mobile phones. It is also believed that delinquents most often have experienced troubled and disturbed relationship. Their family environment has never been smoother nor do they experience good relations with their peers. Intervention plan through DBT will help them to address these above mentioned areas and bring them into main stream of the society.

In Pakistani society, it is a milestone in forensic psychology as it will identify and give realization to the juveniles about their family issues, frustration and mental disorder. This research provided intervention based on DBT so that juveniles became the valuable citizens of Pakistan and work as a normal person after completing their imprisonment period in jails. Pakistan juvenile jails of Punjab and Khyber Pakhtunkhawa were provided intervention for common mental disorders and frustration discomfort. The DBT intervention guide lines provided help to reduce the frustration discomfort among the in the jail environment and to

reduce level of common mental disorders. The findings of the study provided a reliable source of information about the delinquency which was of great help for the policy makers in jail settings and by law enforcement agencies in order to address the juvenile's problems in different provinces of Pakistan and it also facilitate future prospective empirical studies.

Objectives

The purpose of this study was to evaluate:

1. To explore the relationship between Family Functioning, Frustration Discomfort and Common Mental Disorders among juvenile delinquents.
2. To assess the psychometric properties of the scales, Family Functioning, Frustration Discomfort and Common Mental Disorders among juvenile delinquents.
3. To explore the impact of Family Functioning, Frustration Discomfort on Common Mental Disorders among juvenile delinquents.
4. To explore the differences on the basis of demographic variables like age, severity of crime, academic background, family income, single parent/ broken homes, criminal parents, having history of drug abuse by parents, and place of residence on Family Functioning, Frustration Discomfort and Common Mental Disorder among juvenile delinquents.
5. To assess the impact of Dialectical behavior therapy on Family Functioning, Frustration Discomfort and Common Mental Disorders among Juvenile Delinquents.

Hypotheses

1. There will be negative relationship of Family Functioning with Frustration Discomfort and Common Mental Disorders among Juvenile Delinquents.
2. Post scores of Juvenile Delinquents will be high on Family Functioning as compared to their pre scores.

3. Post scores of Juvenile Delinquents will be low on Frustration discomfort and Common Mental Disorders as compared to their pre scores.

4. Frustration discomfort will moderate between Family Functioning and Common Mental Disorders among Juvenile Delinquents.

5. Juveniles Delinquents having single parent will scores high on Common Mental Disorders and Frustration Discomfort as compared to juveniles Delinquents having both parents.

6. Juveniles Delinquents having single parent will report low on Family Functioning as compared to juveniles Delinquents having both parents.

7. Juveniles Delinquents will show differences on Family Functioning, Frustration Discomfort, and Common Mental Disorders on the basis of severity of crime.

Conceptual Framework

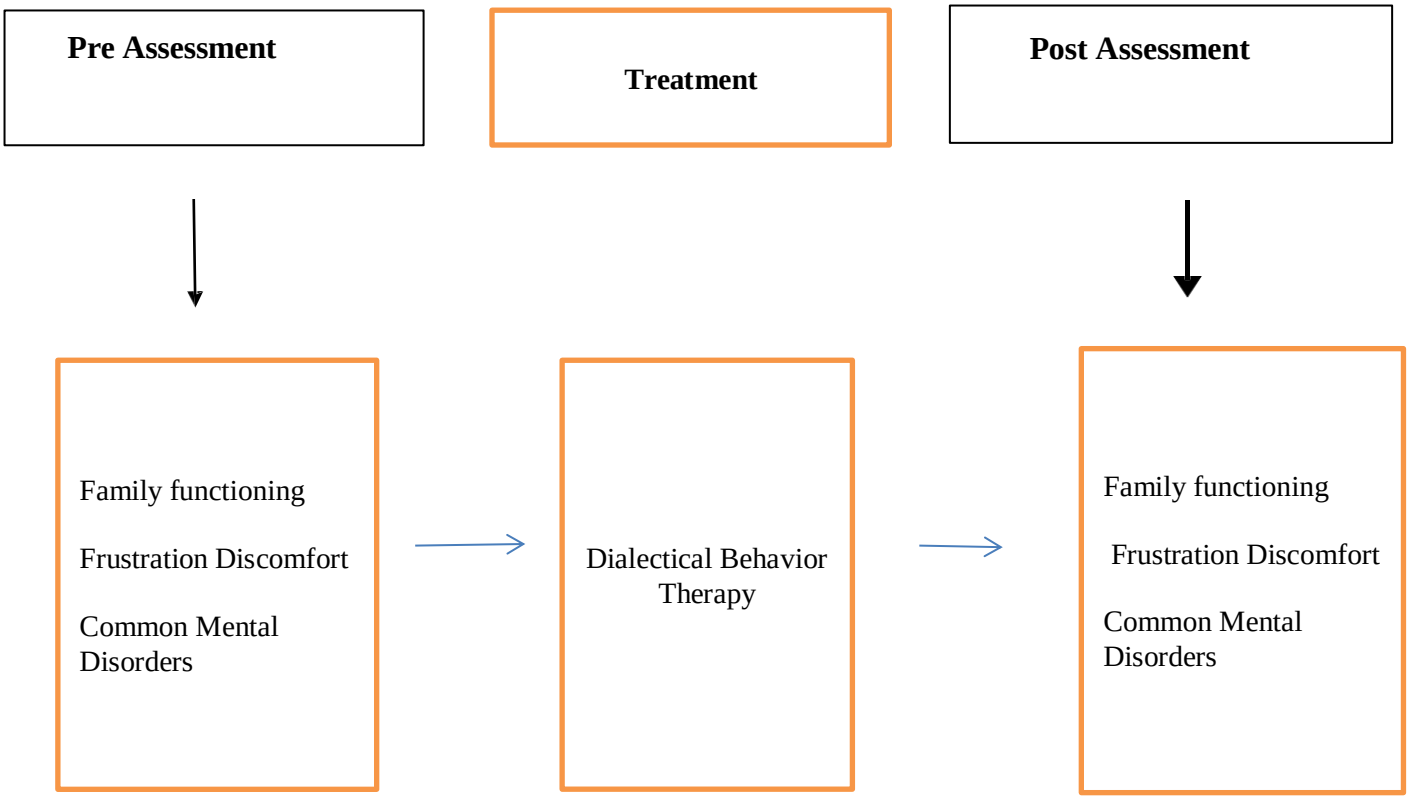


Figure1. Conceptual framework

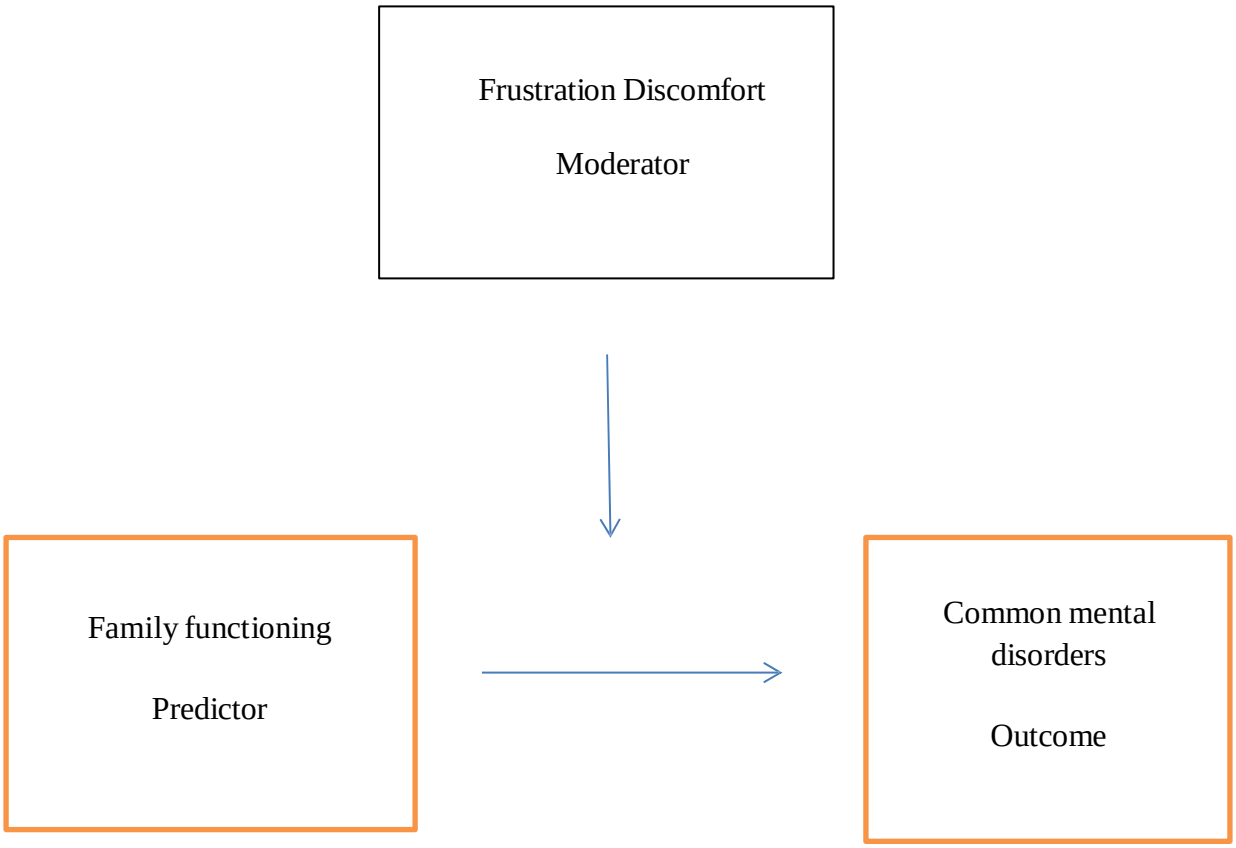


Figure2. Conceptual framework

Chapter 2

Method

Research design

The research design was quantitative and based on quasi experimental design. The research included quantitative research methodology approaches for collecting and analyzing the data.

Sample

Data was collected from different juvenile jails of Pakistan with the permission of IG Punjab. The present research was carried out with convicted male juvenile delinquents into three studies. Study I focused on the translation and adaptation of FDS, BFR and CMDQ on (n=177) juvenile delinquents sample from Adyila jail of Rawalpindi, Pakistan. Study II was main study, its data was comprised of convicted male juvenile delinquents (N=454) with purposive sampling were taken from jails of Bahawalpur, Punjab (n=247), & Haripur, Khyber Pakhtunkhwa (n=207). The age range of the sample was between 13 to 18 years. The categories of crimes would be murder to crimes like dacoits and theft. More over study III was conducted to assess effectiveness of DBT based intervention of Juvenile delinquents (n=14).

Inclusion and Exclusion Criteria of Sample

- Those juveniles were take who were convicted and have imprisonment for at least 5 years.
- Intervention was given to those who had less than 2 years of imprisonment and have high scores on the study variables.
- In Exclusion Criteria no female juvenile delinquents was taken.
- Non-convicted sample was not the part of present study.

Operational Definition

Juvenile Delinquency

Anyone who commits a crime or breaks the law is typically referred to as a juvenile. Local legal statutes define the juvenile delinquent age range (usually 13 to 18 years). Delinquency is a broad notion that encompasses many different types of actions, including stealing, robbery, vandalism, aggression towards people, drug usage, and numerous heterosexual and homosexual practices (Farrington, 2002).

According to the current study, juvenile offenders (aged 13 to 18) who commit delinquent acts include selling illicit narcotics, possessing illegal weapons, committing violent crimes against people, or stealing property (Federal Bureau of Investigation, Washington, 2007).

Family functioning

The social and structural aspects of the overall family environment are referred to as family functioning. It involves how the family interacts and is related to one another, specifically the levels of conflict and cohesion, flexibility, organization, and communication quality (Forney, 2006). According to Alarco (2000), family functioning refers to a family system's capacity to function as a whole and adapt to various circumstances, particularly those that are stressful.

Frustration discomfort

The capacity to resist challenges and stressful circumstances is frustration discomfort. Reduced tolerance for irritation is a typical behavior issue in people with stressful life spans. Aggression, impatience, liability, and disinterest are some behavioral signs. Low tolerance for dissatisfaction is a result of erroneous beliefs that have been formed on a personal level

(Harrington, 2007). In this study, the phrase "frustration discomfort" refers to sources on poor population frustration tolerance.

Common Mental Disorders

A mental disorder is defined as any illness with notable psychological or behavioral traits, a painful or unpleasant symptom, or a functional impairment in one or more crucial domains (APA, 2013).

Instruments

The following scales were used for the present research.

Demographic Sheet

The delinquents' background information, which included offense severity, academic background, family system, and family history of criminal records, was gathered using a demographic questionnaire.

Brief Family Relationship Scale (BFRS)

The 19-item relationship dimension of the family environment (Fok, et al., 2014), which consists of three subscales measuring cohesion (1, 3, 6, 7, 10, 12, 14, 16), expressiveness (4, 8, 17, 18), and conflict (2, 5, 9, 11, 13, 15, 19) and all conflict items has revers scoring. These subscales measure support, expression of opinions, and angry conflict within a family. The main predictors of this study were assessed using the brief family relationship scale (BFRS; α=0.88) developed by Fok et al. (2014). These items served as the basis for the development of the BFRS. These subscales assess the family support for opinion expressing and hostile dispute within the family. It was 5 point likert scale.

The Frustration Discomfort Scale (FDS)

The 28-item frustration discomfort scale (FDS) (Harrington, 2005a) has four subscales of 7 items each: achievement frustration, entitlement, emotional intolerance, and discomfort intolerance. Alpha coefficients of the subscales ranged from 0.84 to 0.88. On a 5- point Likert-type scale, subjects were asked to score the strength of a belief using the following scoring: Absent (1), mild (2), moderate (3), strong (4), and extremely strong (5).

Common Mental Disorders Questionnaire (CMDQ)

The 38-item questionnaire was created by Christensen, Fink, Toft, Frostholm, Ornbl, and Olesen in 2005 to assist general practitioners in evaluating the mental health of their patients. There are six subscales. The somatization 12-item SCL-SOM subscale measures somatic distress on a scale of 1 to 12. The Anxiety ($SCL\text{-}ANX_4$) subscale measures anxiety with 4 items (items 21–24). The seven-item emotional psychiatric disorders (SCL-8) subscale (22-29) is used to assess emotional disorders, while the Depression ($SCl\text{-}DEF_6$), which has six items (28-33), is used to assess depression. The two remaining CMDQ subscales, Illness worry and conviction(Whiteley-7) (8 items) and Alcohol abuse and dependence (CAGE, 4 items) measure alcohol misuse and sickness concern in items 13 through 20 and 34 through 37, respectively. Responses to CMD-SQ items 1 through 33 were graded on a five-point Likert scale, where 0 corresponded to no symptoms at all, 1 to a few, and 2 to a lot Indicators range from 0 for no symptoms at all to 1 for a small amount, 2 for moderately, 3 for quite a deal, and 4 for extremely. Answers were needed to be dichotomized yes/no on the CAGE scale (items 34–37). The patients graded their own general health on the final item, number 38, using a Likert scale with five possible outcomes: Excellent (5 points), Very Good, Good, Fair, and Poor (1 point).

Ethical Consideration

The Department of Psychology at IIUI, the Ethics Committee, and the heads of the institutions all granted their approval. The research conducted on the juveniles in the jails, those juveniles were convicted. In the present study ethical consideration was taking from IG prisoners Lahore for data collection as well for the use of intervention. A complete legal process of permission was done by the researcher and letter was issued from the IG prisoners Lahore. Consent form was taken to confirm the juveniles that their data would remain confidential.

Procedure

The present research was consisted of III studies included,

Study I: Translation, Adaptation and Validation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ)

Study I consisted of Translation & adaptation of BFRS, FDS and CMDQ were carried out, to determine the juveniles' issues. Translation of the scale would be completed in four steps. After the translation of the scales pilot study was conducted. The purpose of the pilot study was to check the reliability and further psychometric properties of the instruments for the present research. The Urdu translated scales were presented to 177 male juveniles. Age range was 13 to 18 years. Sample was taken from the barstool jails of Punjab.

For test Cross language Validation and test retest reliability thesis scales were re-administered to the two equal parts (Group 1 & Group 2) the scale. Group 1 received the

scale's original English form, whereas group 2 received the scale's translated Urdu version. After a week, the same subjects were given the scale again, but in a different way. Groups 1 a (n=10) and 1 b (n=10) were further separated into this time group. The same fashion, Group 2 split into 2a (n=10) and 2b (n=10). The original English version scale was provided to groups 1a and 2a, while the Urdu version scale was given to groups 1b and 2. Correlation between the two groups was then examined. Correlation between English and Urdu-based data was performed for cross validation of BFRS, FDS and CMDQ.

Study II: Main Study was the core of the research on juvenile delinquents in Pakistani prisons is the major study. The main study's objective was to test the theory by gathering data and performing statistical analysis on it. In the main study screening was done by administering the pre testing questionnaires on a large sample The present research was carried out convicted male juvenile delinquents (N=454) with purposive sampling from different jails of Pakistan. Convicted male juvenile delinquents were taken from jails of Bahawalpur, Punjab (n=247), & Haripur, Khyber Pakhtunkhwa (n=207). This data number was calculated with help of sample calculator used for social sciences. The age range of the sample was between 13 to 18 years. The categories of crimes would be murder to crimes like dacoits and theft.

Study III: Translation, Adaptation, Validation and intervention of Dialectical Behavior Therapy (DBT) Adolescence Manual, was carried out. All sessions in the manual was translated and adapted into Urdu language. After pre testing 14 male juveniles were selected.

Therapeutic interventions were given to the 14 male juveniles. After intervention, post testing was done by administering the scales of FDS and CMDQ on single group's pre intervention and post intervention assessment to see the effect of the treatments. The questionnaire booklet was comprised of two scales (Urdu version), which was administered individually on a sample of juveniles. Assurance was given to juveniles that their identity would be kept in confidential. Juveniles were approached in the jails with the permission of IG imprisonment Punjab and Khyber Pakhtunkhwa.

Study I: Translation, Adaptation and Validation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ)

Present study has divided into three phases. These phases were as followed: **Phase I:** Urdu translation of the BFRS, FDS and CMDQ

Phase II: Adaptation and cross validation of the BFRS, FDS and CMDQ (n=40)

Phase III: Pilot study of the Urdu translation BFRS, FDS and CMDQ (n=177)

Phase I: Urdu Translation and Adaptation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ)

Objective

1. To translate & adapt the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ) into Urdu language.

Instruments

The following scales were used for the present research.

Brief Family Relationship Scale (BFRS)

The 19-item relationship dimension of the family environment (Fok, et al., 2014), which consists of three subscales measuring cohesion (1, 3, 6, 7, 10, 12, 14, 16), expressiveness (4, 8, 17, 18), and conflict (2, 5, 9, 11, 13, 15, 19) and all conflict items has revers scoring. These subscales measure support, expression of opinions, and angry conflict within a family. The main predictors of this study were assessed using the brief family relationship scale (BFRS; α=0.88) developed by Fok et al. (2014). These items served as the basis for the development of the BFRS. These subscales assess the family support for opinion expressing and hostile dispute within the family. It was 5 point likert scale.

The Frustration Discomfort Scale (FDS)

The 28-item frustration discomfort scale (FDS) (Harrington, 2005a) has four subscales of 7 items each: achievement frustration, entitlement, emotional intolerance, and discomfort intolerance. Alpha coefficients of the subscales ranged from 0.84 to 0.88. On a 5-point Likert-type scale, subjects were asked to score the strength of a belief using the following scoring: Absent (1), mild (2), moderate (3), strong (4), and extremely strong (5).

Common Mental Disorders Questionnaire (CMDQ)

The 38-item questionnaire was created by Christensen, Fink, Toft, Frostholm, Ornbl, and Olesen in 2005 to assist general practitioners in evaluating the mental health of their patients. There are six subscales. The somatization 12-item SCL-SOM subscale measures somatic distress on a scale of 1 to 12. The Anxiety ($SCL\text{-}ANX_4$) subscale measures anxiety with 4 items (items 21–24). The seven-item emotional psychiatric disorders (SCL-8) subscale (22-29) is used to assess emotional disorders, while the Depression ($SCl\text{-}DEF_6$), which has six items (28-33), is used to assess depression. The two remaining CMDQ subscales, Illness worry and conviction(Whiteley-7) (8 items) and Alcohol abuse and dependence (CAGE, 4 items) measure alcohol misuse and sickness concern in items 13 through 20 and 34 through 37, respectively. Responses to CMD-SQ items 1 through 33 were graded on a five-point Likert scale, where 0 corresponded to no symptoms at all, 1 to a few, and 2 to a lot Indicators range from 0 for no symptoms at all to 1 for a small amount, 2 for moderately, 3 for quite a deal, and 4 for extremely. Answers were needed to be dichotomized yes/no on the alcohol abuse and dependence scale (items 34–37). The patients graded their own general health on the final item, number 38, using a Likert scale with five possible outcomes: Excellent (5 points), Very Good, Good, Fair, and Poor (1 point).

In this step Translation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ) were carried out, to determine the juveniles' issues. Translation method of the scales would be completed in four steps.

Translation into Urdu Language

For the translation of the scales the BFRS, FDS and CMDQ, five specialists who were fluent in both Urdu and English were contacted. The experts gave brief explanations of the research's factors and goals. Among them 2 were graduates of International Islamic University, three professional psychologist were chosen. Experts were asked to use concise and straightforward language translation in Urdu and to have an emphasis on conceptual rather than literal translation. The final Urdu translation that is most appropriate has been chosen.

Committee Approach

A committee of five people (n=5) was assembled to choose the best translation for each item as experts translated the scales. This committee was made up of the study's supervisor, clinical psychologists (n = 2), counselors (n = 2), and the researcher herself from the International Islamic University in Islamabad, Bahria University Islamabad and the University of Faisalabad. Each item on the translated scales was thoroughly examined by all committee members for both language use and consistency with the original content. Best Urdu translation was chosen by the experts.

Back Translation

Three specialists (n = 3), from which the Departments of English at International Islamic University Islamabad (n = 1) and Federal College of Islamabad (n = 2) were asked to translate these Urdu translation scales into English in order to ensure the scale's accuracy.

These specialists were native English speakers who had not participated in the translation of scales in the past, thus they were unfamiliar with the vocabulary and grammar of the scale's original English form.

Committee Approach of Back translation

Bilingual specialists (n = 4) were brought together for a group discussion to evaluate the back translation items and choose the best ones. The committee was made up of the study's supervisor, lecturers in Psychology (n = 2) International Islamic University Islamabad, Assistant Professors in Psychology (n = 2) Bahria University in Islamabad, and the researcher herself from the International Islamic University. All of the committee members agreed that the translated items conveyed the same meaning as the original items or a meaning very similar to it, hence no item needed to be modified in the committee approach of back translation.

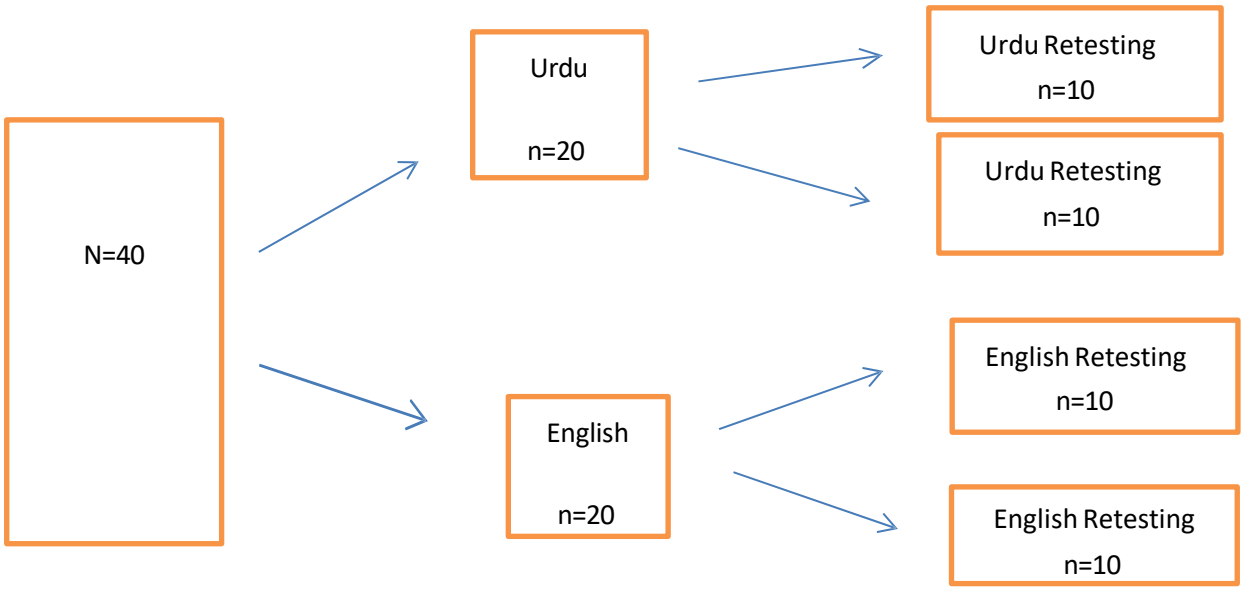
Phase II: Cross Language Validation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ)

Objective

1. To determine the cross language validation of Urdu Translation of Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ)

Sample

For the present study Cross language Validation of the BFRS, FDS and CMDQ a sample of (n=40) was taken from school students age 13-18 years old. They can easily read and understand English as well as Urdu version.



Procedure

For Cross language Validation of BFRS, FDS and CMDQ a sample of (n=40) school students age 13-18 years old. The sample was divided in to two equal parts (Group 1 & Group 2) the scale. Group 1 received the original English version of the scale, and group 2 received the translated Urdu version of the scale. After one week, the same subjects received a second administration of the scale in a different way. The second division of this time group was into groups 1 a (n=10) and 1b (n=10). Likewise, Group 2 divided into 2a (n=10) and 2b (n=10). Groups 1a and 2a received the original English version scale, whereas groups 1b and 2b received the original Urdu version scale. Then, the correlation between the two groups was examined. Correlation was performed for cross validation on scales BFRS, FDS and CMDQ.

Results

Table 1

Cross validation and Test-Retest Reliabilities of Urdu and English version of the BFRS, FDS and CMDQ (n=40)

Scale	Urdu-English (n=10)	English-Urdu (n=10)	Urdu-Urdu (n=10)	English-English (n=10)
Brief Family Relationship Scale	.77*	.76*	.87**	.79*
Frustration discomfort scale	.86**	.82**	.84*	.83**
Common Mental Disorders Questionnaire	.81**	.78*	.74*	.73*

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

Table 1 indicates significant positive correlation for four groups of sample, i.e. Urdu – English, English – Urdu, Urdu – Urdu and English – English. The correlation coefficient for total score of brief family relation scale ranged from 0.76 to 0.87, the frustration discomfort scale ranged from 0.82 to 0.86 and common mental disorder questionnaire ranged from 0.73 to 0.81 that represents the original English and translated Urdu version of the BFRS, FDS and CMDQ which has significant high conceptual equivalence and cross language validity.

Phase III: Pilot Study for Reliability Analysis and Validation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ)

Objective

1. To determine the reliability & validity of Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ) Urdu version.

Sample

For the present study sample comprised of (n=177) juvenile delinquents for determining reliability of the Urdu version of BFRS, FDS and CMDQ. CFA was also run on the pilot study data to check the factor s of Urdu version of each scale on the juvenile delinquents from different jails of Punjab like Adyila, Rawalpindi and Bahawalpur jails, which were convicted in the different jails of Punjab.

Procedure

Data was collected from the juvenile jails of Punjab for the pilot study. Urdu version of BFRS, FDS and CMDQ with demographic information sheet was given to the juveniles. They were assured that their data would be kept confidential and only used for the research purpose. Urdu version scales were easily understandable and filled by the participants. After gathering information from the juveniles data was entered into SPSS for further processing of results.

Results

Table 2

Frequency and Percentage of Demographic variables on juveniles (n = 177)

Variables	Category	*f*	%
Age	15	69	39.0
	16	58	32.8
	17	50	28.2
Education	Illiterate	89	50.3
	Primary	88	49.7
Runaway from school	yes	45	25.4
	no	132	74.6
Family income	> 10000	113	63.8
	> 25000	64	36.2
Father	Alive	147	83.1
	Dead	30	16.9
Mother	Alive	167	94.4
	Dead	10	5.6
Nature of Crime	Drug Smuggling	77	43.5
	Theft	48	27.1
	murder	52	29.4
Releasing time from jail	more than 3 years	100	56.5
	Less than 2.5 years	77	43.5

The above table 2 shows the frequency and percentage of each demographic variable of the study. The age of respondents varies from 15 years to 17 years, 69 out of 177 respondents age is 15 years (39%), 58 respondent has 16 years of age (32.8%) and 50 out of 177 have 17 years (28.2%). In the current study almost 50% of participants are illiterate and 50% have primary education. Out of 177, 74.6% of participants ran away from school and 63.8% respondents' family income is >10000 but <25000. 83.1% of participants' father is alive and 94.4% mother. The majority of participants are involved in drug smuggling

(43.5%), 27.1% are theft and 29.4% are involved in murder. Out of 177 respondents, 56.5% have releasing time from jail is more than 3 years and 43.5% less than 2.5 years.

Table 3

Descriptive Statistics and Alpha-Reliability Coefficient of Scales (n=177)

Scales	k	Range M(SD)	α	Actual	Potential	Skewness	Kurtosis
Somatization	12	4.25 (2.54)	.91	0-38	0-60	2.01	2.36
Anxiety	4	3.74 (1.97)	.86	0-11	0-16	.91	.14
emotional disorders	7	5.15 (3.44)	.81	0-20	0-28	.95	-.11
Depression	6	4.11 (2.71)	.78	0-18	0-24	.87	-.39
Illness worry and conviction	7	2.18 (1.12)	.90	0-21	0-28	1.87	2.41
Narcotic abuse and dependence	4	1.18 (1.12)	.80	0-12	0-16	1.67	2.11
Discomfort Intolerance	7	15.01 (7.96)	.88	7-28	7-28	.94	-.10
Entitlement	7	14.77 (7.99)	.90	7-27	7-28	.94	-.24
Achievement	7	16.57 (7.54)	.80	7-25	7-28	.45	-1.02
Emotional Intolerance	7	15.80 (8.41)	.90	7-27	7-28	.58	-.83
Cohesion	7	10.84 (3.40)	.86	2-12	0-21	-.88	-.64
Conflict	6	3.15 (2.82)	.83	0-10	0-18	.65	-.17
Expressiveness	3	4.28 (1.28)	.71	1-5	0-9	-.18	-.73

Note. k= No. of items, *M*(*SD*)= Mean (Standard Deviation), *α*= Cronbach's Alpha

The table 3 shows the descriptive statistics of study variables. In the table each variable along with number of items (k). Mean value and standard deviation of each variable is also presented in the above table. Reliability is also calculated using α-Reliability test in

the SPSS, the reliability of each variable is >0.70 which is recommended in the social sciences. The range of each variable is compared with actual and potential values. Skewness and Kurtosis of each variable is calculated to check the normality of data, the skewness and kurtosis results show that data is normal and parametric test can be used for further analysis.

Table 4

Correlation between CMDQ and its subscales (n=177)

Variable	1	2	3	4	5	6
Somatization	-	0.88*	0.79*	0.64**	0.85*	0.67*
Anxiety		-	0.73**	0.56**	0.86*	0.67*
emotional			-	0.79*	0.88**	0.57*
disorders						
Depression				-	0.90*	0.61*
Illness worry					-	0.55**
and conviction						
Narcotic abuse						-
and dependence						

***p< .01, *p< .05 Note:* CMDQ =Common Mental Disorders Questionnaire

The results in the above table 4 show the relationship between the variables of the study. Somatization has positive relationship with Anxiety (0.88), emotional disorders (0.79), Depression (0.64), Illness worry and conviction (0.85) and relation with Narcotic abuse and dependence (0.67). Anxiety has positive relation with emotional disorders (0.73), Depression (0.56), Illness worry and conviction (0.86) and relation with Narcotic abuse and dependence (0.67). Emotional disorders have positive relation with Depression (0.79), Illness worry and conviction (0.88) and relation with Narcotic abuse and dependence (0.57). Depression has positive relation with Illness worry and conviction (0.90) and relation with Narcotic abuse and dependence (0.61). Illness worry and conviction and Narcotic abuse and dependence have positive relationship (0.55).

Table 5

Correlation between study Variable FDS and its subscales (n=177)

Variables	1	2	3	4
Achievement	-	0.71*	0.83**	0.54*
Entitlement		-	0.86*	0.78**
Emotional Intoleranc e			-	0.64**
Discomfort Intolerance				-

***p< .01, *p< .05 Note:* FDS = frustration discomfort scale

The results in the above table 5 show the relationship between the variables of the study. Achievement has positive relationship with entitlement (0.71), emotional intolerance (0.83) and relation with discomfort intolerance (0.54). Entitlement also has positive relationship with emotional intolerance (0.86) and relation with discomfort intolerance (0.78). Emotional intolerance has positive relation with discomfort intolerance (0.64).

Table 6

Correlation between study Variable BFRS and its subscales (n=177)

Variable	1	2	3
Conflict	-	-.52*	0.89*
Cohesion		-	-0.67*
Expressiveness			-

**p< .05 Note:* BFRS = Brief Family Relationship Scale

The results in the above table 6 show the relationship between the variables of the study. Conflict has negative relationship with cohesion (-.52) and positive relation with expressiveness (.89). Cohesion and expressiveness also have negative relationship with each other (-.67).

Results for CFA Measurement Model

A confirmatory factor analysis on the sample data (n=177) using AMOS 21.0 (Arbuckle, 1994) was conducted by researchers. This was to assess the latent structure which consists of all constructs in the proposed conceptual model with method of maximum likelihood estimation. The first-order confirmatory factor analysis consisting of all latent factors simultaneously as correlated first-order constructs was estimated.

All construct average variance extracted are above the thresholds of 0.50 and reliability is above the thresholds of 0.70, so all latent constructs guarantee good reliability properties as seen in the below table. Researchers believe that the scales of all first-order factors have satisfactory reliability properties (Bagozzi & Yi 1988; Hair et al. 2010). The reliability for all scales of first order factors has been achieved. The first-order measurement model has been performed and tested. Convergent validity was applied by using statistically significant as $p<.01$ and threshold of *.70*. Researchers have recommended that factor loading above cutoff value of 0.50 is ideal, and in addition the standardized factor loadings of greater than 0.40 are also acceptable.

Figure 3: Common Mental Disorders Questionnaire CFA

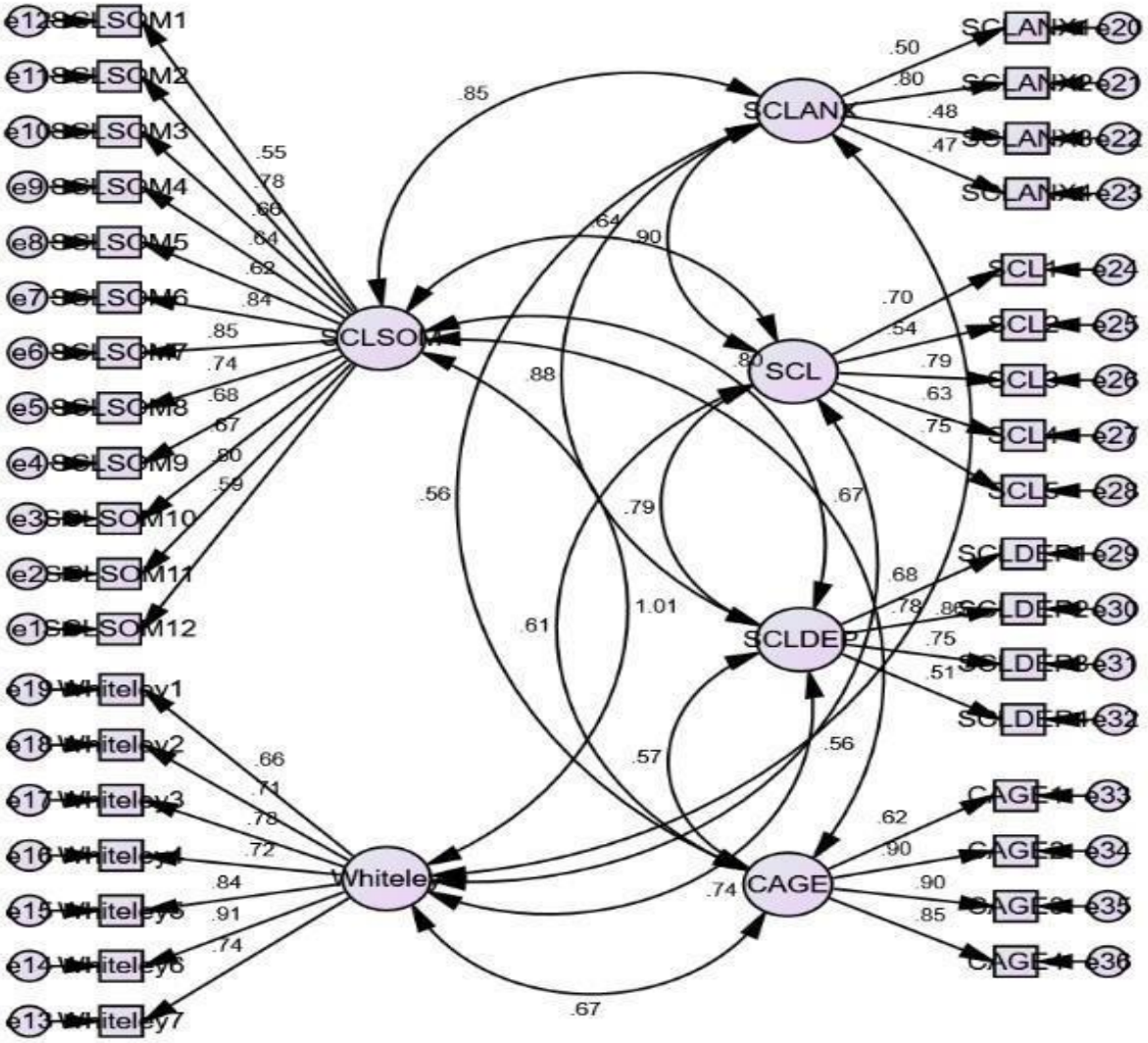


Table 7

Factor Loadings, Average Variance Extracted (AVE) and Construct Reliability of Common Mental Disorders Questionnaire (n=177)

Scale	Items	Factor Loading	AVE Score	CR Values
Emotional psychiatric disorders			.51	.81
	SCL1	0.70		
	SCL2	0.54		
	SCL3	0.78		
	SCL4	0.63		
	SCL5	0.74		
	SCL6	0.72		
	SCL7	0.56		
Narcotic abuse and dependence			.69	.90
	CAGE1	0.62		
	CAGE2	0.90		
	CAGE3	0.89		
	CAGE4	0.85		
Anxiety			.52	.86
	SCLANX1	0.49		
	SCLANX2	0.80		
	SCLANX3	0.87		
	SCLANX4	0.67		
Depression			.47	.78
	SCLDEP1	0.67		
	SCLDEP2	0.77		
	SCLDEP3	0.74		
	SCLDEP4	0.51		
	SCLDEP5	0.64		
	SCLDEP6	0.54		
Illness worry and conviction			.60	.91
	Whiteley1	0.65		
	Whiteley2	0.75		
	Whiteley3	0.78		
	Whiteley4	0.72		
	Whiteley5	0.84		
	Whiteley6	0.91		
	Whiteley7	0.73		
Somatization			.50	.92
	SCLSOM1	0.55		
	SCLSOM2	0.77		
	SCLSOM3	0.66		
	SCLSOM4	0.63		
	SCLSOM5	0.62		
	SCLSOM6	0.84		
	SCLSOM7	0.8		
	SCLSOM8	0.74		

	SCLSOM9	0.68
	SCLSOM10	0.66
	SCLSOM11	0.80
	SCLSOM12	0.59

The above table 7 shows the factor loading (estimated value) of each dimension.

SCLSOM was measured by 12 items, Illness worry and conviction was measured by seven items, SCLANX was measured by four items, SCL was measured by seven items, SCLDEP was measured by six items and Narcotic abuse and dependence was measured by four items. If any item having factor loading ≥0.40 (Cua et al., 2001), it will be included for further analysis. No item has factor loading of less than 0.40 so for further analysis we will not exclude any item.

The loading value of each item, decision, AVE and CR values are given in the below table. Convergent validity is measured by using AVE formula, the value of AVE greater than 0.50 is accepted of the scale. Generally, AVE acceptance value is >0.50 but according to Fornell and Larcker (1981) AVE between 0.50-0.30 is also acceptable if composite reliability (CR) is >0.60. Generally composite reliability value >0.7 is accepted for good reliability of the scale. If other benchmarks (Loading, AVE, CR) are within an acceptable range than reliability value between 0.60-0.70 acceptable. The results show that all values are in the acceptable range. The above figure shows the loading of each item.

Table 8

Model fit Indices for the Common Mental Disorders Questionnaire (n=177)

Fit Indices	X^2	df	XMIN/*df*	RMSEA	IFI	NFI	CFI	TLI
Model 1	818.32	473	1.73	0.045	.921	.908	.923	.942
Benchmark	-	-	< 3	< 0.08	≥ 0.90	≥ 0.90	≥ 0.90	≥ 0.90

Note. *p=REMSEA <.01, *p= CMIN<3.0;

The above table 8 shows the model fit indices of Common Mental Disorders Questionnaire, the results show that all indicators are within the range and best fit for analysis.

Figure 4: Frustration Discomfort CFA

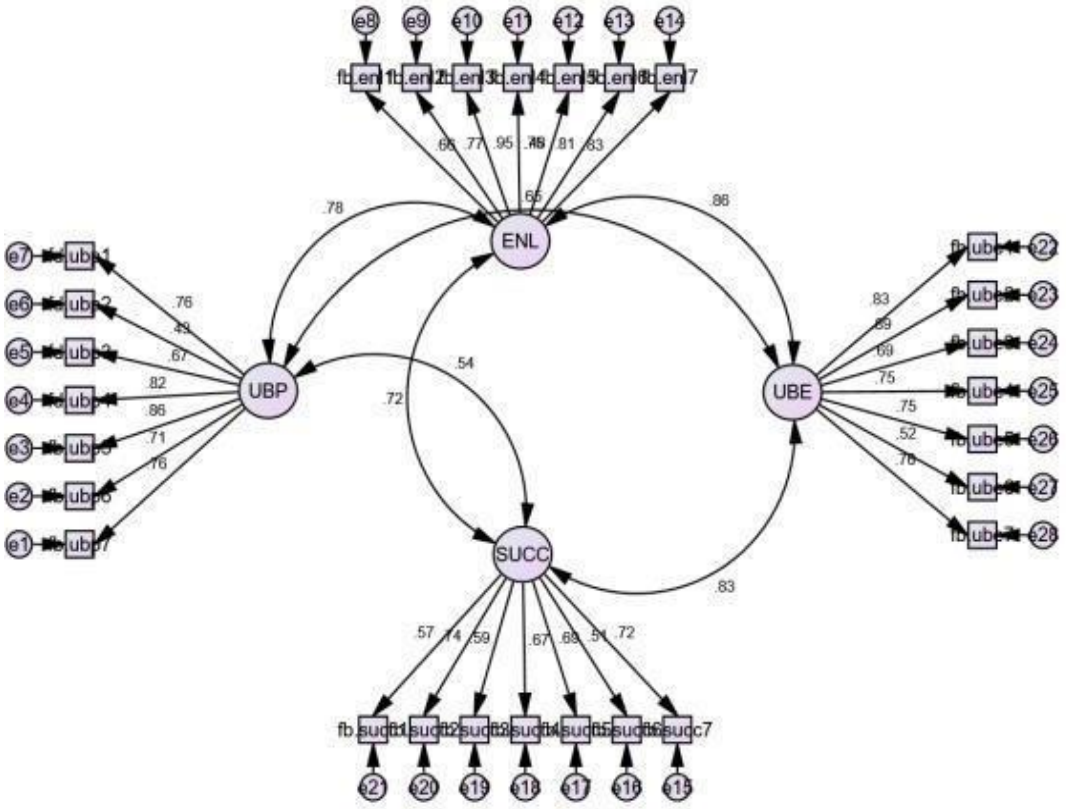


Table 9

Factor Loadings, Average Variance Extracted (AVE) and Construct Reliability frustration discomfort scale (FDS) (n=177)

Scales	Items	Factor Loading	AVE Score	CR Values
Entitlement			.58	.90
	enl1	0.65		
	enl2	0.77		
	enl3	0.94		
	enl4	0.74		
	enl5	0.47		
	enl6	0.80		
	enl7	0.83		
Achievement			.52	.83
	succ1	0.57		
	succ2	0.73		
	succ3	0.59		
	succ4	0.67		
	succ5	0.69		
	succ6	0.51		
	succ7	0.71		
Emotional Intolerance			.56	.90
	EI1	0.83		
	EI2	0.89		
	EI3	0.68		
	EI4	0.74		
	EI5	0.75		
	EI6	0.52		
	EI7	0.76		
Discomfort Intolerance			.53	.88
	DCI1	0.76		
	DCI2	0.43		
	DCI3	0.67		

DCI4	0.81
DCI5	0.85
DCI6	0.70
DCI7	0.75

The above table 9 shows the factor loading (estimated value) of each dimension. Discomfort intolerance was measured by seven items, entitlement was measured by seven items, achievement was measured by seven items and emotional intolerance was measured by seven items. If any item having factor loading ≥0.40 (Cua et al., 2001), it will be included for further analysis. No item has factor loading of less than 0.40 so for further analysis we will not exclude any item.

The loading value of each item, decision, AVE and CR values are given in the below table. Convergent validity is measured by using AVE formula, the value of AVE greater than 0.50 is accepted of the scale. Generally, AVE acceptance value is >0.50 but according to Fornell and Larcker (1981) AVE between 0.50-0.30 is also acceptable if composite reliability (CR) is >0.60. Generally composite reliability value >0.7 is accepted for good reliability of the scale. If other benchmarks (Loading, AVE, CR) are within an acceptable range than reliability value between 0.60-0.70 acceptable. The results show that all values are in the acceptable range. The above figure shows the loading of each item.

Table 10

Model fit Indices for the Frustration Discomfort Scale (n=177)

Fit Indices	X^2	df	XMIN/df	RMSEA	IFI	NFI	CFI	TLI
Model 1	708.54	344	2.05	0.057	.917	.929	.919	.907
Benchmark	-	-	< 3	< 0.08	≥ 0.90	≥ 0.90	≥ 0.90	≥ 0.90

Note. *p=REMSEA <.01, *p= CMIN<3.0;

The above table 10 shows the model fit indices of Frustration Discomfort Scale, the results show that all indicators are within the range and best fit for analysis.

Figure5: Brief Family Relation CFA

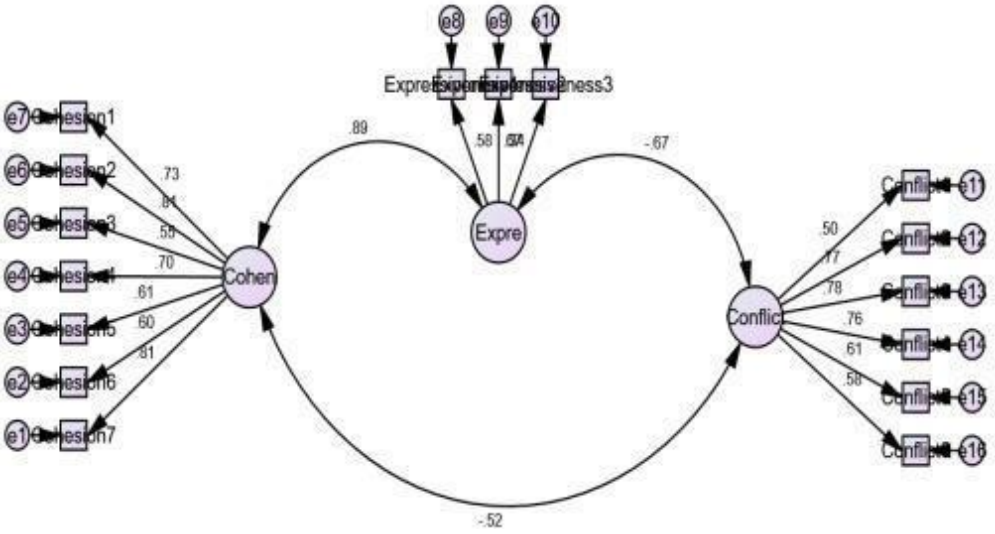


Table 11

Convergent Validity: Factor Loadings, Average Variance Extracted (AVE) and Construct Reliability Brief Family Relation Scale (n=177)

Scale	Items	Factor Loading	AVE Score	CR Values
Cohesion			.50	.86
	Cohesion1	0.72		
	Cohesion2	0.81		
	Cohesion3	0.55		
	Cohesion4	0.70		
	Cohesion5	0.60		
	Cohesion6	0.60		
	Cohesion7	0.80		
Conflict			.51	.83
	Conflict1	0.50		
	Conflict2	0.77		
	Conflict3	0.78		
	Conflict4	0.75		
	Conflict5	0.61		
	Conflict6	0.57		
Expressiveness			.43	.70
	Expressiveness1	0.57		
	Expressiveness2	0.66		
	Expressiveness3	0.64		

The above 11 table shows the factor loading (estimated value) of each dimension. Cohesion was measured by seven items; conflict was measured by six items and expressiveness was measured by three items. If any item having factor loading ≥0.40 (Cua et al., 2001), it will be included for further analysis. No item has factor loading of less than 0.40 so for further analysis we will not exclude any item.

The loading value of each item, decision, AVE and CR values are given in the below table. Convergent validity is measured by using AVE formula, the value of AVE greater than 0.50 is accepted of the scale. Generally, AVE acceptance value is >0.50 but according to Fornell and Larcker (1981) AVE between 0.50-0.30 is also acceptable if composite reliability (CR) is >0.60. Generally composite reliability value >0.7 is accepted for good reliability of the scale. If other benchmarks (Loading, AVE, CR) are within an acceptable range than reliability value between 0.60-0.70 acceptable. The results show that all values are in the acceptable range. The above figure shows the loading of each item.

Table 12

Model fit Indices for the Brief Family Relation Scale (n=177)

Fit Indices	X^2	*df*	XMIN/*df*	RMSEA	IFI	NFI	CFI	TLI
Model 1	259.83	115	2.26	0.059	.908	.913	.904	.911
Benchmark	-	-	< 3	< 0.08	≥ 0.90	≥ 0.90	≥ 0.90	≥ 0.90

Note. *p=REMSEA <.01, *p= CMIN<3.0;

The above table 12 shows the model fit indices of Brief Family Relation Scale, the results show that all indicators are within the range and best fit for analysis.

Discussion

Urdu language was conducted for the purpose of the instrument understandable for the juvenile population. Researcher need to administer this instrument on Pakistani juvenile population, so that target population could understand Urdu language more easily and feel comfortable in responding the items properly in Urdu language. The instrument was being translated by following all the steps of translation, described by Brislin (1986). Scale translation involved the forward translation by bilingual experts and committee approach, backward translation by different bilingual experts (not those who translated the forward part) and the committee approach by same experts. Parallel versions of translation involved several bilingual experts who translated the same questionnaire independently. A consensus meeting was held as the final step of the study, to select the best reconciled version of the translated scale in order to obtain the purpose of the current study.

The important step of translation phase is to determine the cross language validity of the translated scale by analyzing a comparison of translated Urdu version with the original English language version of the scale. In order to validate the scale, both English and Urdu versions of the scale were administered on a sample of 40 school students from Islamabad. Two groups of students were administered twice with Urdu-English and Urdu-Urdu sequence and then these two groups were further divided into four subgroups of 10 student's individuals each. Test-retest reliabilities and correlation of these groups; Urdu-English, Urdu-Urdu, English-English and English-Urdu, the results indicated significant positive relationship between the two versions of scale. Urdu-Urdu correlation is highly positive and frustration discomfort scale Urdu translation version showed more comprehendible to students (Table 1).

The present study focused on Impact of Family Functioning and Frustration Discomfort on Common Mental Disorders among Juvenile Delinquents; Efficacy of Dialectical Behavior Therapy. The antisocial and criminal behavior committed by people under the age of 18 is referred to as juvenile delinquency (Young, 2017). The main aim of this study was to assess the psychometric properties of the scales BFRS, FDS and CMDQ among Juvenile Delinquents. The tools included CMDQ and its subscales, BFRS and sub-scales, FDS and its sub-scales. In Pakistan, most of the juvenile delinquents are not highly educated, so the researcher translated all the scales in Urdu language for comprehension of delinquents so they can easily understand and respond to each item.

In Table 2, demographic information of juveniles was obtained. In the current study translation of Common Mental Disorder Questionnaire, Brief Family Relationship Scale and Frustration Discomfort Scale in Urdu language was the main objective. The subsequent goal was to find out Alpha reliability coefficients of Urdu versions. The original scales in English version have been widely used and translated in several languages.

In Table 2, the Alpha reliability analysis of the translated scales was carried out. The findings revealed that the translated versions of scales had high reliability and validity as determined with juvenile delinquents of jails of Adyaila Rawalpindi and Bahawalpur in Pakistani culture. The results showed that alpha reliability coefficient of all scales and subscales were satisfactory (see Table 2).The inter scale correlation showed that all the subscales were unequivocally related with each other. In a previous study, test-retest reliability of CMDQ in adolescent juveniles.

Common Mental Disorder Questionnaire was used to assess patient's mental health. Covering anxiety, emotional disorder, concern and depression the questionnaire consisted 38 items with six sub-scales, each of which has 4 to 12 items. According to the study's findings, all of the questions had great internal consistency, with a Cronbach's alpha of 0.94. The results showed a moderate to nearly perfect level of population-specific CMDQ reliability (Kirsten Kaya, 2014).

A study on Brief Family Relationship Scale determined that family functioning needs to be examined across different contexts and cultures by validating and adapting an instrument. In the procedure, symmetrical method or centric process was used to make more appropriate adaptation. The process of adaptation was done in six stages which included forward and backward translations, pilot testing and complete psychometric study to build internal consistency and to check both criterion and convergent validity.

By Anderson and Bushman (2002) the results could be discussed in the light of general aggression model. In the model it is suggested that in the presence of an immediate factor levels of aggressive behaviors and the situational variables gets higher and because of provocation frustration grows. In most of the cases on present study in the current situation many cases on present study for aggressiveness frustration becomes a cause.

The present results suggested that in the thinking processes as compared to non-frustrated peers, frustrated youth shows more chances to be furious and unsociable. In this study it was continuously reported by the aggressive or versatile young generation that a greater number of unsociable beliefs that ranged from the beliefs that the police are unfair and the courts pander to rich people to the notions that criminals are sometimes justified in

their acts and breaking the law is rewarding. An antisocial script is observed to be developed by offenders about the unfair nature of rules of society and also about the adults who apply them. These evaluation of the legal system as biased and positive appraisals of criminal behavior may have stick together into an interpretation of the world and this interpretation may be connected with their elevated levels of anger.

The findings of the study revealed that three scales conflict, cohesion and expressiveness were generated through factor and parallel analysis. All of the generated factors had acceptable internal consistency. Among three generated scales of BFRS family cohesion and family conflict had high internal consistency while expressiveness had moderate internal consistency than others (Olana & Tefera, 2020).

Four means of discipline are also claimed by Bank & Burraston 2001 (that are commonly used by the parents to control their children) these harsh discipline methods often create frustration and aggression among children as the main cause of delinquent, furthermore these children are also at higher rates of Narcotic abuse. Poor parenting such as thrashing or rebuking a child in front of others, using such words for children that embarrass them, no words of appreciating them, always doing their comparison with others or bad communication are the different factors described by Hunner & Walke, (2002). Miller & Knutson, (1997) also conducted a study and search out that with violent crimes or further child criminality harsh parental monitoring is linked very forcibly.

In the table 3 of results, validity of the scales was seen. SCLSOM was measured by 12 items, Whitely was measured by 7 items, SCLANX with 4 items, SCL with five items, SCLDEP with four items and narcotic abuse and dependence was measured by four items. According to the findings the Urdu versions of the scale had good validity. The

CFA model showed that all the indicators were within the range and were best fit for analysis (Table 4).

A previous research conducted on Frustration Discomfort Scale validation states that the scale includes four dimensions of beliefs; emotional intolerance, discomfort intolerance and entitlement. The purpose of the study was to translate and validate Frustration Discomfort Scale by Harrington (2005) in a French population to assess its psychometric properties. After translating the scale from English to French it was administered on a sample of 289. The results showed good psychometric qualities. The construct validity was assessed using confirmatory factor analysis. Validity of the scale was also good. Reliability as well as convergent validity indicated that French version of Frustration Discomfort Scale is a relevant measure of frustration intolerance (Chamayou, 2016).

The Common Mental Disorder Questionnaire is capable of identifying mental problems, providing practical self-help techniques, teaching people how to support one another, and teaching people how to avoid mental health disorders. In this study, the Common Mental Disorder Questionnaire (CMDQ) for young adults (16–30 years old) juvenile population was translated into Chichewa for use in Malawi and its psychometric qualities were assessed. The questionnaire's translated Chichewa version was originally piloted with 14 young adults at Malawi University before being given to 132 young people in rural Malawi. The results showed that the scale's Chichewa version's internal consistency was generally good. The version's psychometric qualities were strong (Sandra, 2022).

Table 5 shows the construct reliability. The variables were Entitlement, Achievement, Emotional intolerance and Discomfort intolerance. Discomfort intolerance was

measured by 7 times, entitlement by 7 seven times, achievement was also measured by seven times and emotional intolerance by seven times. The findings showed that all the values of the scales were in acceptable range. The family relation CFA model showed that all the indicators were within the range and best fit for analysis (Table 6).

The study's findings suggested that the Arabic version of the Brief Family Relationship Scale is likewise a reliable and valid measurement that can be applied in Saudi Arabia. Cronbach alphas varied between 0.68 and 0.76, indicating moderate reliability, and moderate correlations were found between the subscales of the Brief Family Relationship Scale (Saifuddin, 2022).

In table 7, convergent validity and construct reliability was seen. The translated scales were Cohesion, Conflict and Expressiveness. Cohesion was measured by seven times, conflict was measured by six times and expressiveness was measured by three times. In findings it was observed that all of the values were in acceptable range. This showed that the validity and reliability of the Urdu version of these scales was good. The Urdu version of scales was reliable. The CFA model of Family Relationship Scale showed that all indicators were within the range and best fit for analysis (Table 8).

A previous study aimed to examine the reliability and validity of the Urdu version of the Family Relationship Scale in Pakistani juveniles. Family Relationship Scale is time saving and easy to administer. The translation process was done in three steps; namely forward translation, back translation and expert panel discussion. With convenient sampling technique a sample of 982 was collected.

In the results, Cronbach’s alpha for FRS was 0.974. Confirmatory factor analysis (CFA) revealed that all the items factor loading of FRS were more than 0.32. The FRS Urdu

version is proved to be reliable and useful instrument for monitoring, assessing and screening Pakistani juveniles' psychosomatic symptoms (Mudassir & Jahangir, 2022). Another previous study on Family Functioning Scale aimed to translate in Urdu language and find out its psychometric properties on Pakistani adult juvenile population.

The results revealed that the Urdu version of scale had good internal consistency Furthermore, the findings reflect that Urdu version of scale is a psychometrically sound and reliable measure to examine family functioning in Pakistani adult juvenile population (Kareem, 2022). There haven't been many researches that look at whether those who are bullied at school or online are more prone to act in a delinquent manner. Even less is known about the possibility that adverse feelings (such as anger or irritation) stemming from victimization moderate the links between bullying or cyber-bullying and delinquency (as anticipated by Agnew's general strain theory). The current study makes use of information from a national sample of 2,670 American middle and high school pupils. According to the findings, young people who have experienced bullying or cyber-bullying and bad feelings as a result are more prone to engage in delinquency. While they did not partially buffer the link between cyber- bullying and delinquency, negative emotions did not mediate the link between bullying and delinquency (Charern & Alexandra, 2020).

Limitation and Suggestions

- In the present study sample for determination of cross language validity included male adolescences only. For further researches female adolescences should be taken so that BFRS, FDS and CMDQ validity can be determined on scores of both genders.

- The study was conducted on the sample of male juveniles in the jail so the future researchers can conduct research on the female sample additionally, this will strengthen the reliability of Urdu version of the scales.
- The data was taken from the barstool jails of Punjab, future researchers could collect data from all barstool; jails of Pakistan for generalizing the findings specifically Sindh and Baluchistan.
- This study included the translation of three scales into Urdu translation for assessment of frustration, family relations and common mental disorders on the juvenile population; other than these measures can be used for translation to get maximum data related to juveniles in the Pakistani jails.
- The translated version of the BFRS, FDS and CMDQ can be used across Pakistani less educated children population for further researches as Urdu is native language of Pakistan. So they can easily understand and grasp the question statements of the scales in Urdu language and feel comfortable in answering them.

Conclusion

It was concluded with the help of this research that both versions of BFRS, FDS and CMDQ have uniformity in conceptual meaning of the scale in Pakistani adolescent population. It also showed that the Urdu vocabulary words used in the scale are simple, easy to understand, appropriately giving the meaning of the sentence, conveying the concept to the population in Pakistan. Cross language validity reflect that Urdu version of BFRS, FDS and CMDQ could appear to be valid, reliable and Pakistani culture fair.

In the present study, Common Mental Disorder Questionnaire, its subscales, Brief Family Relationship Scale, its subscales were translated in Urdu and these scales were effectively used on Pakistani juvenile population. For the better understanding of the scales

as mostly juvenile population in the Pakistani jails are less educated. It was observed in the findings that the Urdu version of scales had good validity and it was reliable. The results were run on CFA and the CFA models also indicated the scales good reliability and validity. In future researchers can do studies on FDS, CMDQ and BFRS in different dimension as it has now Urdu translation. Especially on those populations which cannot easily understand English in Pakistan. These Urdu version scales can also help in diagnosis, when utilized alongside other evaluation tools so that right appraisal and powerful treatment plan can be utilized for the female and male juveniles and those offenders which are there in schools.

Study II: Main Study

Objectives

The main study aimed to assess following objectives:

1. To explore the relationship between Family Functioning, Frustration Discomfort and Common Mental Disorders among juvenile delinquents.
2. To explore the impact of Family Functioning, Frustration Discomfort on Common Mental Disorders among juvenile delinquents.
3. To explore the differences on the basis of demographic variables like severity of crime, academic background, family income, single parent/ broken homes, criminal parents, and having history of drug abuse by parents on Family Functioning, Frustration Discomfort and Common Mental Disorder among juvenile delinquents.

Hypotheses

1. There will be negative relationship of Family Functioning with Frustration Discomfort and Common Mental Disorders among Juvenile Delinquents.
2. Frustration discomfort will moderate between Family Functioning and Common Mental Disorders among Juvenile Delinquents.
3. Juveniles Delinquents having single parent will scores high on Common Mental Disorders and Frustration Discomfort as compared to juveniles Delinquents having both parents.
4. Juveniles Delinquents having single parent will report low on Family Functioning as compared to juveniles Delinquents having both parents.

5. Juveniles Delinquents will show differences on Family Functioning, Frustration Discomfort, and Common Mental Disorders on the basis of severity of crime.

Operational Definition

Juvenile Delinquency

Generally, anyone who commits a crime or who violates a legal code is called as juvenile. The defining age group juvenile delinquents, is set by local legal statue (typically around 13 to 18 years). Delinquency is a heterogeneous concept, including behaviors as diverse as theft, burglary, robbery, vandalism, violence against persons, drug use (Farrington, 1992).

In the present research juvenile delinquents with age range 13 to 18 years, who have delinquency offenses, involve arson or theft of property commission of violent crimes against person's illegal weapon possession and sale of illegal drugs (Federal Bureau of Investigation, 2007). In present study convicted juvenile delinquents will be Bahawalpur, Punjab, & Haripur, Khyber Pakhtunkhwa.

Family Functioning

The social and structural aspects of the overall family environment are referred to as family functioning. It involves how the family interacts and is related to one another, specifically the levels of conflict and cohesion, expressiveness, organization, and conflict (Forney, 2006). According to Alarco (2000), family functioning refers to a family system's capacity to function as a whole and adapt to various circumstances, particularly those that are stressful. In this study family functioning is define in terms of scores on family adaptability and cohesion evaluation scales Brief Family Relationship Scale (BFRS).

Frustration discomfort

Frustration discomfort is the ability to withstand obstacles and stressful situations. Decreased frustration tolerance is a common behavior problem of juveniles who have stressful life span. Low frustration tolerance is rooted in the personal formation of irrational beliefs (Harrington, 2007). In this study Frustration discomfort was define in terms of scores on low frustration tolerance among Juvenile delinquents.

Common Mental Disorders

Mental health is evaluated using the Common Mental Disorders. It has been demonstrated in the past to offer a sensitive and focused device for general practitioners. With a focus on worry, anxiety, depression, somatoform disorders, and Narcotic misuse, the CMDQ offers a tool for evaluating patients' mental health (Sogaard, 2009). In this study Common Mental Disorders is define in terms of sources on high scores on mental disorders among Juvenile delinquents

Instruments

Demographic Sheet

Demographic questionnaire was used to obtain background information of the delinquents, which included age, severity of crime, academic background, family income and family history of criminal record.

Brief Family Relationship Scale (BFRS)

The 19-item relationship dimension of the family environment (Fok, et al., 2014), which consists of three subscales measuring cohesion (1, 3, 6, 7, 10, 12, 14, 16), expressiveness (4, 8, 17, 18), and conflict (2, 5, 9, 11, 13, 15, 19) and all conflict items has revers scoring. These subscales measure support, expression of opinions, and angry conflict

within a family. The main predictors of this study were assessed using the brief family relationship scale (BFRS; α=0.88) developed by Fok et al. (2014). These items served as the basis for the development of the BFRS. These subscales assess the family support for opinion expressing and hostile dispute within the family. It was 5 point likert scale.

The Frustration Discomfort Scale (FDS)

The 28-item frustration discomfort scale (FDS) (Harrington, 2005a) has four subscales of 7 items each: achievement frustration, entitlement, emotional intolerance, and discomfort intolerance. Alpha coefficients of the subscales ranged from 0.84 to 0.88. On a 5-point Likert-type scale, subjects were asked to score the strength of a belief using the following scoring: Absent (1), mild (2), moderate (3), strong (4), and extremely strong (5).

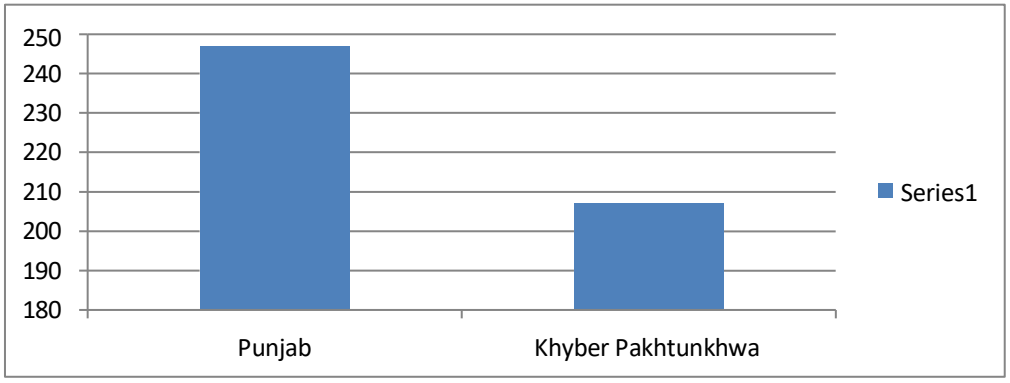
Common Mental Disorders Questionnaire (CMDQ)

The 38-item questionnaire was created by Christensen, Fink, Toft, Frostholm, Ornbl, and Olesen in 2005 to assist general practitioners in evaluating the mental health of their patients. There are six subscales. The somatization 12-item SCL-SOM subscale measures somatic distress on a scale of 1 to 12. The Anxiety ($SCL\text{-}ANX_4$) subscale measures anxiety with 4 items (items 21–24). The seven-item emotional psychiatric disorders (SCL-8) subscale (22-29) is used to assess emotional disorders, while the Depression ($SCl\text{-}DEF_6$), which has six items (28-33), is used to assess depression. The two remaining CMDQ subscales, Illness worry and conviction(Whiteley-7) (8 items) and Narcotic abuse and dependence (CAGE, 4 items) measure Narcotic misuse and sickness concern in items 13 through 20 and 34 through 37, respectively. Responses to CMD-SQ items 1 through 33 were graded on a five-point Likert scale, where 0 corresponded to no symptoms at all, 1 to a few, and 2 to a lot Indicators range from 0 for no symptoms at all to 1 for a small amount, 2 for

moderately, 3 for quite a deal, and 4 for extremely. Answers were needed to be dichotomized yes/no on the Narcotic abuse and dependence scale (items 34–37). The patients graded their own general health on the final item, number 38, using a Likert scale with five possible outcomes: Excellent (5 points), Very Good, Good, Fair, and Poor (1 point).

Sample

Sample of the main study was comprised of convicted male juvenile delinquents (N=454) with purposive sampling from different jails of Pakistan. Convicted male juvenile delinquents were taken from jails of Bahawalpur, Punjab (n=247), & Haripur, Khyber Pakhtunkhwa (n=207). The age range of the sample was between 13 to 18 years. The categories of crimes were murder to crimes like dacoits and theft.



Graph1. Sample Distribution

Inclusion Criteria

The criteria of selection of sample was as follows, convicted juvenile delinquents who were present in barstool jails during the time of data collection, who gave consent to participate in the study. Those juveniles were included in the main study, which were in jail for at least last six months and their family is in regular contact with them.

Exclusion Criteria

Female juveniles and non-convicted male juvenile delinquents were not the part of this main study.

Procedure

Initially translation, adaptation and validation of BFRS, FDS and CMDQ was done. The questionnaire booklet comprised of three scales (Urdu version), which was administered individually on a sample of juveniles (N=454). Required demographic information was taken on a separately designed demographic information sheet regarding severity of crime, family history with criminal background, academic background among juvenile delinquents. Instructions for giving responses to the items of the scales were printed on the respective questionnaires. Juveniles were also given assurance that their identity would be kept confidential. They were asked to respond to all the scale items according to the given instructions. Juveniles were approached in the jails with the permission of IG imprisonment Punjab and Khyber Pakhtunkhwa.

Results

Frequency Analysis

Table 13

Frequency and Percentage of Demographic variables (N= 454)

Variables	Category	*f*	%
Age	15	177	38.9
	16	148	32.6
	17	129	28.4
Education	Illiterate	146	32.1
	Primary	92	20.2
	matric	37	8.1
	FA and above	72	15.8
Runaway from school	yes	145	31.9
	no	309	68.1
Family income	> 10000	113	24.9
	> 25000	341	75.1
Parents status	divorced	30	6.6
	separated	17	3.7
	living together	302	66.5
	one of them died	105	23.1
Nature of Crime	murder	107	23.6
	drug smuggling	271	59.7
	terrorism	22	4.8
	kidnapping	10	2.2
Releasing time from jail	more than 3 years	276	60.8
	Less than 2.5 years	178	39.2

The above table 13 shows the frequency and percentage of each demographic variable of the study. The age of respondents varies from 15 years to 17 years, 177 out of 454 respondents age is 15 years (38.9), 148 respondent has 16 years of age (32.6%) and 129 out

of 454 have 17 years (28.4%). In the current study almost Illiterate are 146(32.1%), Primary 92 (20.2%), matric 37(8.1%), FA and above 7(15.8%) education. Out of 454, 31.9% of participants ran away from school and 24.9% respondents' family income is >10000 but <25000 are 75.1%. Out of 454 participants' Divorced parents are 30 (6.6%), separated 17 (3.7%), living together 302 (66.5%), one of them died 105 (23.1%). The majority of participants are involved in drug smuggling (59.7%), 4.8% are terrorism and 23.6% are involved in murder. Out of 454 respondents, 60.8% have releasing time from jail is more than 3 years and 39.2 % less than 2.5 years.

Table 14

Descriptive Statistics and Alpha-Reliability Coefficient of Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ) (N=454)

				Range			
Scales	k	M(SD)	α	Actual	Potential	Skewness	Kurtosis
Somatization	12	14.90(8.09)	.83	0-38	0-60	.92	-.32
Anxiety	4	11.42(7.80)	.86	0-11	0-16	.49	-1.05
emotional disorders	7	15.93(8.52)	.80	0-22	0-28	.57	-.87
Depression	6	11.10(3.23)	.78	0-19	0-24	-1.01	-.38
Illness worry and conviction	7	4.36(1.23)	.90	0-20	0-28	-.17	-.80
Narcotic abuse and dependence	4	13.42(5.80)	.76	0-12	0-16	.59	-1.03
Discomfort Intolerance	7	7.18(5.84)	.81	7-28	7-28	.64	-.18
Entitlement	7	6.39(9.93)	.90	7-27	7-28	2.25	5.26
Achievement	7	4.02(4.47)	.84	7-25	7-28	.88	-.46
Emotional Intolerance	7	7.65(7.94)	.89	7-27	7-28	1.03	.45
Cohesion	7	3.62(4.53)	.86	2-12	0-21	1.46	2.08
Conflict	6	4.83(6.90)	.83	0-10	0-18	2.19	4.78
Expressiveness	3	3.95(3.88)	.61	1-5	0-9	1.31	-.30

Note. k= No. of items, *M*(*SD*)= Mean (Standard Deviation), *α*= Cronbach's Alpha

The table 14 shows the descriptive statistics of study variables. In the table each variable along with number of items (k). Mean value and standard deviation of each variable is also presented in the above table. Reliability is also calculated using α-

Reliability test in the SPSS, the reliability of each variable is >0.60 which is recommended in the social sciences. The range of each variable is compared with actual and potential values. Skewness and Kurtosis of each variable is calculated to check the normality of data, the skewness and kurtosis results show that data is normal and parametric test can be used for further analysis.

Table 16

Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and All Common Mental Disorders (N = 454)

Model		*β*	*SE*	*t*	*p*	95% CI *LL*	95% CI *UL*
CMDQ	constant	-39.59	17.44	-2.27	.02	-73.87	-5.30
	Family Relations	1.87	.94	1.99	.05	.02	3.72
	FD	1.43	.27	5.28	.00	.90	1.96
	FR x FD	-.05	.01	-3.47	.00	-.08	-.02
	R^2	.27			.00		
	ΔR^2	.02			.00		
SD	constant	-35.19	5.63	-6.26	.00	-46.24	-24.13
	Family Relations	1.62	.30	5.34	.00	1.03	2.22
	FD	.84	.09	9.58	.00	.67	1.01
	FR x FD	-.04	.00	-7.62	.00	-.04	-.03
	R^2	.37			.00		
	ΔR^2	.08			.00		
AD	constant	-2.41	2.99	-.80	.42	-8.29	3.47
	Family Relations	.18	.16	1.14	.26	-.13	.50
	FD	.06	.05	1.31	.19	-.03	.15
	FR x FD	.00	.00	-.23	.82	-.01	.00
	R^2	.12			.00		
	ΔR^2	.00			.82		
ED	constant	4.01	5.11	.78	.43	-6.03	14.04
	Family Relations	-.15	.28	-.53	.60	-.69	.40

	FD	-.06	.08	-.73	.47	-.21	.10
	FR x FD	.01	.00	2.10	.04	.00	.02
	R^2	.18			.00		
	ΔR^2	.01			.04		
Dep	constant	7.99	2.94	2.72	.01	2.21	13.78
	Family Relations	-.45	.16	-2.81	.01	-.76	-.13
	FD	-.09	.05	-1.90	.06	-.18	.00
	FR x FD	.01	.00	3.30	.00	.00	.01
	R^2	.17			.00		
	ΔR^2	.02			.00		
Narcotic Abuse And Dependence	constant	-13.55	4.17	-3.25	.00	-21.74	-5.36
	Family Relations	.59	.22	2.64	.01	.15	1.03
	FD	.41	.06	6.38	.00	.29	.54
	FR x FD	-.02	.00	-4.67	.00	-.02	-.01
	R^2	.28			.00		
	ΔR^2	.03			.00		
Whitely	constant	-.40	2.44	-.16	.87	-5.20	4.39
	Family Relations	.14	.13	1.04	.30	-.12	.40
	FD	.20	.04	5.26	.00	.12	.27
	FR x FD	-.01	.00	-4.70	.00	-.01	-.01
	R^2	.22			.00		
	ΔR^2	.04			.00		

Note. DV = Dependent Variable, CMD = Common Mental Disorders, SD = Somatic Disorders, AD = Anxiety Disorders, ED = Emotional Disorders, Dep = Depression, FD = Frustration Discomfort, FR = Family Relations, Whitely = Illness worry and conviction, CAGE = Narcotic abuse and dependence, CI = Class Interval, LL = Lower Level, UP = Upper Level.

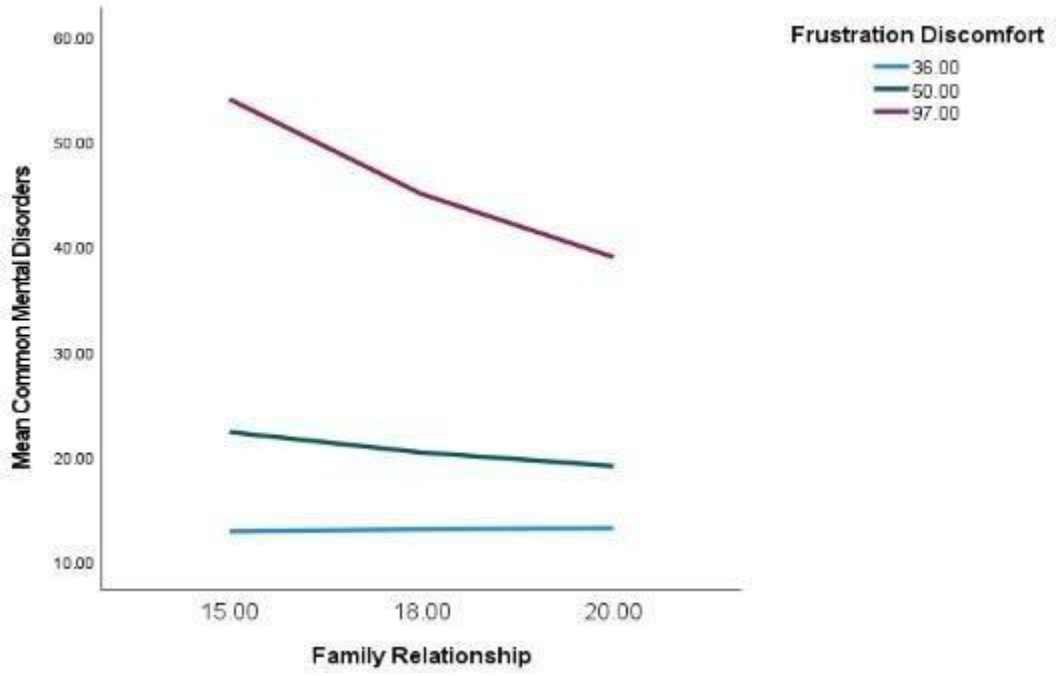
The results in table 15 showed the moderation effect of frustration discomfort between family relationships and all common mental health disorders (Somatic Disorders, Anxiety Disorders, Emotional Disorders, Depression, Narcotic abuse and dependence, and Illness worry and conviction). Findings revealed that the R^2 value of .27 in model 1 explained a 27% variance in mental health disorders with $p < .01$. Following that, the R^2 value of .37 in model 2 explained a 37% variance in somatic disorders, 12% variance in anxiety disorders (Model 3), 18% variance in emotional disorders (Model 4), 17% variance in depression (Model 5), 28% variance in Narcotic abuse and dependence disorders (Model 6), and 22% variance in Illness worry and conviction disorders (Model 7) with $p < .01$.

Meanwhile, family relations significantly and positively predicted mental health disorders in models 1, 2, and 6, frustration discomfort significantly and positively predicted mental health disorders in models 1, 2, 6, and 7, and family relations*frustration discomfort as moderation significantly and positively predicted mental health disorders in models 4 and 5, and 6.

On the other hand, family relations and frustration discomfort significantly and negatively predicted mental health disorders in model 5, and family relations*frustration discomfort as moderation significantly and negatively predicted mental health disorders in models 1, 2, 6, and 7 (see Figure 6-12)

Figure 6

Data Visualization for the Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and Common Mental Health Disorders (N = 454)



Elevated frustration discomfort serves as a detrimental moderator in the relationship between common mental disorders and family relationships, as seen in Figure 6. This suggests that poorer family relationships are linked to more mental disorders, particularly when levels of frustration and discomfort are high.

Figure 7

Data Visualization for the Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and Somatic Disorders (N = 454)

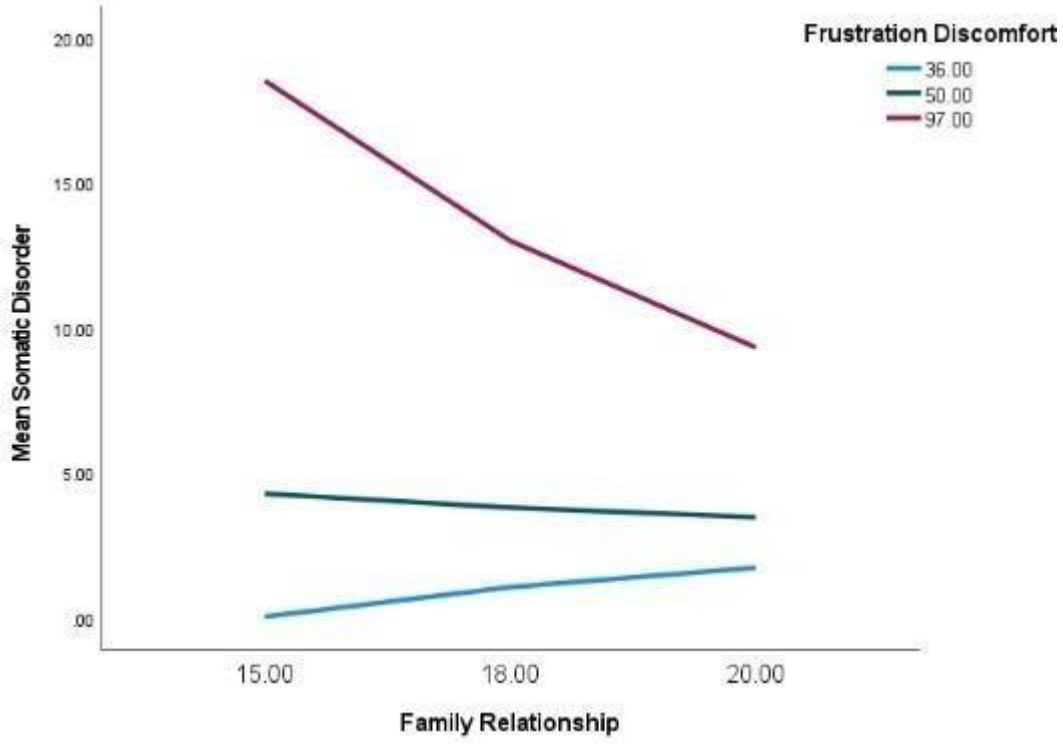
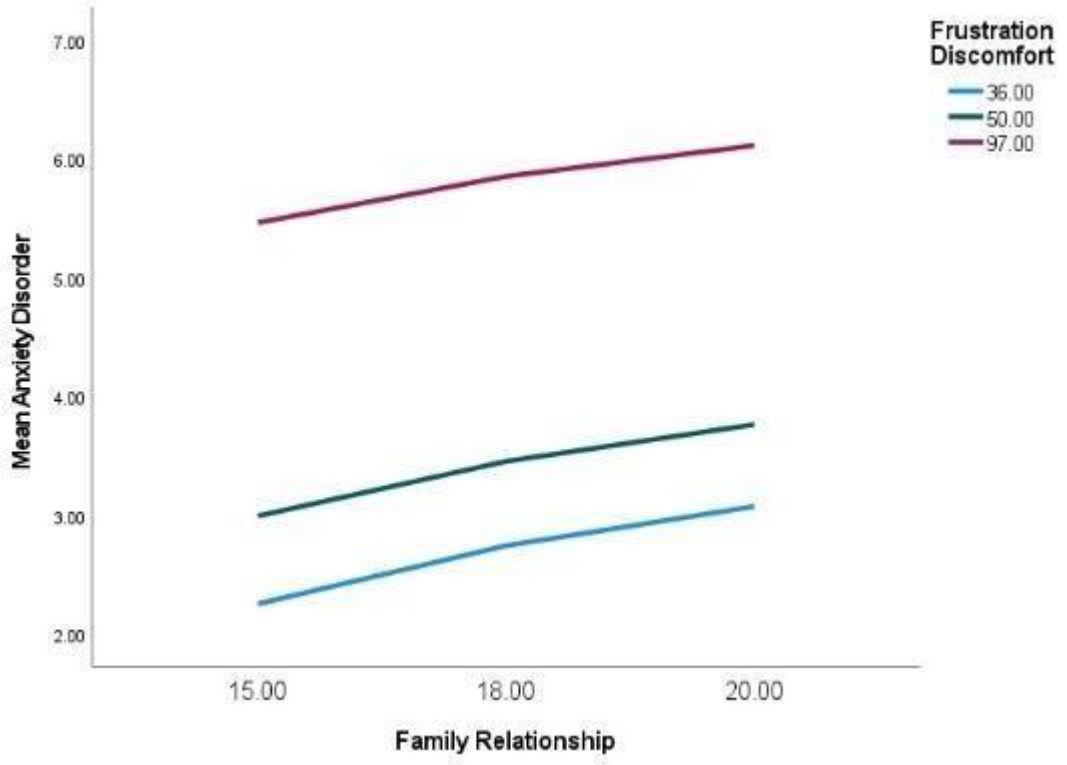


Figure 7 shows that higher frustration discomfort negatively moderates the relationship between family relations and somatic disorders. This means weak family relations are linked to higher mental disorders when frustration's discomfort are high.

Figure 8

Data Visualization for the Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and Anxiety Disorders (N = 454)



As shown in Figure 8, higher frustration discomfort acts as a positive moderator in the link between anxiety disorders and family relationships. This implies that solid family relationships are associated with an increase in anxiety disorders, especially when levels of frustration discomfort are high.

Figure 9

Data Visualization for the Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and Emotional Disorders (N = 454)

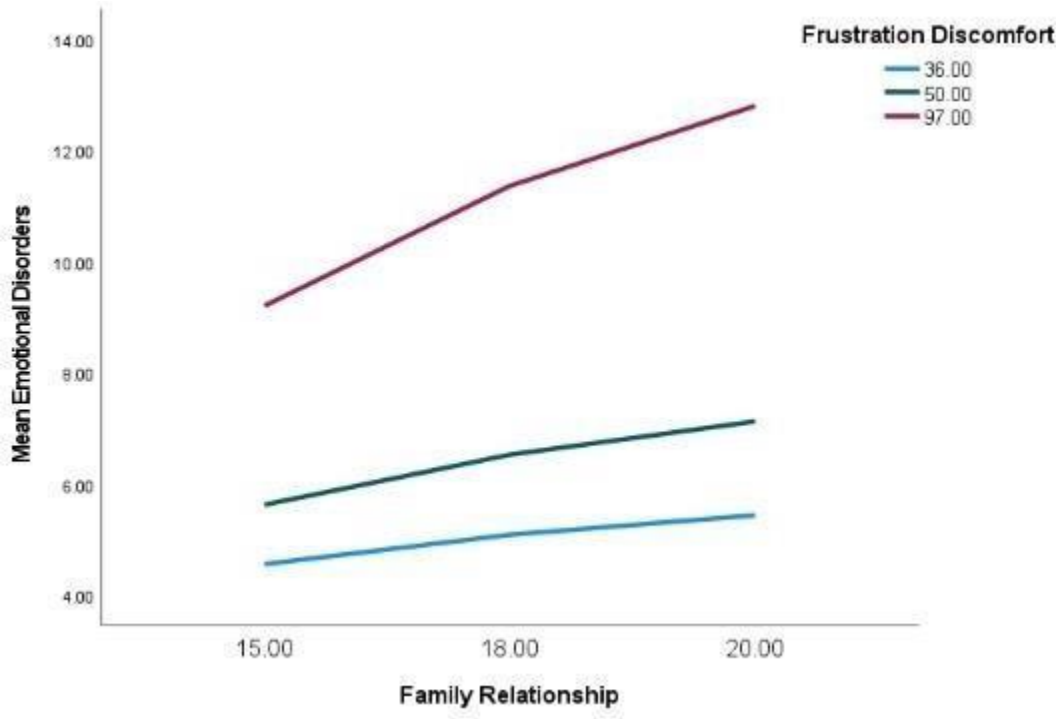
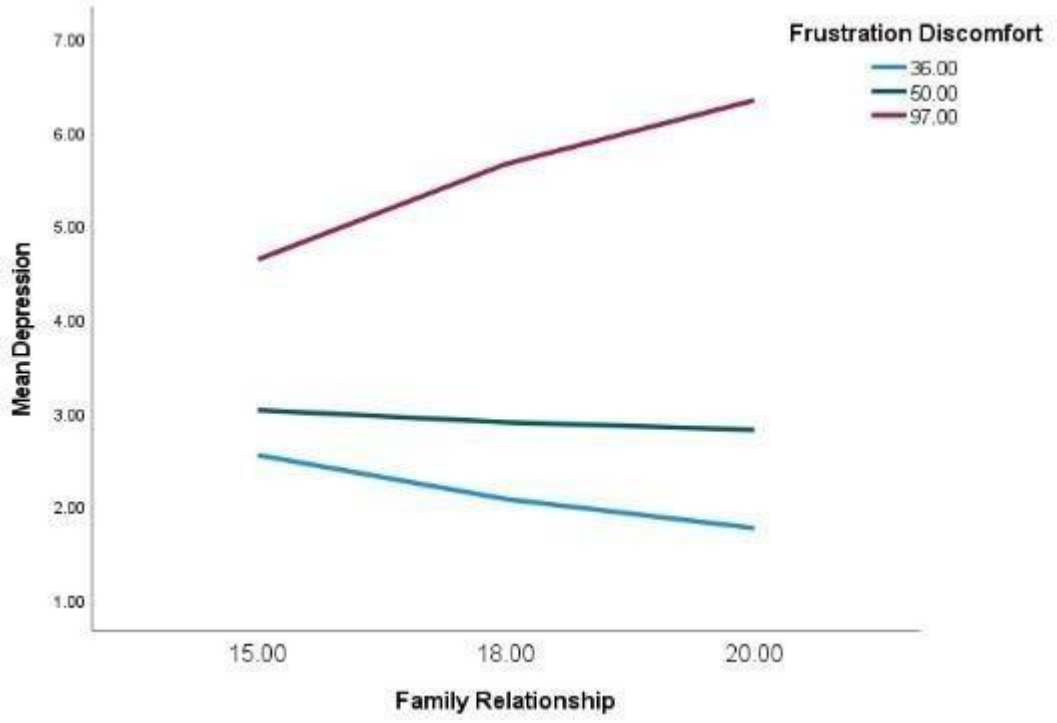


Figure 9 depicted that higher frustration discomfort acts as a positive moderator in the link between emotional disorders and family relationships. This indicates that higher family relationships are associated with an increase in emotional disorders, especially when levels of frustration discomfort are also high.

Figure 10

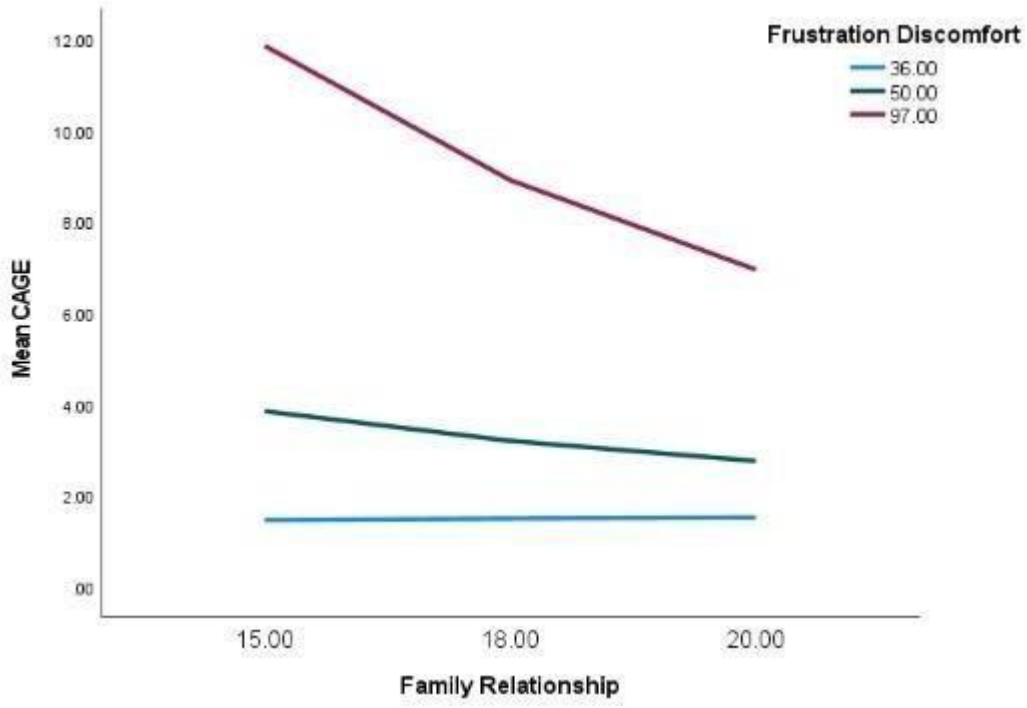
Data Visualization for the Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and Depression (N = 454)



As revealed in Figure 10, higher frustration discomfort positively moderates the link between depression and family relationships. This infers that good family relationships are associated with an increase in depression, while lower frustration discomfort negatively moderates the link between family relationships and depression.

Figure 11

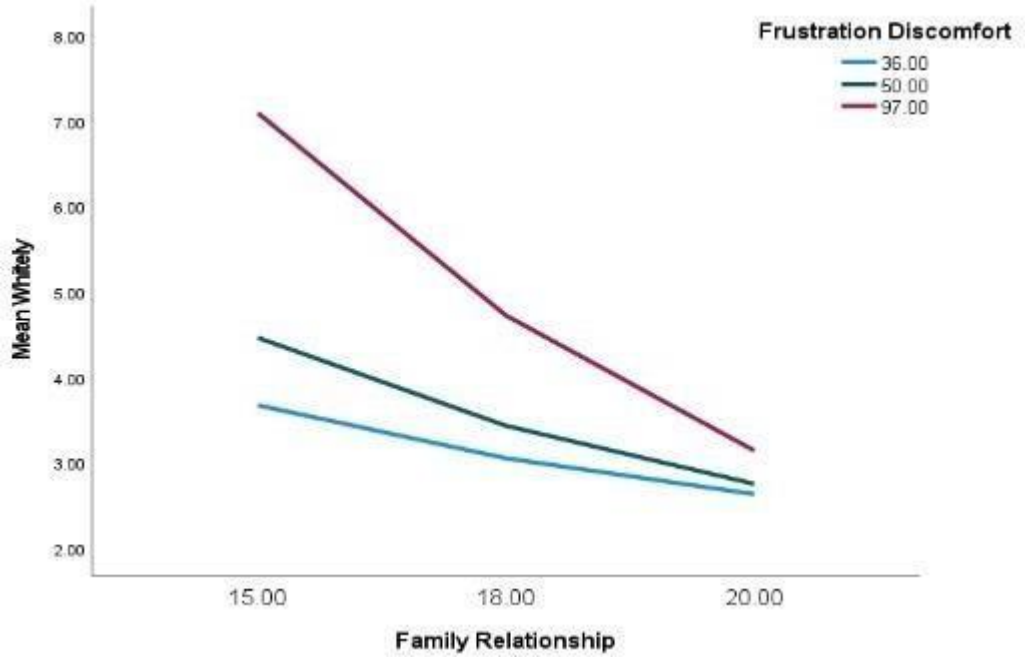
Data Visualization for the Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and Narcotic abuse and dependence Disorders (N = 454)



As shown in Figure 11, higher frustration discomfort negatively moderates the link between Narcotic abuse and dependence disorders and family relationships. This implies that weak family relationships are associated with an increase in Narcotic abuse and dependence disorders when levels of frustration discomfort are high.

Figure 12

Data Visualization for the Moderation Effect of Frustration Discomfort on the Relationship between Family Relations and Illness worry and conviction Disorders (N = 454)



As revealed in Figure 12, higher frustration discomfort negatively moderates the link between Illness worry and conviction disorders and family relationships. This implies that poor family relationships are associated with an increase in Illness worry and conviction disorders when levels of frustration discomfort are high.

Table 17

Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and All Common Mental Disorders (N = 454)

Model		*β*	*SE*	*t*	*p*	95% CI *LL*	95% CI *UL*
CMD	constant	.42	17.37	.02	.98	-33.71	34.56
	Family Relations	.42	.94	.45	.65	-1.42	2.26
	EI	3.12	1.06	2.96	.00	1.05	5.20
	FR x EI	-.10	.06	-1.86	.06	-.21	.01
	R^2	.14			.00		
	ΔR^2	.01			.06		
SD	constant	.26.33	5.73	-4.60	.00	-37.58	-15.08
	Family Relations	1.42	.31	4.61	.00	.82	2.03
	EI	2.76	.35	7.93	.00	2.07	3.44
	FR x EI	-.13	.02	-6.89	.00	-.16	-.09
	R^2	.21			.00		
	ΔR^2	.08			.00		
AD	constant	5.81	2.66	2.18	.03	.58	11.04
	Family Relations	-.25	.14	-1.76	.08	-.53	.03
	EI	-.28	.16	-1.70	.09	-.59	.04
	FR x EI	.03	.01	2.96	.00	.01	.04
	R^2	.16			.00		
	ΔR^2	.02			.00		
ED	constant	17.86	4.67	3.82	.00	8.68	27.04
	Family Relations	-.78	.25	-3.11	.00	-1.28	-.29
	EI	-1.11	.28	-3.90	.00	-1.67	-.55

	FR x EI	.08	.02	5.04	.00	.05	.11
	R^2	.18			.00		
	ΔR^2	.05			.00		
Dep	constant	8.08	2.89	2.80	.01	2.40	13.75
	Family Relations	-.31	.16	-2.00	.05	-.62	-.01
	EI	-.35	.18	-1.98	.05	-.69	.00
	FR x EI	.02	.01	2.52	.01	.01	.04
	R^2	.04			.00		
	ΔR^2	.01			.01		
NARCOTIC ABUSE AND DEPENDENCE	constant	-4.34	4.13	-1.05	.29	-12.45	3.77
	Family Relations	.25	.22	1.14	.26	-.18	.69
	EI	1.05	.25	4.19	.00	.56	1.54
	FR x EI	-.04	.01	-3.14	.00	-.07	-.02
	R^2	.15			.00		
	ΔR^2	.02			.00		
Illness worry and conviction	constant	8.77	2.28	3.85	.00	4.30	13.24
	Family Relations	-.36	.12	-2.89	.00	-.60	-.11
	EI	.20	.14	1.43	.15	-.07	.47
	FR x EI	-.01	.01	-.81	.42	-.02	.01
	R^2	.19			.00		
	ΔR^2	.00			.42		

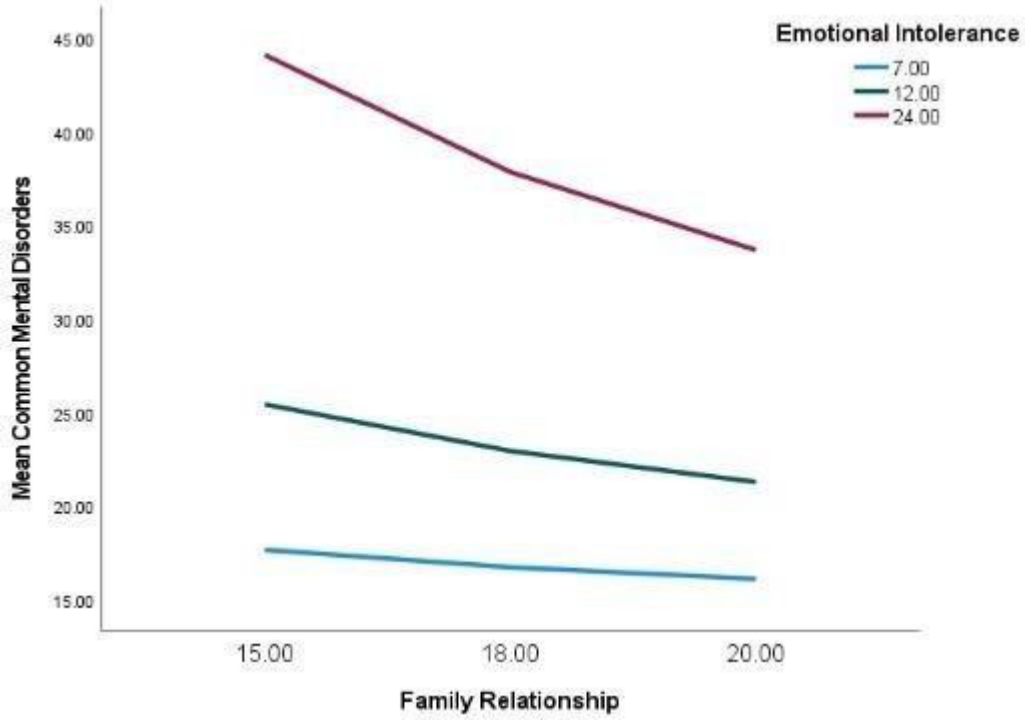
Note. DV = Dependent Variable, CMD = Common Mental Health Disorders, SD = Somatic Disorders, AD = Anxiety Disorders, ED = Emotional Disorders, Dep = Depression, Illness worry and conviction = Illness worry and

conviction, CAGE = Narcotic abuse and dependence, EI = Emotional Intolerance, FR = Family Relations, CI = Class Interval, LL = Lower Level, UP = Upper Level.

The results in Table 17 show the moderation effect of emotional intolerance between family relationships and all common mental health disorders (Somatic Disorders, Anxiety Disorders, Emotional Disorders, Depression, Narcotic abuse and dependence, and Illness worry and conviction). Findings revealed that the R^2 value in model 1 explained a 14% variance in mental health disorders. Following that, the R^2 value of .21 in model 2 explained a 21% variance in somatic disorders, 16% variance in anxiety disorders (Model 3), 18% variance in emotional disorders (Model 4), 4% variance in depression (Model 5), 15% variance in Narcotic abuse and dependence disorders (Model 6), and 19% variance in Illness worry and conviction disorders (Model 7). Meanwhile, family relations significantly and positively predicted mental health disorders in models 2, Emotional Intolerance significantly and positively predicted mental health disorders in models 1, 2, and 6, and family relations* Emotional Intolerance as moderation significantly and positively predicted mental health disorders in models 3, 4 and 5. On the other hand, family relations and emotional intolerance significantly and negatively predicted mental health disorders in model 4 and 5, and family relations*emotional intolerance as moderation significantly and negatively predicted mental health disorders in models 2 and 6 (see Figure 13-19)

Figure 13

Data Visualization for the Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and Common Mental Health Disorders (N = 454)



Elevated emotional intolerance serves as a detrimental moderator in the relationship between common mental disorders and family relationships, as seen in Figure 13. This suggests that poorer family relationships are linked to more mental disorders, particularly when levels of emotional intolerance are high.

Figure 14

Data Visualization for the Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and Somatic Disorders (N = 454)

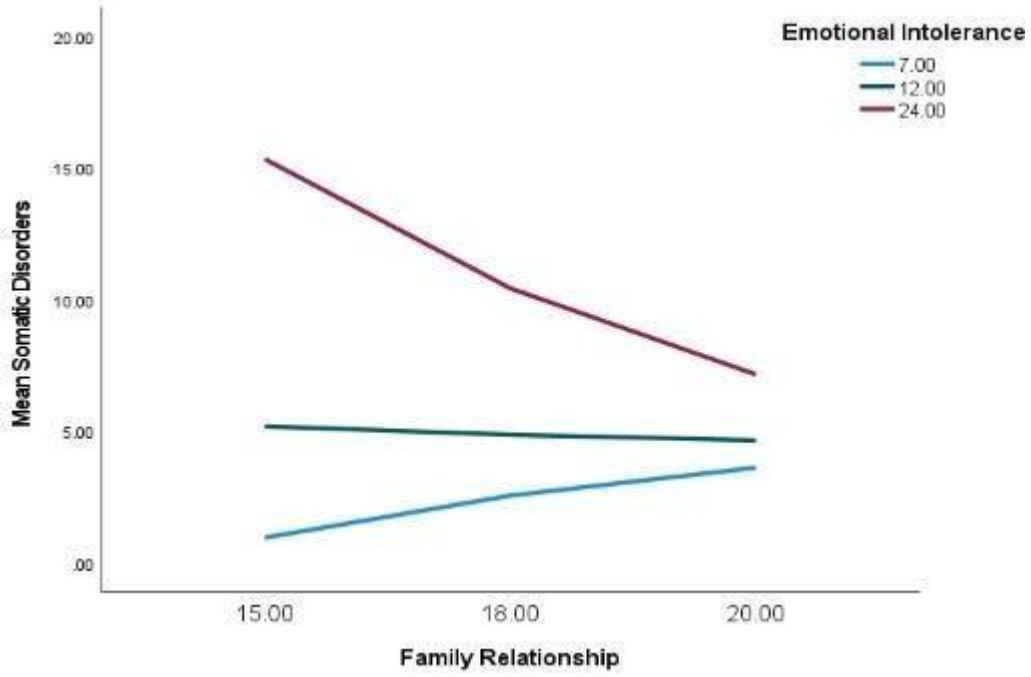
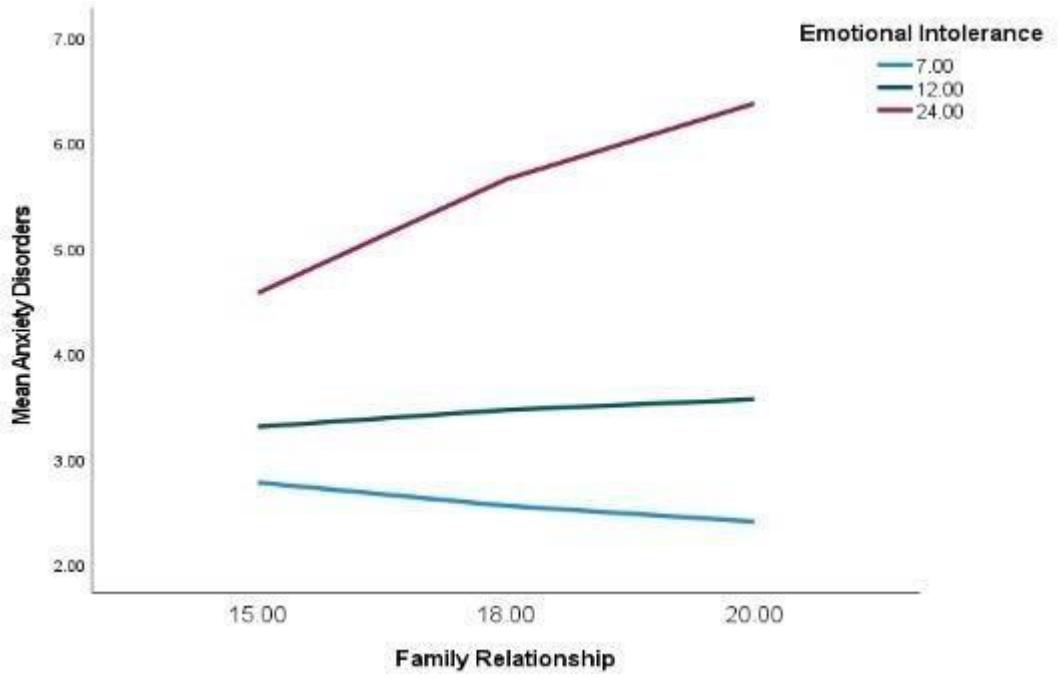


Figure 14 shows that higher emotional intolerance negatively moderates the relationship between family relations and somatic disorders. This means weak family relations are linked to higher mental disorders when emotional intolerance are high

Figure 15

Data Visualization for the Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and Anxiety Disorders (N = 454)



As shown in Figure 15, higher emotional intolerance acts as a positive moderator in the link between anxiety disorders and family relationships. This implies that strong family relationships are associated with an increase in anxiety disorders, especially when levels of emotional intolerance are high.

Figure 16

Data Visualization for the Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and Emotional Disorders (N = 454)

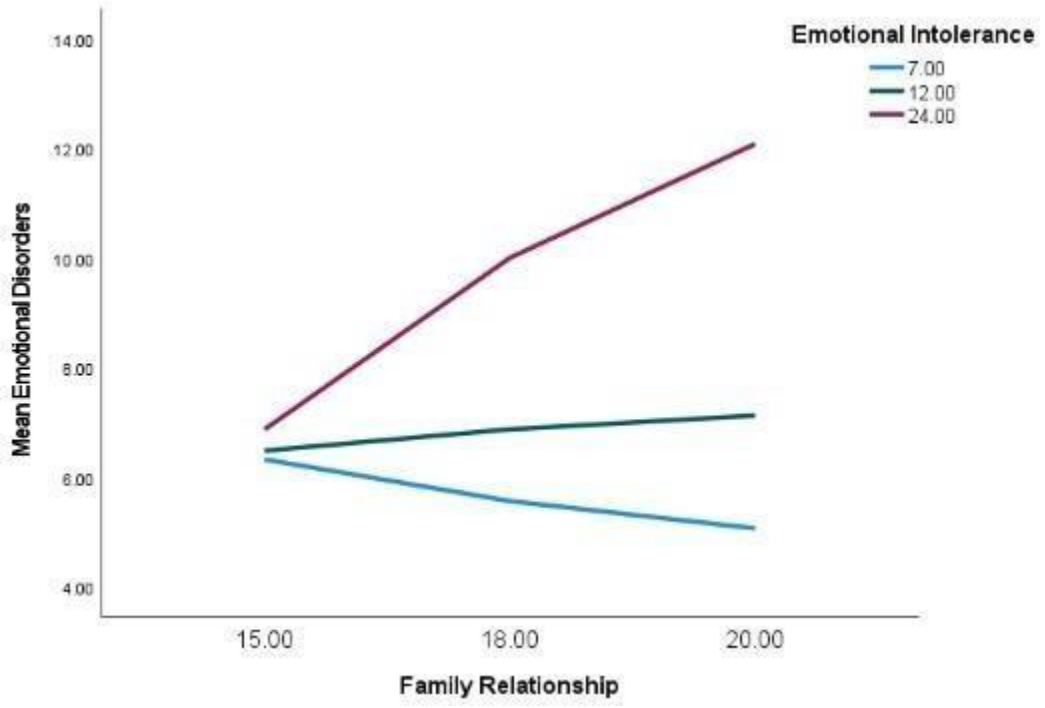
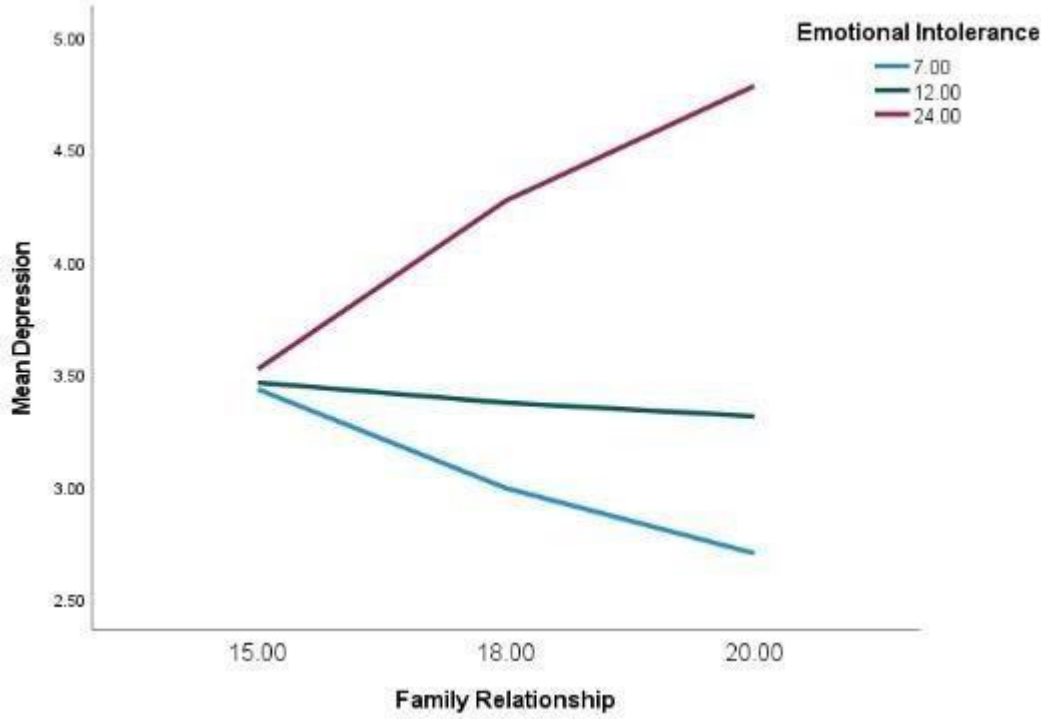


Figure 16 depicted that higher emotional intolerance acts as a positive moderator in the link between emotional disorders and family relationships. This indicates that higher family relationships are associated with an increase in emotional disorders, especially when levels of emotional intolerance are also high.

Figure 17

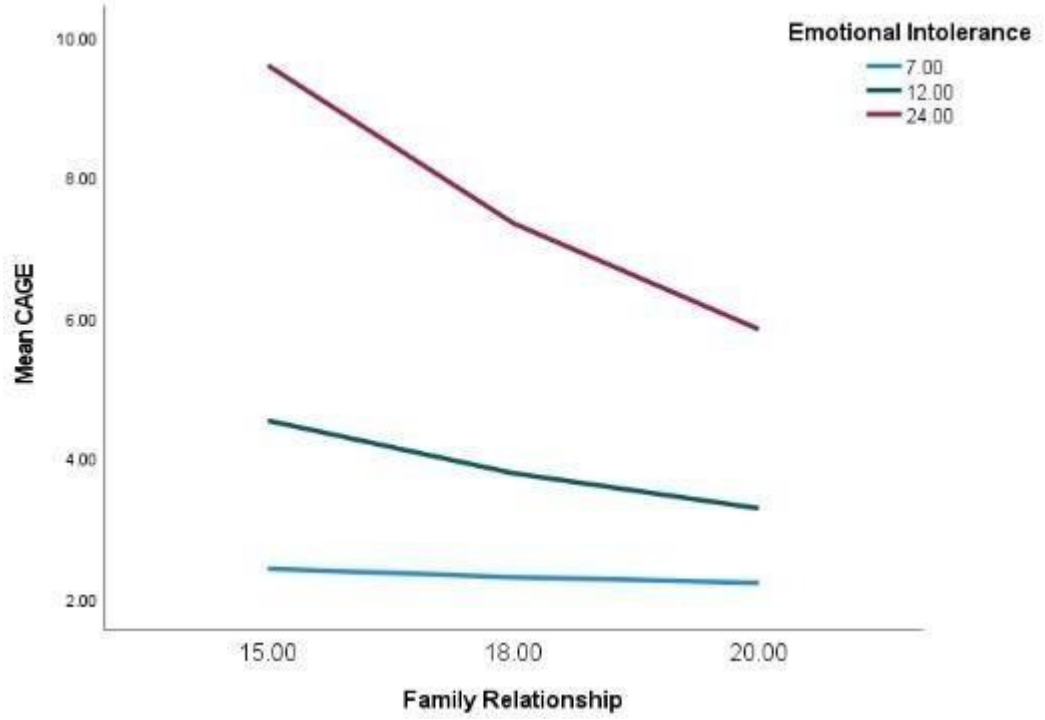
Data Visualization for the Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and Depression (N = 454)



As revealed in Figure 17, higher emotional intolerance positively moderates the link between depression and family relationships. This infers that good family relationships are associated with an increase in depression, while lower emotional intolerance negatively moderates the link between family relationships and depression.

Figure 18

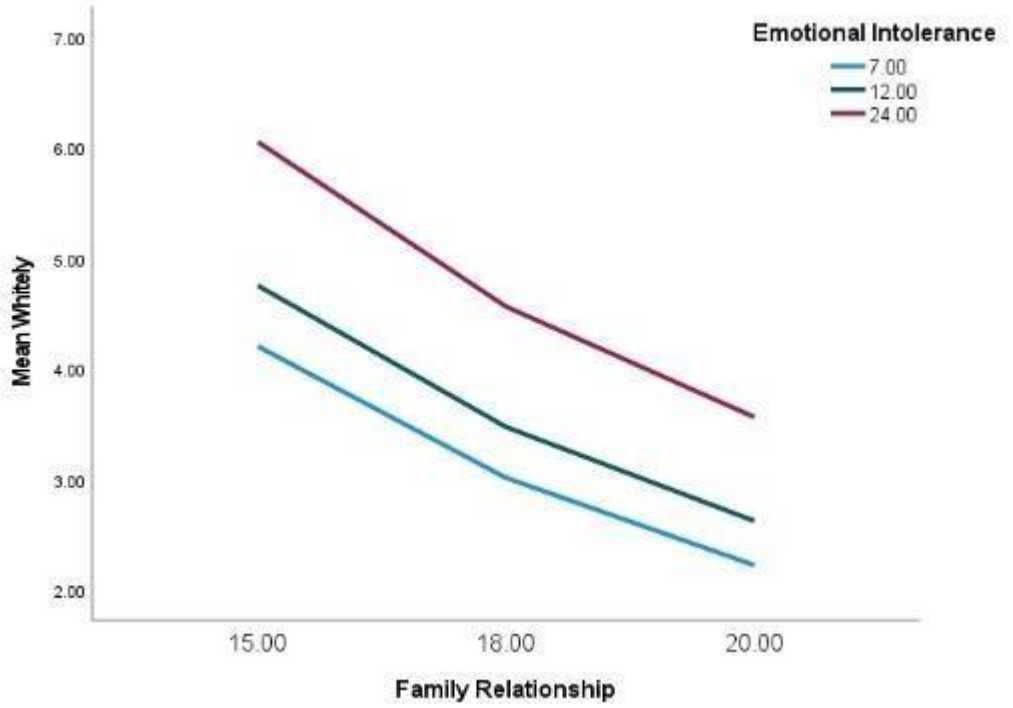
Data Visualization for the Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and Narcotic Abuse And Dependence Disorders (N = 454)



As shown in Figure 18, higher emotional intolerance negatively moderates the link between Narcotic abuse and dependence disorders and family relationships. This implies that weak family relationships are associated with an increase in Narcotic abuse and dependence disorders when levels of emotional intolerance are high.

Figure 19

Data Visualization for the Moderation Effect of Emotional Intolerance on the Relationship between Family Relations and Illness worry and conviction Disorders (N = 454)



As revealed in Figure 19, higher emotional intolerance negatively moderates the link between Illness worry and conviction disorders and family relationships. This implies that poor family relationships are associated with an increase in Illness worry and conviction disorders when levels of emotional intolerance are high.

Table 18

Moderation Effect of Entitlement on the Relationship between Family Relations and All Common Mental Disorders (N = 454)

Model		β	*SE*	*t*	*p*	95% CI *LL*	95% CI *UL*
CMD	constant	-.28.49	14.97	-1.90	.06	-57.91	.93
	Family Relations	1.70	.82	2.08	.04	.09	3.32
	Entitlement	4.85	.92	5.25	.00	3.03	6.67
	FR x Entitlement	-.18	.05	-3.51	.00	-.28	-.08
	R^2	.25			.00		
	ΔR^2	.02			.00		
SD	constant	-22.87	4.75	-4.82	.00	-32.20	-13.54
	Family Relations	1.07	.26	4.11	.00	.56	1.58
	Entitlement	2.50	.29	8.53	.00	1.92	3.08
	FR x Entitlement	-.10	.02	-6.39	.00	-.13	-.07
	R^2	.37			.00		
	ΔR^2	.06			.00		
AD	constant	-6.04	2.59	-2.34	.02	-11.13	-.96
	Family Relations	.46	.14	3.23	.00	.18	.74
	Entitlement	.47	.16	2.97	.00	.16	.79
	FR x Entitlement	-.02	.01	-2.21	.03	-.04	.00
	R^2	.08			.00		
	ΔR^2	.01			.03		
ED	constant	.16	4.44	.04	.97	-8.57	8.89
	Family Relations	.17	.24	.71	.48	-.31	.65
	Entitlement	-.03	.27	-.10	.92	-.57	.51
	FR x Entitlement	.02	.02	1.24	.22	-.01	.05
	R^2	.14			.00		
	ΔR^2	.00			.22		
Dep	constant	6.26	2.55	2.45	.01	1.24	11.28
	Family Relations	-.29	.14	-2.11	.04	-.57	-.02
	Entitlement	-.27	.16	-1.70	.09	-.58	.04
	FR x Entitlement	.03	.01	2.90	.00	.01	.04
	R^2	.12			.00		

	ΔR^2	.02			.00		
Narcotic abuse and dependence	constant	-8.57	3.57	-2.40	.02	-15.58	-1.56
	Family Relations	.42	.20	2.14	.03	.03	.80
	Entitlement	1.30	.22	5.89	.00	.86	1.73
	FR x Entitlement	-.05	.01	-4.20	.00	-.07	-.03
	R^2	.26			.00		
	ΔR^2	.03			.00		
Illness worry and conviction	constant	-1.43	2.02	-.71	.48	-5.40	2.54
	Family Relations	.22	.11	1.95	.05	.00	.43
	Entitlement	.87	.12	7.00	.00	.63	1.12
	FR x Entitlement	-.04	.01	-6.40	.00	-.06	-.03
	R^2	.25			.00		
	ΔR^2	.07			.00		

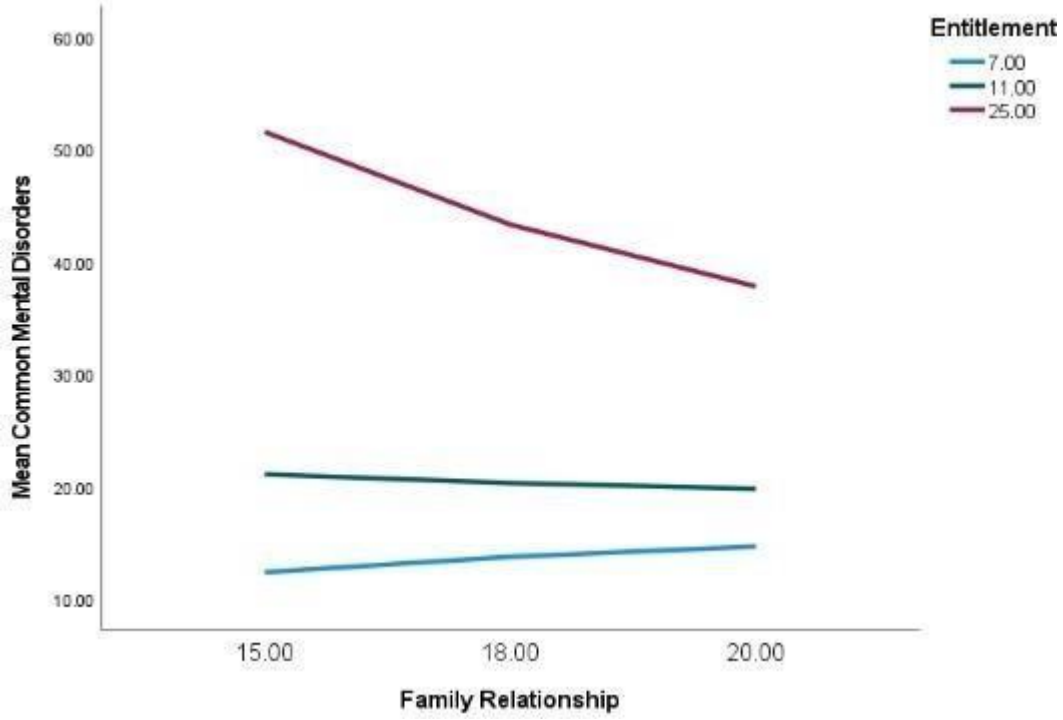
Note. DV = Dependent Variable, CMHD = Common Mental Health Disorders, SD = Somatic Disorders, AD = Anxiety Disorders, ED = Emotional Disorders, Dep = Depression, Whitely = Illness worry and conviction, CAGE= Narcotic abuse and dependence, FR = Family Relations, CI = Class Interval, LL = Lower Level, UP = Upper Level.

Table 18 shows how entitlement moderated the association between family relationships and numerous major mental health disorders (such as Somatic Disorders, Anxiety Disorders, Emotional Disorders, Depression, Narcotic abuse and dependence, and Illness worry and conviction). Model 1 with an R^2 value of .25 explained 25% of the variance in mental health issues, according to the findings. Model 2 also explained 37% of the variance in somatic disorders, Model 3 explained 8% of the variance in anxiety disorders, Model 4 explained 14% of the variance in emotional disorders, Model 5 explained 12% of the variance in depression, Model 6 explained 26% of the variance in Narcotic abuse and dependence disorders, and Model 7 explained 25% of the variance in Illness worry and conviction disorders. Furthermore, in Models

1, 2, 3, 6, and 7, family relationships strongly and positively predicted mental health disorders. In the same models (1, 2, 3, 6, and 7), entitlement also significantly and positively predicted mental health disorders. Only in Model 5 did the interaction term of family relations and entitlement significantly and positively predict depression. Surprisingly, in Model 5, family relationships and entitlement significantly predicted mental health conditions in a negative way. Furthermore, in Models 1, 2, 3, 6, and 7, the interaction term of family relations and entitlement strongly and negatively predicted common mental health disorders (see Figure 20-26).

Figure 20

Data Visualization for the Moderation Effect of Entitlement on the Relationship between Family Relations and Common Mental Health Disorders (N = 454)



Higher entitlement serves as a detrimental or negative moderator in the relationship between common mental disorders and family relationships, as seen in Figure 20. This suggests that poorer family relationships are linked to more mental disorders, particularly when levels of entitlements are high.

Figure 21

Data Visualization for the Moderation Effect of Entitlement on the Relationship between Family Relations and Somatic Disorders (N = 454)

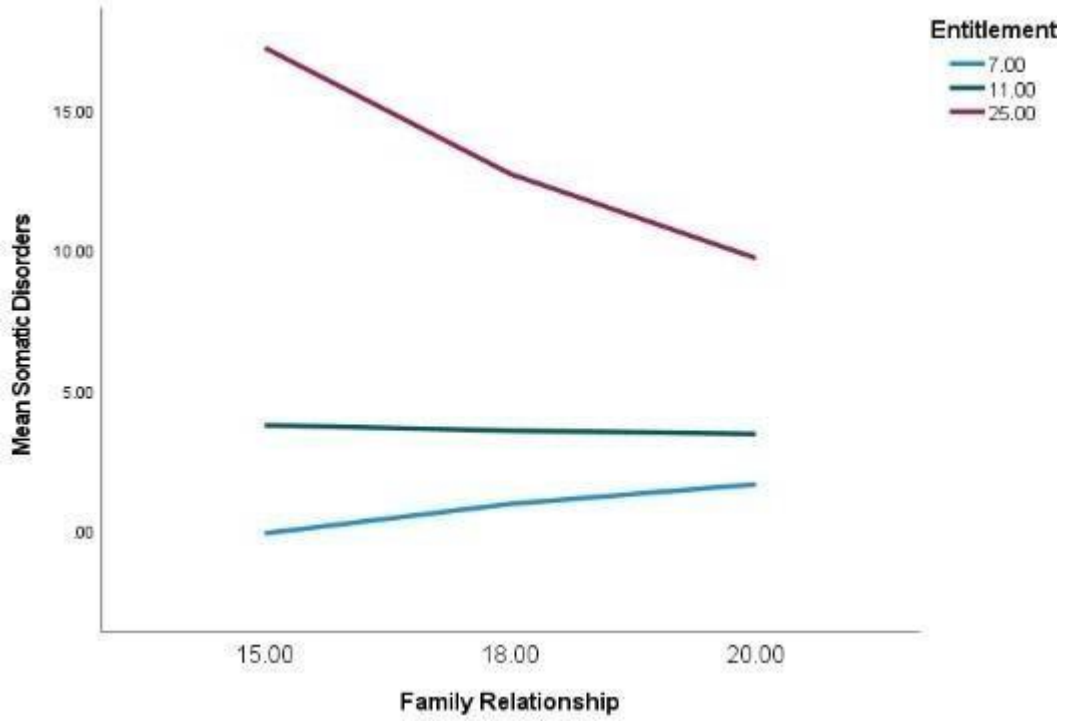
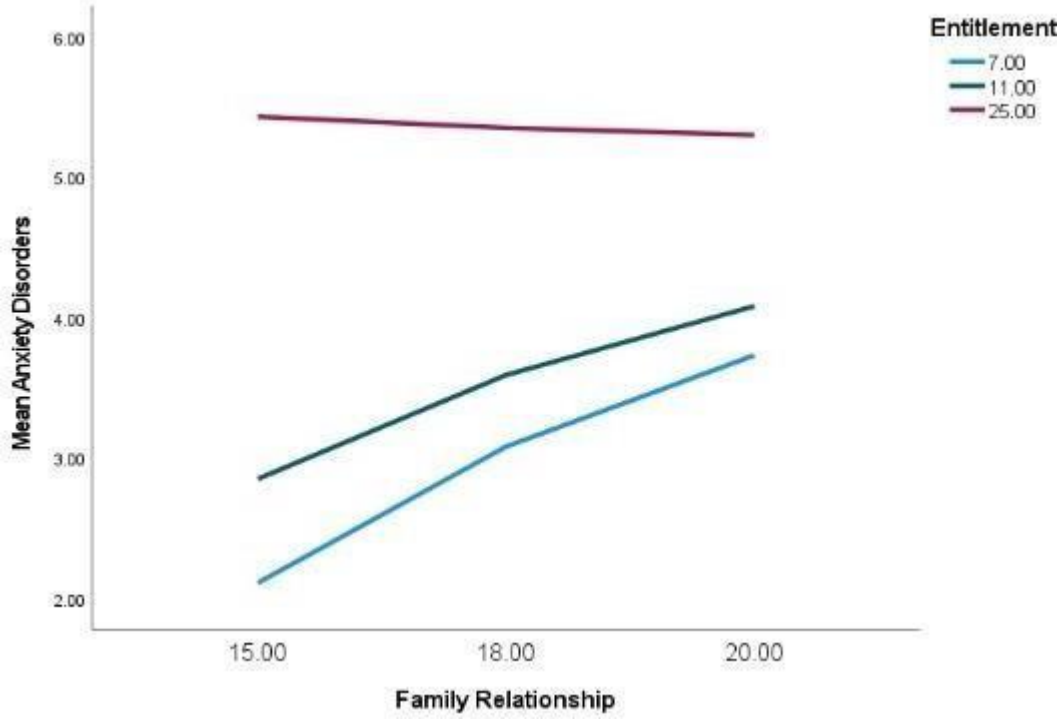


Figure 21 shows that higher entitlement negatively moderates the relationship between family relations and somatic disorders. This means weak family relations are linked to higher mental disorders when entitlements are high.

Figure 22

Data Visualization for the Moderation Effect of Entitlement on the Relationship between Family Relations and Anxiety Disorders (N = 454)



As shown in Figure 22, higher entitlements act as a positive moderator in the link between anxiety disorders and family relationships. This implies that strong family relationships are associated with an increase in anxiety disorders, especially when levels of entitlements are high.

Figure 23

Data Visualization for the Moderation Effect of Entitlement on the Relationship between Family Relations and Emotional Disorders (N = 454)

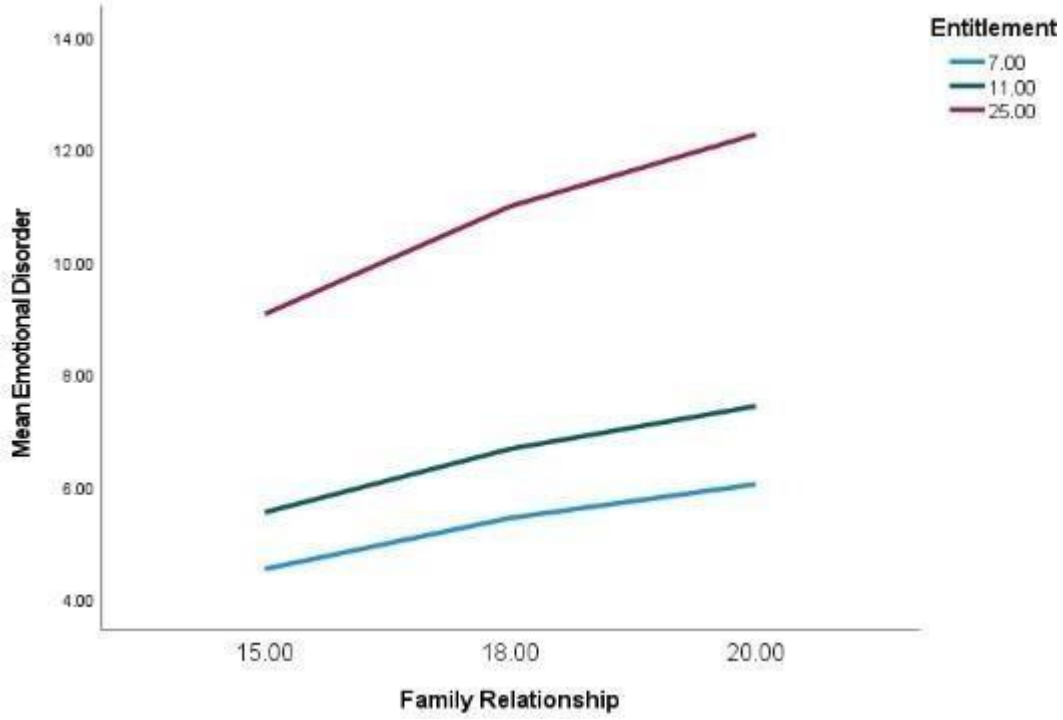
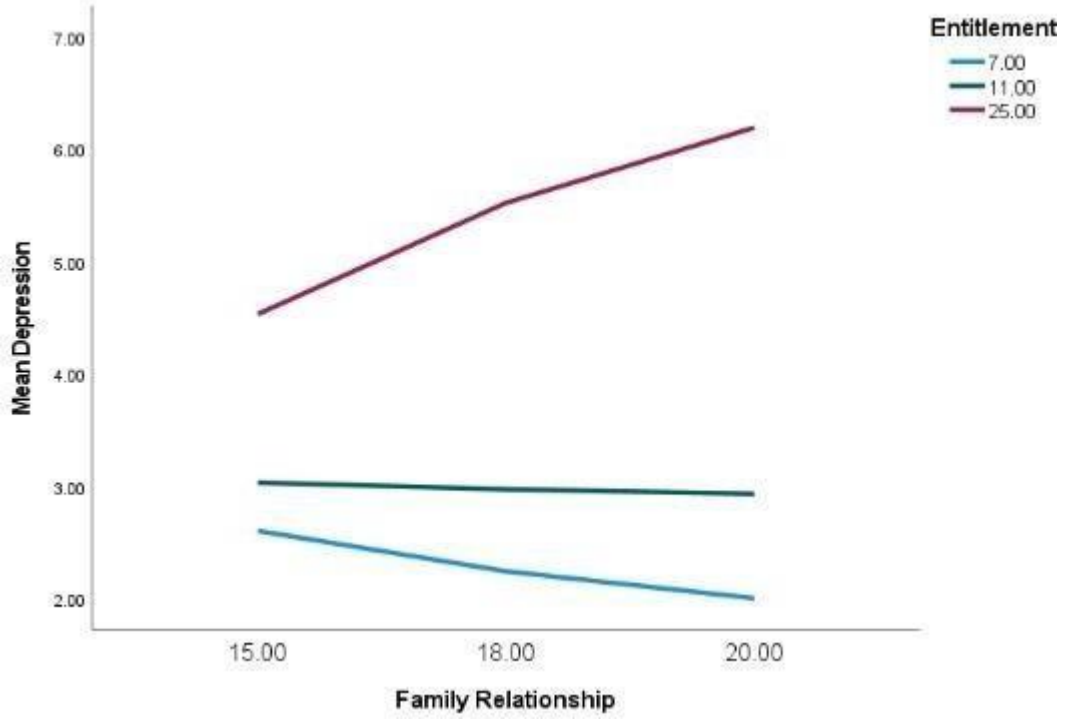


Figure 23 depicted that higher entitlement acts as a positive moderator in the link between emotional disorders and family relationships. This indicates that higher family relationships are associated with an increase in emotional disorders, especially when levels of entitlements are also high.

Figure 24

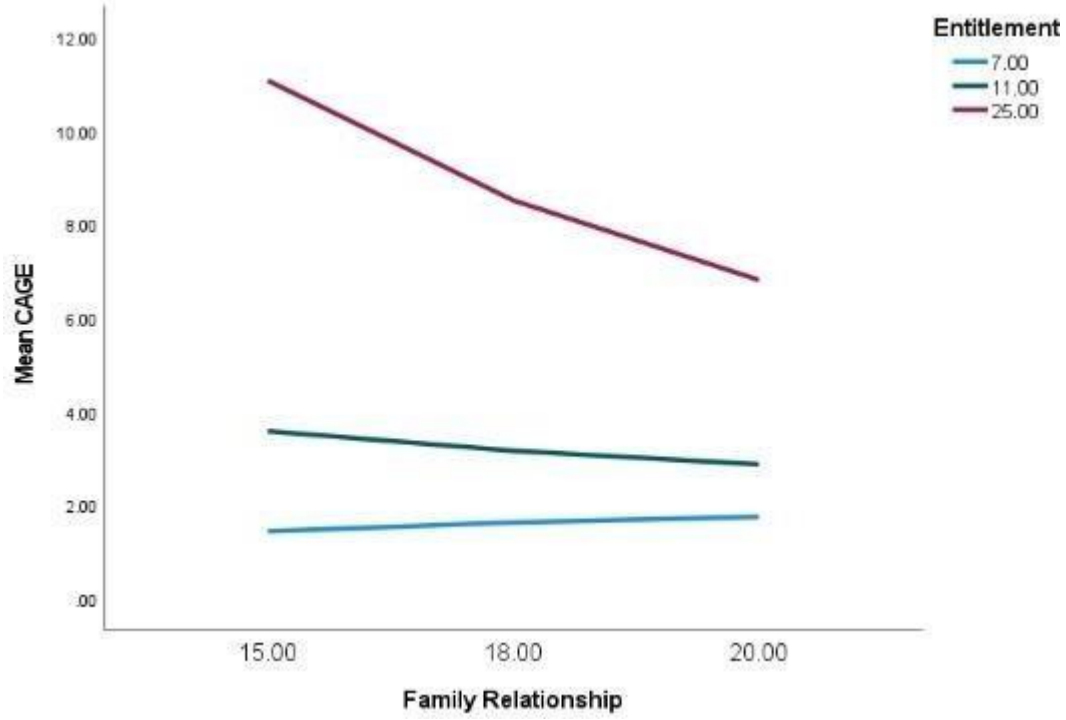
Data Visualization for the Moderation Effect of Entitlement on the Relationship between Family Relations and Depression (N = 454)



As revealed in Figure 24, higher entitlement positively moderates the link between depression and family relationships. This infers that good family relationships are associated with an increase in depression, while lower entitlement negatively moderates the link between family relationships and depression.

Figure 25

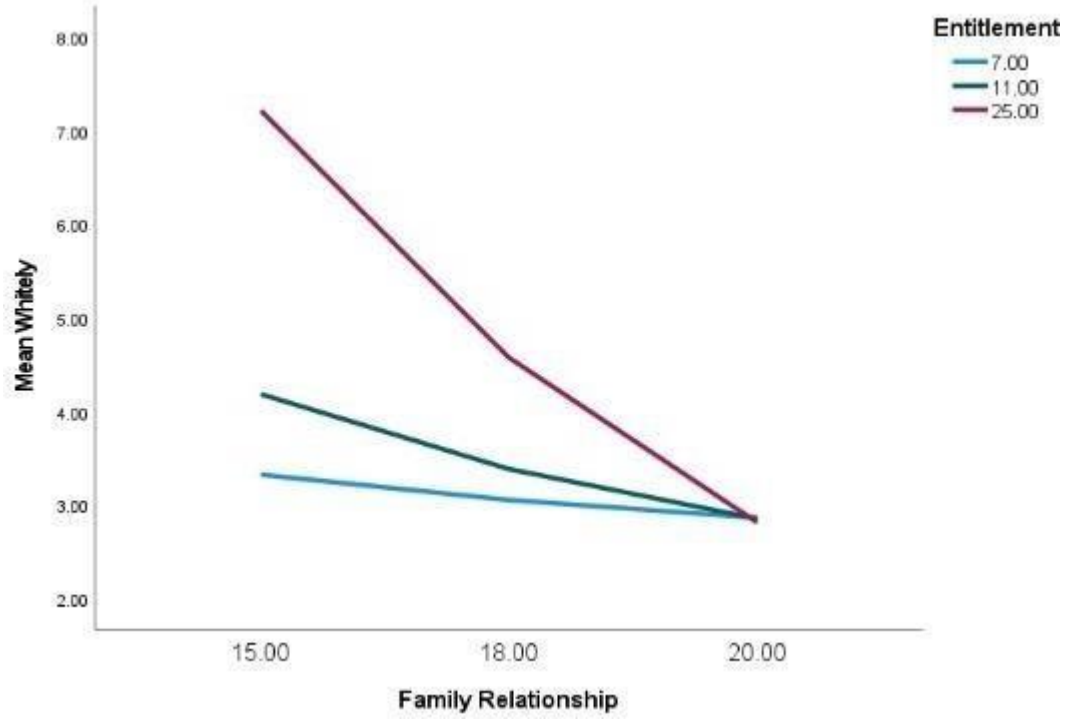
Data Visualization for the Moderation Effect of Entitlement on the Relationship between Family Relations and Narcotic abuse and dependence Disorders (N = 454)



As shown in Figure 25, higher entitlement negatively moderates the link between Narcotic abuse and dependence disorders and family relationships. This implies that weak family relationships are associated with an increase in Narcotic abuse and dependence disorders when levels of entitlements are high.

Figure 26

Data Visualization for the Moderation Effect of Entitlement on the Relationship between Family Relations and Illness worry and conviction Disorders (N = 454)



As revealed in Figure 26, higher entitlement negatively moderates the link between Illness worry and conviction disorders and family relationships. This implies that poor family relationships are associated with an increase in Illness worry and conviction disorders when levels of entitlements seem to be high.

Table 19

Moderation Effect of Achievement Frustration on the Relationship between Family Relations and All Common Mental Disorders (N = 454)

Model		*β*	*SE*	*t*	*p*	95% CI *LL*	95% CI *UL*
CMD	constant	-12.56	18.19	-.69	.49	-48.30	23.18
	Family Relations	.93	.96	.98	.33	-.94	2.81
	AF	3.87	1.13	3.44	.00	1.66	6.09
	FR x AF	-.14	.06	-2.36	.02	-.25	-.02
	R^2	.14			.00		
	ΔR^2	.01			.02		
SD	constant	-17.33	6.07	-2.85	.00	-29.27	-5.39
	Family Relations	.81	.32	2.53	.01	.18	1.44
	AF	2.15	.38	5.72	.00	1.41	2.89
	FR x AF	-.09	.02	-4.55	.00	-.13	-.05
	R^2	.20			.00		
	ΔR^2	.04			.00		
AD	constant	.56	2.98	.19	.85	-5.30	6.42
	Family Relations	.11	.16	.69	.49	-.20	.42
	AF	.04	.18	.22	.83	-.32	.40
	FR x AF	.00	.01	.32	.75	-.02	.02
	R^2	.05			.00		
	ΔR^2	.00			.75		
ED	constant	1.12	5.16	.22	.83	-9.02	11.26
	Family Relations	.16	.27	.60	.55	-.37	.69
	AF	-.06	.32	-.18	.86	-.68	.57

	FR x AF	.02	.02	.96	.34	-.02	.05
	R^2	.09			.00		
	ΔR^2	.00			.34		
Dep	constant	8.28	2.92	2.84	.00	2.55	14.02
	Family Relations	-.39	.15	-2.56	.01	-.69	-.09
	AF	-.38	.18	-2.08	.04	-.73	-.02
	FR x AF	.03	.01	3.08	.00	.01	.05
	R^2	.11			.00		
	ΔR^2	.02			.00		
Narcotic abuse and dependence	constant	-7.37	4.30	-1.71	.09	-15.82	1.08
	Family Relations	.36	.23	1.59	.11	-.09	.80
	AF	1.23	.27	4.62	.00	.71	1.75
	FR x AF	-.05	.01	-3.56	.00	-.08	-.02
	R^2	.17			.00		
	ΔR^2	.02			.00		
Illness worry and conviction	Constant	1.09	2.38	.46	.65	-3.59	5.76
	Family Relations	.09	.12	.72	.47	-.16	.34
	AF	.70	.15	4.73	.00	.41	.99
	FR x AF	-.04	.01	-4.58	.00	-.05	-.02
	R^2	.19			.00		
	ΔR^2	.04			.00		

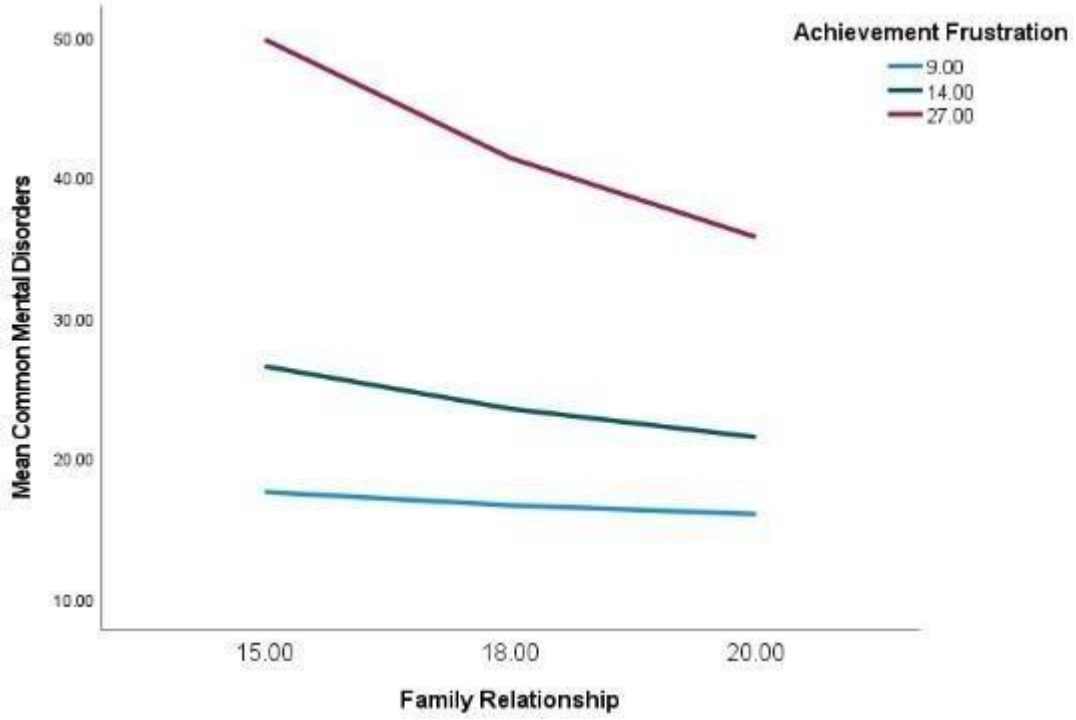
Note. DV = Dependent Variable, CMHD = Common Mental Health Disorders, SD = Somatic Disorders, AD = Anxiety Disorders, ED = Emotional Disorders, Dep = Depression, Whitely = Illness worry and conviction, CAGE=

Narcotic abuse and dependence, AF = Achievement Frustration, FR = Family Relations, CI = Class Interval, LL = Lower Level, UP = Upper Level.

In study Table 19, an outcome reveals that how achievement frustration moderated the association between family relationships and numerous major mental health disorders (such as Somatic Disorders, Anxiety Disorders, Emotional Disorders, Depression, Narcotic abuse and dependence , and Illness worry and conviction). Model 1 with an R^2 value of .14 explained 14% of the variance in mental health disorders, according to the findings. Model 2 also explained 20% of the variance in somatic disorders, Model 3 explained 5% of the variance in anxiety disorders, Model 4 explained 9% of the variance in emotional disorders, Model 5 explained 11% of the variance in depression, Model 6 explained 17% of the variance in Narcotic abuse and dependence disorders, and Model 7 explained 19% of the variance in Illness worry and conviction disorders. Furthermore, in Model 2 family relationships strongly and positively predicted mental health disorders. In models 2, 6, and 7, achievement frustration also significantly and positively predicted mental health disorders. Only in Model 5 did the interaction term of family relations and achievement frustration significantly and positively predict depression. Moreover, in Model 5, family relationships and achievement frustration significantly predicted mental health conditions in a negative way. Furthermore, in Models 1, 2, 6, and 7, the interaction term of family relations and achievement frustration strongly and negatively predicted common mental health disorders (see Figure 27-33).

Figure 27

Data Visualization for the Moderation Effect of Achievement Frustration on the Relationship between Family Relations and Common Mental Health Disorders (N = 454)



Higher achievement frustration serves as a detrimental or negative moderator in the relationship between common mental disorders and family relationships, as seen in Figure 27. This suggests that poorer family relationships are linked to more mental disorders, particularly when levels of achievement frustration will be high.

Figure 28

Data Visualization for the Moderation Effect of Achievement Frustration on the Relationship between Family Relations and Somatic Disorders (N = 454)

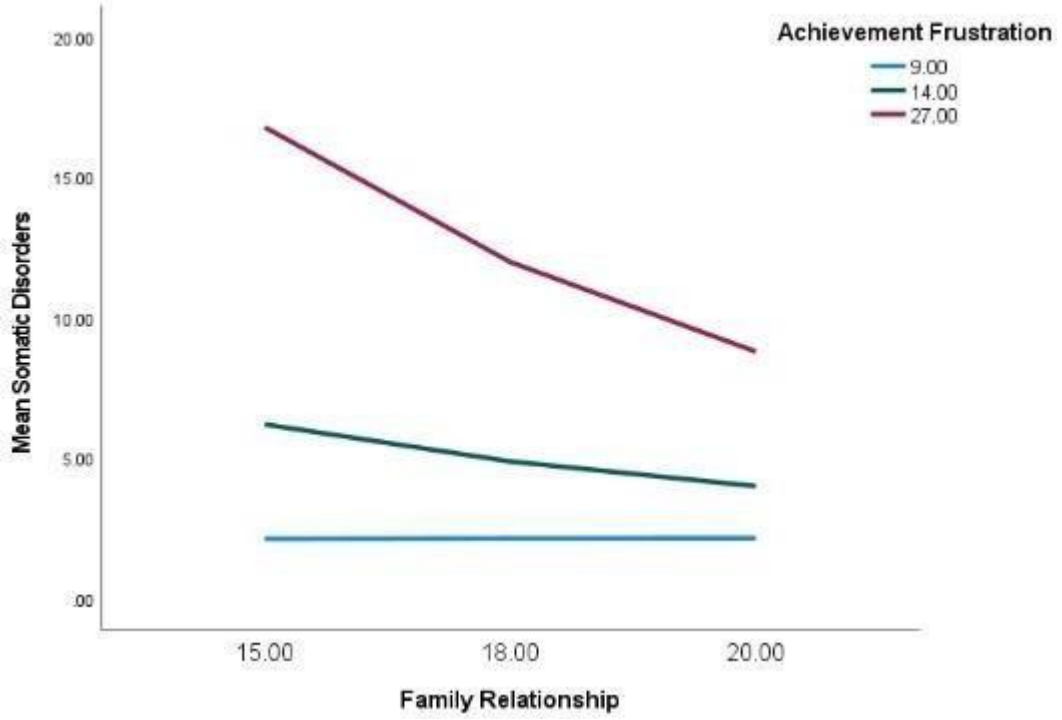
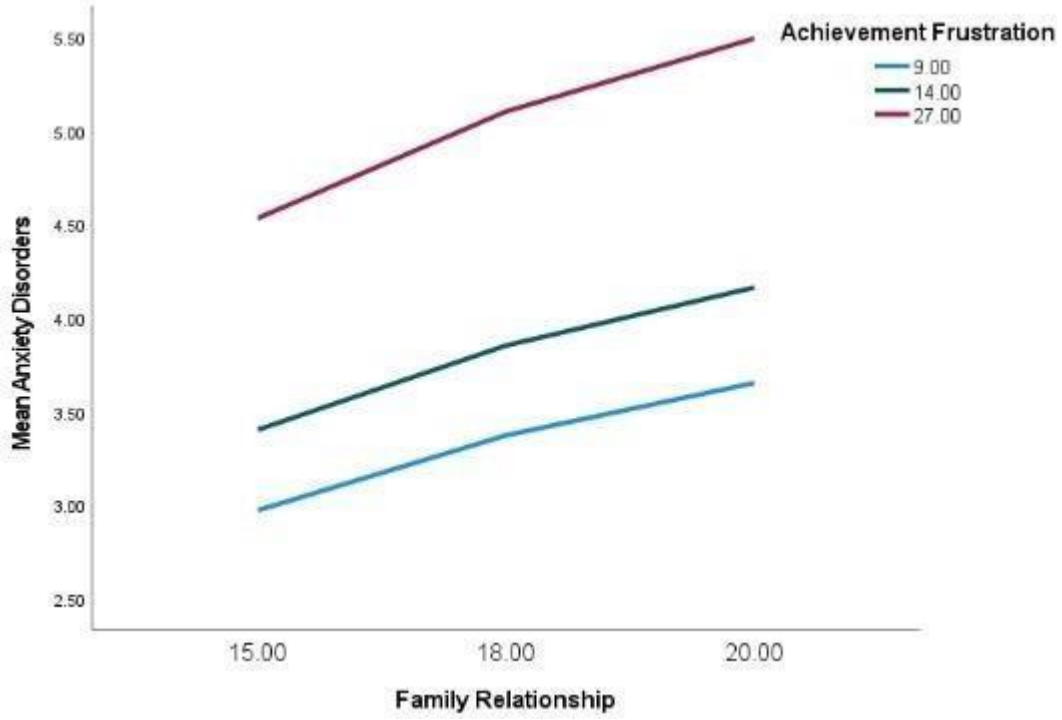


Figure 28 shows that higher achievement frustration negatively moderates the relationship between family relations and somatic disorders. This means weak family relations are linked to higher mental disorders when achievement frustration seems to be high.

Figure 29

Data Visualization for the Moderation Effect of Achievement Frustration on the Relationship between Family Relations and Anxiety Disorders (N = 454)



As shown in Figure 29, higher achievement frustration act as a positive moderator in the link between anxiety disorders and family relationships. This implies that strong family relationships are associated with an increase in anxiety disorders, as levels of achievement will be high.

Figure 30

Data Visualization for the Moderation Effect of Achievement Frustration on the Relationship between Family Relations and Emotional Disorders (N = 454)

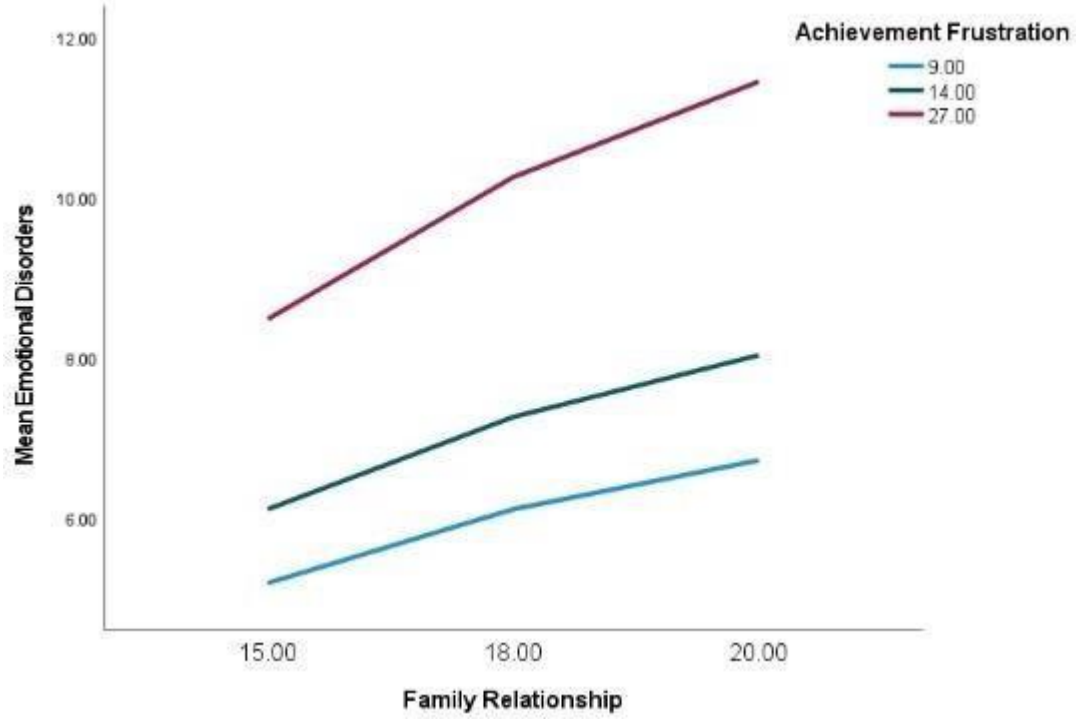
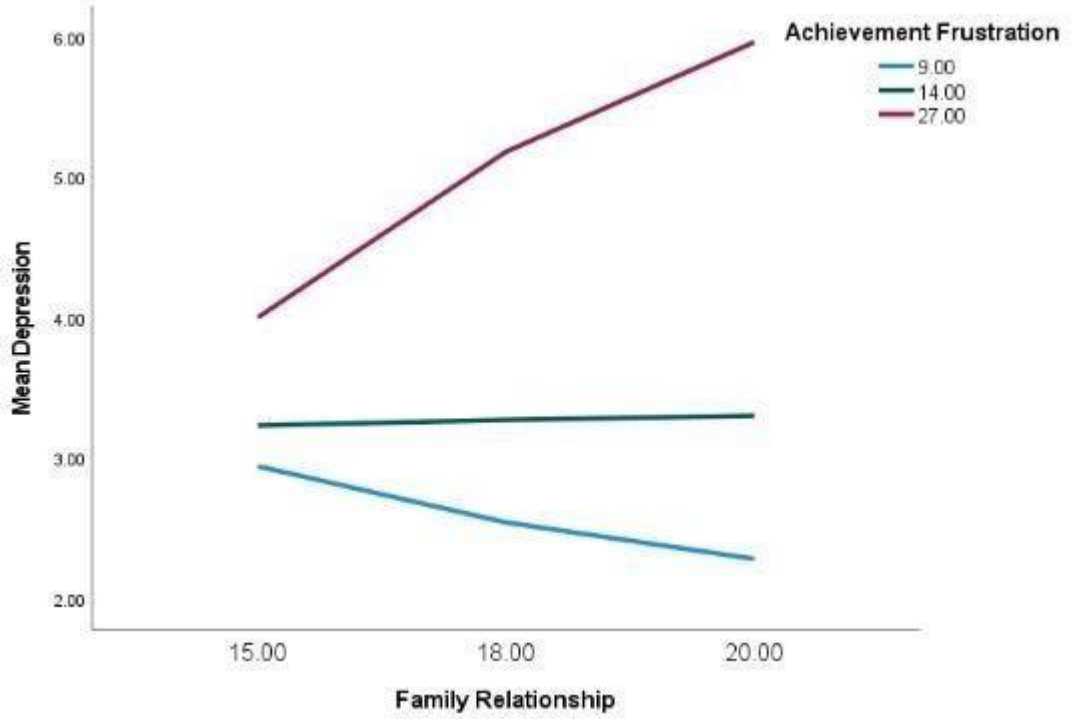


Figure 30 depicted that higher achievement frustration acts as a positive moderator in the link between emotional disorders and family relationships. This indicates that higher family relationships are associated with an increase in emotional disorders, as levels of achievement frustration increased.

Figure 31

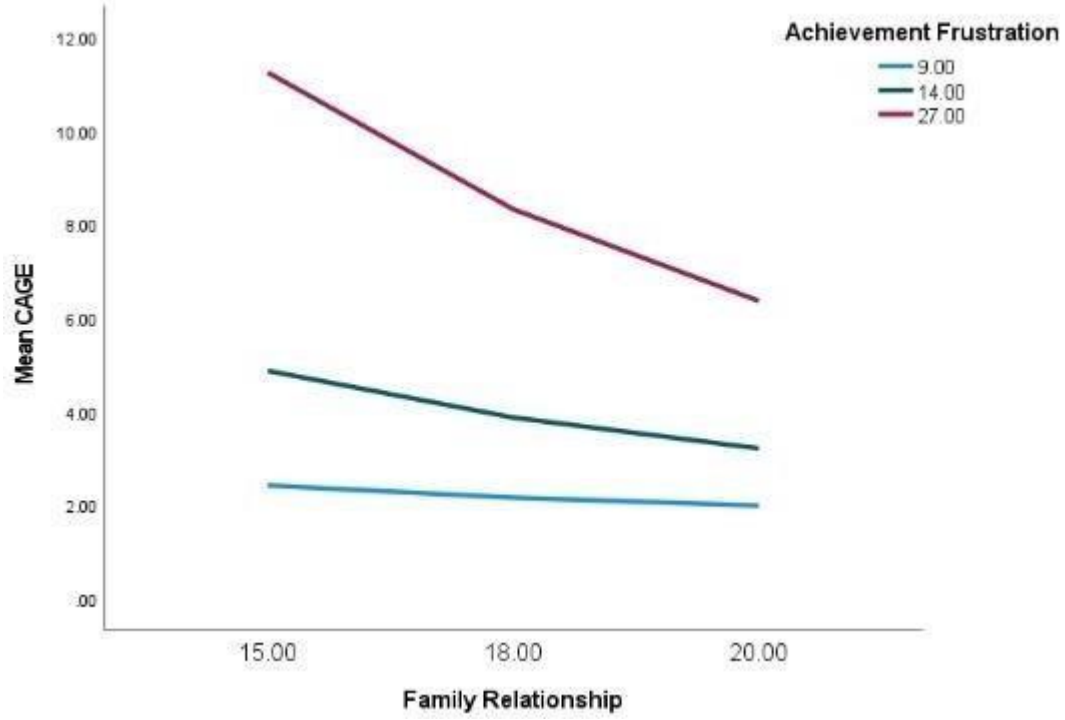
Data Visualization for the Moderation Effect of Achievement Frustration on the Relationship between Family Relations and Depression (N = 454)



As revealed in Figure 31, higher achievement frustration positively moderates the link between depression and family relationships. This infers that good family relationships are associated with an increase in depression, while lower achievement frustration negatively moderates the link between family relationships and depression.

Figure 32

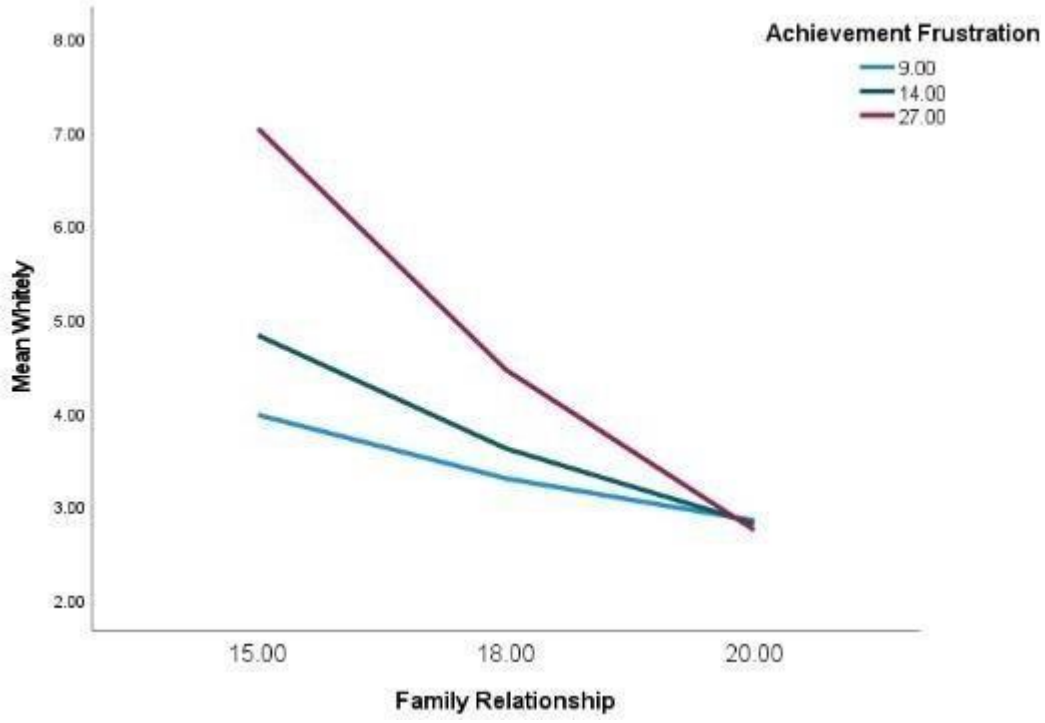
Data Visualization for the Moderation Effect of Achievement Frustration on the Relationship between Family Relations and Narcotic abuse and dependence Disorders (N = 454)



As shown in Figure 32, higher achievement frustration negatively moderates the link between Narcotic abuse and dependence disorders and family relationships. This implies that weak family relationships are associated with an increase in Narcotic abuse and dependence disorders with higher level of achievement frustration.

Figure 33

Data Visualization for the Moderation Effect of Achievement Frustration on the Relationship between Family Relations and Illness worry and conviction Disorders (N = 454)



As revealed in Figure 33, higher achievement frustration negatively moderates the link between Illness worry and conviction disorders and family relationships. This implies that poor family relationships are associated with an increase in Illness worry and conviction disorders as levels of achievement frustration increased.

Table 20

Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and All Common Mental Disorders (N = 454)

						95% CI	
Model		*β*	*SE*	*t*	*p*	*LL*	*UL*
CMD	constant	-34.14	13.73	-2.49	.01	-61.13	-7.15
	Family Relations	1.75	.74	2.36	.02	.30	3.20
	DI	5.41	.82	6.62	.00	3.81	7.02
	FR x DI	-.20	.04	-4.55	.00	-.28	-.11
	R^2	.31			.00		
	ΔR^2	.03			.00		
SD	constant	-23.89	4.56	-5.24	.00	-32.86	-14.93
	Family Relations	1.10	.25	4.46	.00	.61	1.58
	DI	2.61	.27	9.62	.00	2.08	3.15
	FR x DI	-.11	.01	-7.55	.00	-.14	-.08
	R^2	.37			.00		
	ΔR^2	.08			.00		
AD	constant	-5.71	2.42	-2.36	.02	-10.48	-.95
	Family Relations	.39	.13	3.02	.00	.14	.65
	DI	.47	.14	3.23	.00	.18	.75
	FR x DI	-.02	.01	-2.15	.03	-.03	.00
	R^2	.12			.00		
	ΔR^2	.01			.03		
ED	constant	-7.15	4.12	-1.74	.08	-15.24	.94
	Family Relations	.50	.22	2.25	.03	.06	.93
	DI	.52	.25	2.13	.03	.04	1.00

	FR x DI	-.01	.01	-.62	.53	-.03	.02
	R^2	.19			.00		
	ΔR^2	.00			.53		
Dep	constant	2.51	2.25	1.12	.26	-1.91	6.92
	Family Relations	-.17	.12	-1.41	.16	-.41	.07
	DI	.03	.13	.25	.81	-.23	.30
	FR x DI	.01	.01	1.79	.07	.00	.03
	R^2	.26			.00		
	ΔR^2	.01			.07		
Narcotic Abuse And Dependence	constant	-9.85	3.35	-2.94	.00	-16.43	-3.27
	Family Relations	.45	.18	2.48	.01	.09	.80
	DI	1.42	.20	7.10	.00	1.02	1.81
	FR x DI	-.06	.01	-5.28	.00	-.08	-.04
	R^2	.29			.00		
	ΔR^2	.04			.00		
Illness worry and conviction	constant	2.96	2.00	1.48	.14	-.96	6.88
	Family Relations	-.03	.11	-.24	.81	-.24	.19
	DI	.57	.12	4.82	.00	.34	.81
	FR x DI	-.03	.01	-4.33	.00	-.04	-.01
	R^2	.21			.00		
	ΔR^2	.03			.00		

Note. DV = Dependent Variable, CMHD = Common Mental Health Disorders, SD = Somatic Disorders, AD = Anxiety Disorders, ED = Emotional Disorders, Dep = Depression, DI = Discomfort Intolerance, Whitely = Illness

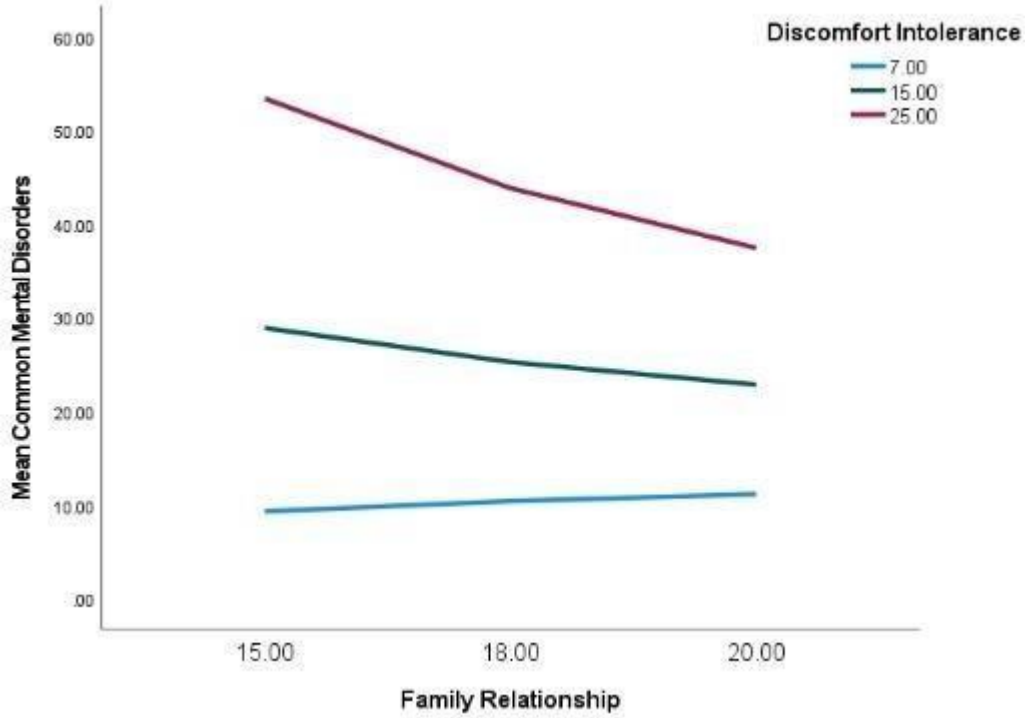
worry and conviction, CAGE= Narcotic abuse and dependence, FR = Family Relations, CI = Class Interval, LL = Lower Level, UP = Upper Level.

The results in Table 20 disclose the moderation effect of discomfort intolerance between family relationships and all common mental health disorders (Somatic Disorders, Anxiety Disorders, Emotional Disorders, Depression, Narcotic abuse and dependence, and Illness worry and conviction). Findings revealed that the R^2 value of .31 in model 1 explained a 31% variance in mental health disorders. Following that, the R^2 value of .37 in model 2 explained a 37% variance in somatic disorders, 12% variance in anxiety disorders (Model 3), 19% variance in emotional disorders (Model 4), 26% variance in depression (Model 5), 29% variance in Narcotic abuse and dependence disorders (Model 6), and 21% variance in Illness worry and conviction disorders (Model 7) with $p < .01$. Meanwhile, family relations significantly and positively predicted mental health disorders in models 1, 2, 3, 4, and 6, discomfort intolerance significantly

and positively predicted mental health disorders in models 1, 2, 3, 4, 6, and 7. On the other hand, interaction terms of family relations* discomfort intolerance as moderation significantly and negatively predicted mental health disorders in models 1, 2, 3, 6, and 7 (see Figure 34-40).

Figure 34

Data Visualization for the Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and Common Mental Health Disorders (N = 454)



Higher discomfort intolerance serves as a detrimental or negative moderator in the relationship between common mental disorders and family relationships, as seen in Figure 34. This suggests that poorer family relationships are linked to more mental disorders, particularly when levels of discomfort intolerance will be high.

Figure 35

Data Visualization for the Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and Somatic Disorders (N = 454)

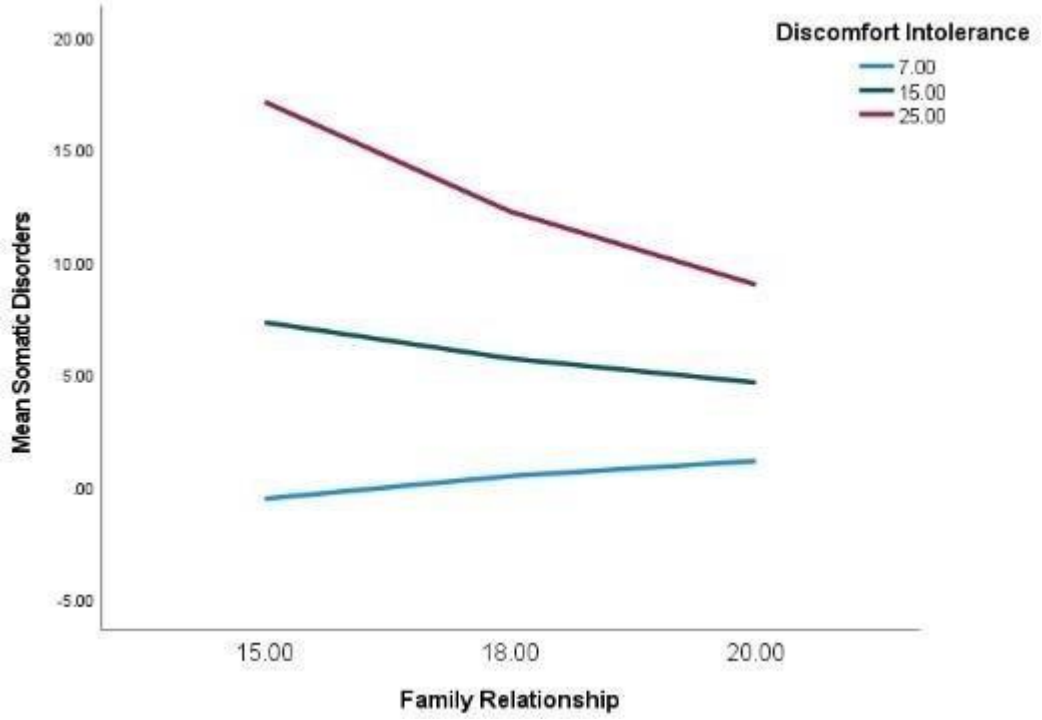
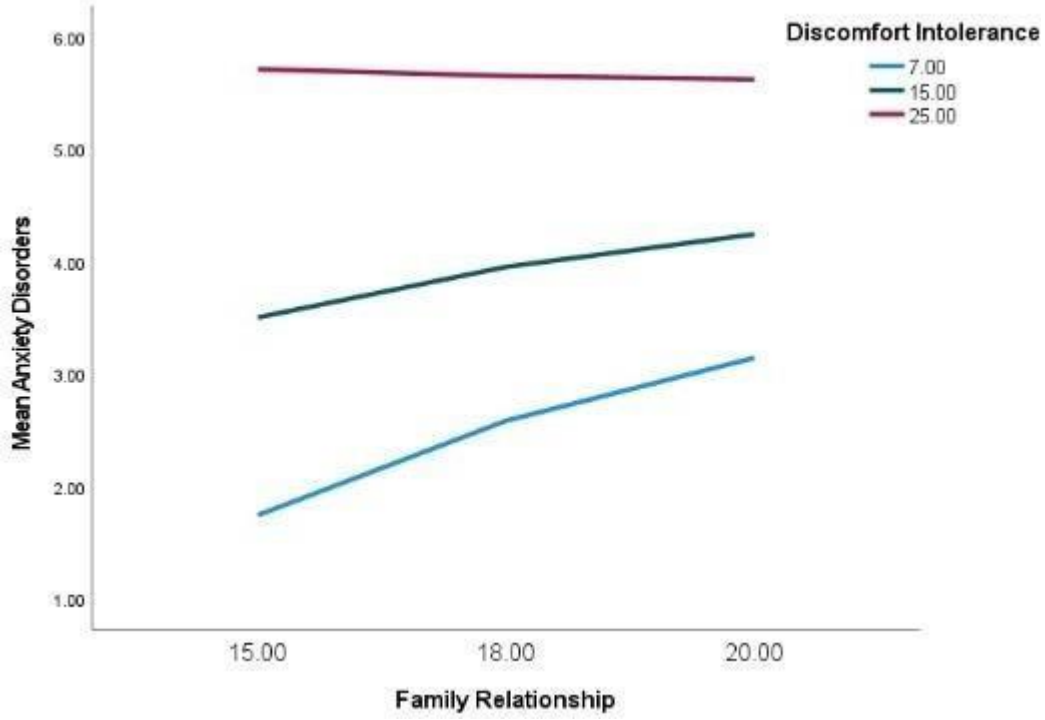


Figure 35 shows that higher discomfort intolerance negatively moderates the relationship between family relations and somatic disorders. This means weak family relations are linked to higher mental disorders when discomfort intolerance seems to be high.

Figure 36

Data Visualization for the Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and Anxiety Disorders (N = 454)



As shown in Figure 36, higher discomfort intolerance act as a positive moderator in the link between anxiety disorders and family relationships. This implies that strong family relationships are associated with an increase in anxiety disorders, as levels of discomfort intolerance will be high.

Figure 37

Data Visualization for the Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and Emotional Disorders (N = 454)

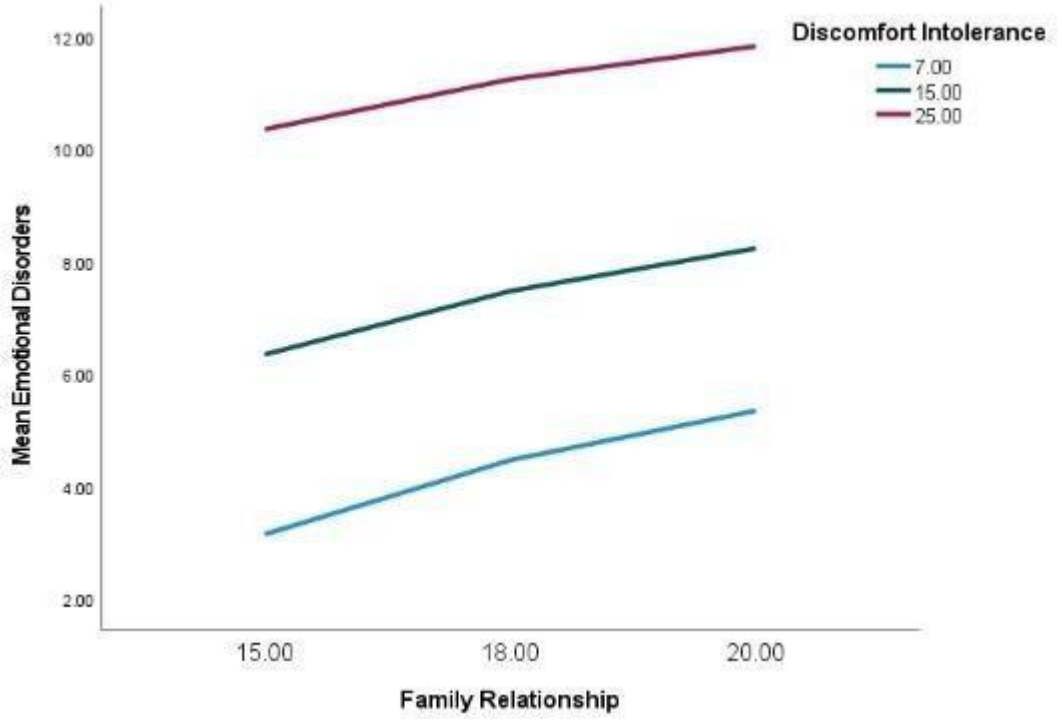
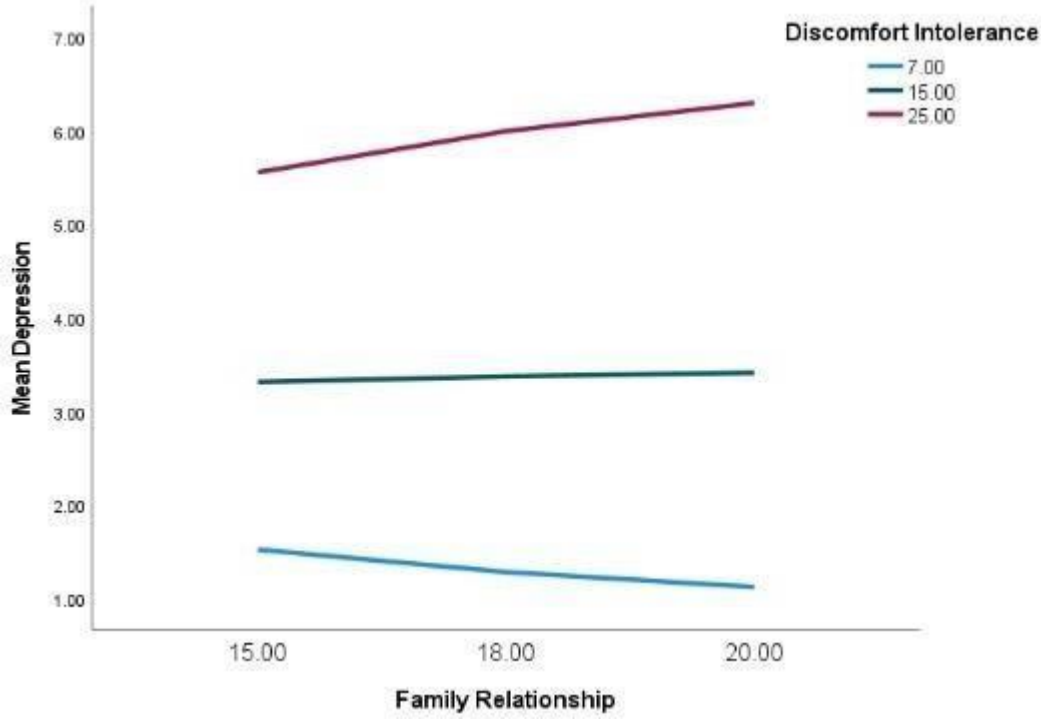


Figure 37 depicted that higher discomfort intolerance acts as a positive moderator in the link between emotional disorders and family relationships. This indicates that higher family relationships are associated with an increase in emotional disorders, as levels of discomfort intolerance increased.

Figure 38

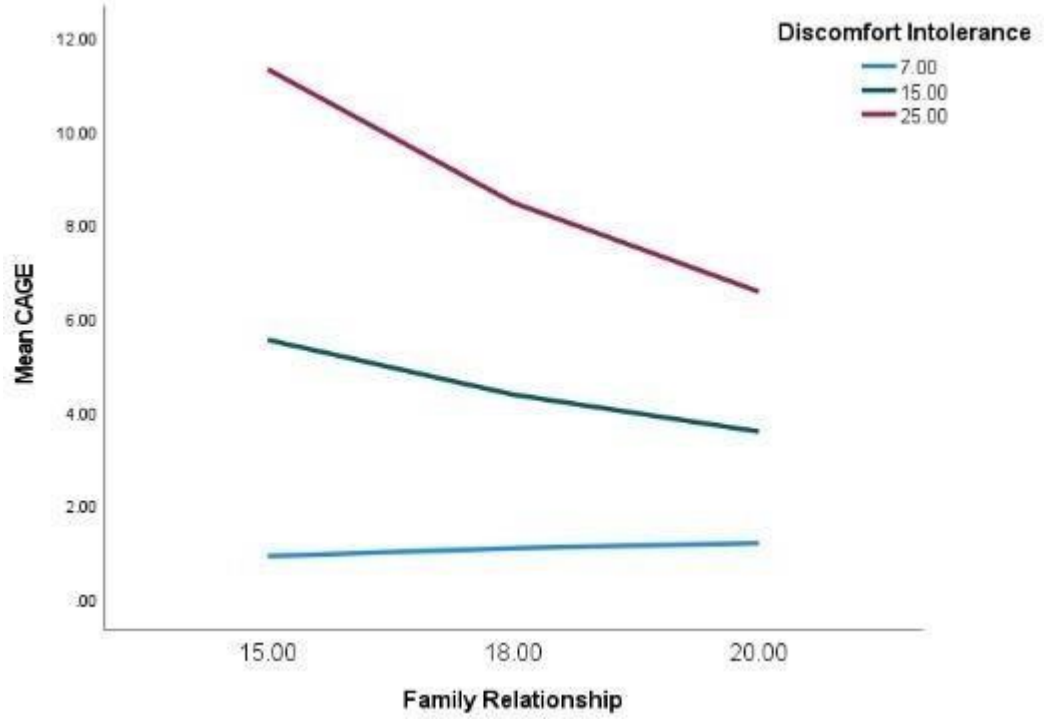
Data Visualization for the Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and Depression (N = 454)



As revealed in Figure 38, higher discomfort intolerance positively moderates the link between depression and family relationships. This infers that good family relationships are associated with an increase in depression, while lower discomfort intolerance negatively moderates the link between family relationships and depression.

Figure 39

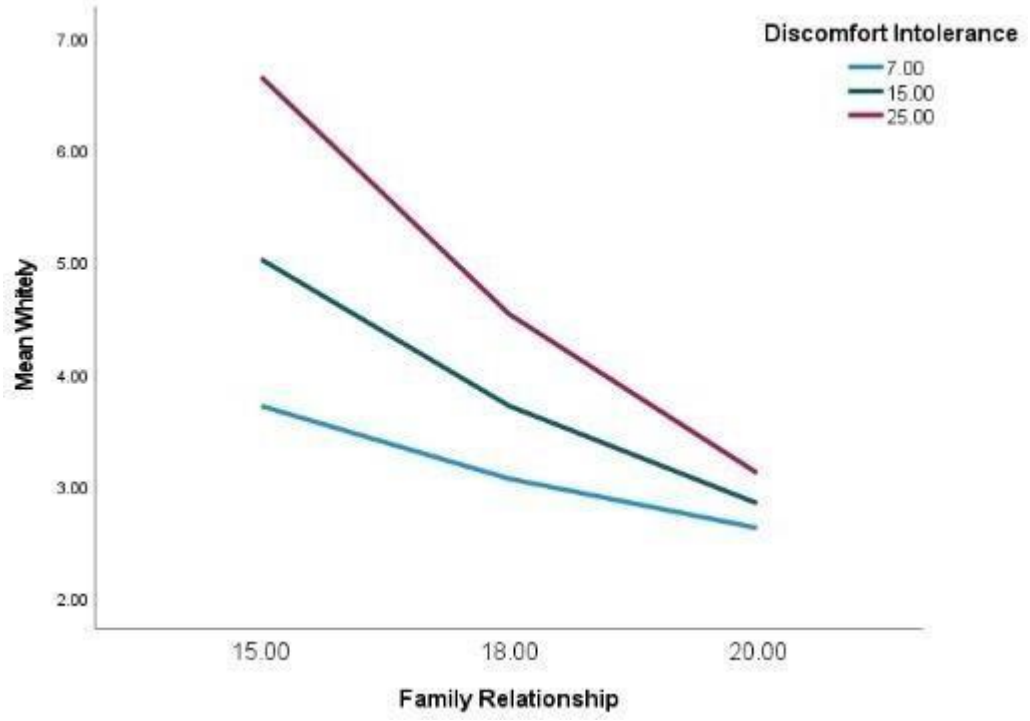
Data Visualization for the Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and Narcotic abuse and dependence Disorders (N = 454)



As shown in Figure 39, higher discomfort intolerance negatively moderates the link between Narcotic abuse and dependence disorders and family relationships. This implies that weak family relationships are associated with an increase in Narcotic abuse and dependence disorders with higher level of discomfort intolerance.

Figure 40

Data Visualization for the Moderation Effect of Discomfort Intolerance on the Relationship between Family Relations and Illness worry and conviction Disorders (N = 454)



As revealed in Figure 40, higher discomfort intolerance negatively moderates the link between Illness worry and conviction disorders and family relationships. This implies that poor family relationships are associated with an increase in Illness worry and conviction disorders as levels of discomfort intolerance increased.

Table 15

Correlation matric of FDS, BFRS, and CMD and its sub scales (N=454)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Discomfort Intolerance	-	.71**	.46**	.52**	.05**	-.15**	.06**	.30**	.36**	.32**	.16**	.31**	.16**	.32**	.79**
Emotional Intolerance		-	.68**	.74**	-.05**	-.23**	.14**	.53**	.22**	.30**	.32**	.45**	.19**	.46**	.92**
Discomfort Intolerance			-	.67**	-.08**	-.14**	.26**	.35**	.18**	.24**	.30**	.32**	.05	.33**	.83**
Entitlement				-	.07**	-.05**	-.01	.49**	.33**	.40**	.50**	.45**	.12**	.58**	.88**
Cohesion					-	.57**	-.48**	-.16**	.02**	.07**	-.04	-.14**	-.38**	-.15**	.21**
Conflict						-	-.49**	-.20**	-.02**	-.08**	-.12**	-.16**	-.26**	-.28**	-.18**
Expressiveness							-	.12**	.21**	.26**	.22**	.08	.39**	.89**	.32**
Somatization								-	.68**	.61**	.68**	.91*	.45**	.97**	.48**
Anxiety									-	.87**	.59**	.62**	.38**	.75**	.39**
Emotional disorders										-	.81**	.57**	.36**	.80**	.38**
Depression											-	.65**	.42**	.82**	.38**
Narcotic abuse and dependence												-	.52**	.91**	.45**
TCDM														-	.48**
TFDS															-
TBFRS															

**p< .01,Note: FDS= Frustration Discomfort Scale, BFRS= brief family relations scale, CMDQ= common mental disorder questionnaire

Table 15 shows that there correlation between total of FDS, BFRS, and CMD and its sub scales among the scores of juveniles. Table indicates that there significant (**p<.01) correlation between scales and sub scales of the present study. Some variables are positively correlated and some are negatively correlated. Family relation is negatively correlated with the frustration discomfort sub scales as it is clear that if frustration increases family relations will be low between juveniles and family.

Table 21

One way ANOVA for education-wise differences on FDS sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F(4, 449)	p	η_2
					Lower Bound	Upper Bound			
Entitlement	illiterate	146	14.59	7.88	13.30	15.88	.488	.745	.004
	primary	92	15.01	8.12	13.33	16.69			
	middle	37	16.32	8.66	13.44	19.21			
	matric	72	15.38	8.01	13.49	17.26			
	FA above	107	15.68	8.70	14.01	17.35			
Discomfort Intolerance	illiterate	146	14.37	7.99	13.06	15.68	.796	.528	.007
	primary	92	14.14	7.72	12.54	15.74			
	middle	37	15.97	8.89	13.01	18.94			
	matric	72	15.75	8.12	13.84	17.66			
	FA above	107	15.34	8.26	13.75	16.92			
Achievement	illiterate	146	16.21	7.92	14.91	17.50	.510	.729	.003
	primary	92	15.91	7.98	14.26	17.57			
	middle	37	18.00	8.55	15.15	20.85			
	matric	72	16.49	7.15	14.81	18.17			

	FA above	107	16.54	7.69	15.07	18.02			
Emotional Intolerance	illiterate	146	15.69	8.69	14.27	17.11	.561	.691	.004
	primary	92	15.18	8.62	13.40	16.97			
	middle	37	17.51	8.65	14.63	20.40			
	matric	72	16.15	8.19	14.23	18.08			
	FA above	107	16.21	8.46	14.58	17.83			

The above table 22 indicates mean, standard deviation and F values of education wise (illiterate, primary, middle, matric and FA & above) on the scores of juvenile delinquents on *FDS sub scales* (p>.01). The results in table also indicate the η values to check the eta square effect size among different educational groups.

Table 22

One way ANOVA for education-wise differences on BFRS sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F(4, 449)	p	η_2
					Lower Bound	Upper bound			
Cohesion	illiterate	146	11.02	3.346	10.47	11.57	.295	.882	.002
	primary	92	11.04	3.134	10.39	11.69			
	middle	37	11.65	2.658	10.76	12.54			
	matric	72	11.07	3.230	10.31	11.83			
	fa above	107	11.09	3.397	10.44	11.74			
Conflict	illiterate	146	4.43	1.286	4.22	4.64	.752	.557	.003
	primary	92	4.43	1.142	4.20	4.67			
	middle	37	4.49	1.325	4.04	4.93			
	matric	72	4.31	1.158	4.03	4.58			
	fa above	107	4.21	1.272	3.96	4.45			
Expressiveness	illiterate	146	3.19	3.013	2.70	3.68	.333	.856	.006
	primary	92	3.20	2.849	2.61	3.79			
	middle	37	2.76	2.565	1.90	3.61			
	matric	72	3.10	2.633	2.48	3.72			
	fa above	107	3.36	2.850	2.82	3.91			

The table 22 indicates mean, standard deviation and F values of education wise (illiterate, primary, middle, matric and FA & above) on the scores of juvenile delinquents on *BFRS sub scales* ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different educational groups.

Table 23

One way ANOVA for education-wise differences on CMDQ sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
Somatization	illiterate	146	5.98	9.668	4.40	7.56	.998	.408	.001
	primary	92	5.22	7.323	3.70	6.73			
	middle	37	6.43	10.660	2.88	9.99			
	matric	72	8.18	11.551	5.47	10.89			
	FA above	107	6.72	10.761	4.66	8.78			
Anxiety	illiterate	146	3.92	4.444	3.20	4.65	.133	.970	.009
	primary	92	3.88	4.377	2.97	4.79			
	middle	37	3.89	4.215	2.49	5.30			
	matric	72	4.31	4.468	3.26	5.36			
	FA above	107	4.12	4.756	3.21	5.03			
Emotional	illiterate	146	7.40	8.012	6.09	8.71	.287	.886	.004
	primary	92	7.21	7.605	5.63	8.78			
	middle	37	7.59	7.286	5.17	10.02			
	matric	72	8.39	8.061	6.49	10.28			
	FA above	107	7.89	8.366	6.28	9.49			

Depression	illiterate	146	3.33	4.311	2.62	4.03	.546	.702	.001
	primary	92	3.35	4.303	2.46	4.24			
	middle	37	3.89	4.458	2.41	5.38			
	matric	72	4.13	4.741	3.01	5.24			
	FA above	107	3.83	4.938	2.89	4.78			
Narcotic abuse and dependence	illiterate	146	4.53	6.643	3.44	5.61	.754	.556	.006
	primary	92	4.14	5.278	3.05	5.23			
	middle	37	5.05	6.996	2.72	7.39			
	matric	72	5.88	8.169	3.96	7.79			
	FA above	107	5.07	7.521	3.63	6.52			
Illness worry and conviction	illiterate	146	3.77	3.725	3.16	4.38	.815	.516	.003
	primary	92	3.49	3.578	2.75	4.23			
	middle	37	4.16	3.532	2.98	5.34			
	matric	72	4.44	4.226	3.45	5.44			
	FA above	107	4.18	4.218	3.37	4.99			

The table 23 indicates mean, standard deviation and F values of education wise (illiterate, primary, middle, matric and FA & above) on the scores of juvenile delinquents on CMDQ sub scales ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different educational groups.

Table 24

One way ANOVA for education-wise differences on total of FDS, BFRS and CMDQ (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η
					Lower Bound	Upper Bound			
TCDM	illiterate	146	25.72	28.028	21.13	30.30	.909	.458	.003
	primary	92	24.13	21.905	19.59	28.67			
	middle	37	27.92	28.623	18.38	37.46			
	matric	72	31.85	32.963	24.10	39.59			
	FA above	107	28.71	31.725	22.63	34.79			
TFDS	illiterate	146	60.86	27.305	56.39	65.32	.705	.589	.002
	primary	92	60.25	28.442	54.36	66.14			
	middle	37	67.81	29.622	57.93	77.69			
	matric	72	63.76	26.149	57.62	69.91			
	FA above	107	63.77	28.588	58.29	69.25			

TFAM	illiterate	146	17.58	3.564	16.99	18.16	.111	.979	.007
	primary	92	17.54	3.488	16.82	18.27			
	middle	37	17.89	3.026	16.88	18.90			
	matric	72	17.44	3.276	16.67	18.21			
	FA above	107	17.50	3.674	16.80	18.21			

The table 24 indicates mean, standard deviation and F values of education wise (illiterate, primary, middle, matric and FA & above) on the scores of juvenile delinquents on total of FDS, BFRS and CMDQ ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different educational groups.

Table 25

One way ANOVA for parents status-wise differences on FDS sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
Entitlement	divorced	30	16.20	7.073	13.56	18.84	.649	.584	.002
	separated	17	12.76	8.363	8.46	17.06			
	living together	302	15.24	8.152	14.31	16.16			
	one of them died	105	15.20	8.621	13.53	16.87			
Discomfort Intolerance	divorced	30	15.87	7.477	13.07	18.66	2.219	.085	.004
	separated	17	10.29	3.917	8.28	12.31			
	living together	302	15.20	8.331	14.26	16.15			
	one of them died	105	14.50	7.901	12.98	16.03			
Achievement	divorced	30	18.40	8.336	15.29	21.51	2.543	.056	.008
	separated	17	11.94	5.250	9.24	14.64			
	living together	302	16.44	7.823	15.55	17.32			
	one of them died	105	16.51	7.741	15.02	18.01			
Emotional	divorced	30	17.73	7.930	14.77	20.69	1.160	.325	.004

Intolerance	separated	17	12.94	6.230	9.74	16.14
	living together	302	15.98	8.616	15.00	16.95
	one of them died	105	15.77	8.714	14.09	17.46

The table 25 indicates mean, standard deviation and F values of parents status in the family (divorced, separated, living together and one of them died) on the scores of juvenile delinquents on total of FDS subscales ($p>.01$). The results in table also indicate the η_2 values to check the eta square effect size among different parents status of juveniles.

Table 26

One way ANOVA for parents status-wise differences on BFRS sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
Cohesion	divorced	30	11.43	3.09	10.28	12.59	.359	.782	.002
	separated	17	11.00	3.70	9.09	12.91			
	living together	302	11.00	3.21	10.64	11.36			
	one of them died	105	11.31	3.30	10.68	11.95			
Conflict	divorced	30	4.70	1.02	4.32	5.08	1.290	.277	.004
	separated	17	4.59	1.46	3.84	5.34			
	living together	302	4.36	1.23	4.22	4.50			
	one of them died	105	4.24	1.26	3.99	4.48			
Expressiveness	divorced	30	2.77	2.54	1.82	3.72	1.910	.127	.002
	separated	17	2.18	2.87	.70	3.66			
	living together	302	3.39	2.91	3.06	3.72			
	one of them died	105	2.87	2.66	2.35	3.38			

The table 26 indicates mean, standard deviation and F values of parents status in the family (divorced, separated, living together and one of them died) on the scores of juvenile delinquents on total of BFRS sub scales ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different parents status of juveniles.

Table 27

One way ANOVA for parents status-wise differences on CMDQ sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
Somatization	divorced	30	9.20	12.98	4.35	14.05	1.872	.133	.003
	separated	17	2.29	3.63	.42	4.16			
	living together	302	6.50	9.55	5.42	7.58			
	one of them died	105	5.90	10.54	3.86	7.95			
Anxiety	divorced	30	4.97	5.14	3.04	6.89	1.421	.236	.005
	separated	17	2.29	3.80	.34	4.25			
	living together	302	4.10	4.44	3.60	4.61			
	one of them died	105	3.79	4.44	2.93	4.65			
Emotional	divorced	30	8.00	9.09	4.60	11.40	.607	.611	.004
	separated	17	5.12	8.38	.80	9.43			
	living together	302	7.72	7.67	6.85	8.59			
	one of them died	105	7.74	8.32	6.13	9.35			
Depression	divorced	30	4.57	5.58	2.48	6.65	.711	.546	.004
	separated	17	2.65	2.66	1.28	4.02			

	living together	302	3.62	4.43	3.12	4.12			
	one of them died	105	3.52	4.74	2.61	4.44			
	divorced	30	6.60	8.90	3.28	9.92	1.400	.242	.009
Alcohol	separated	17	2.41	2.93	.90	3.92			
abuse and	living together	302	4.74	6.70	3.98	5.49			
dependence	one of them died	105	5.01	7.20	3.62	6.40			
	divorced	30	4.37	4.14	2.82	5.91	.548	.649	.007
Illness worry	separated	17	4.59	3.48	2.80	6.38			
and	living together	302	3.79	3.83	3.36	4.23			
conviction	one of them died	105	4.17	4.03	3.39	4.95			

The table 27 indicates mean, standard deviation and F values of parents status in the family (divorced, separated, living together and one of them died) on the scores of juvenile delinquents on CMDQ sub scales ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different parents status of juveniles.

Table 28

One way ANOVA for parents status-wise differences on total of FDS, BFRS and CMDQ (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
	divorced	30	33.33	37.20	19.44	47.23	1.155	.327	.004
	separated	17	17.12	16.01	8.88	25.35			
TCDM	living together	302	27.25	27.69	24.11	30.38			
	one of them died	105	27.17	30.37	21.29	33.05			
	divorced	30	68.20	27.27	58.02	78.38	2.012	.112	.005
	separated	17	47.94	14.86	40.30	55.59			
TFDS	living together	302	62.85	28.15	59.66	66.04			
	one of them died	105	61.99	28.12	56.55	67.43			
	divorced	30	18.00	3.22	16.80	19.20	.424	.736	.002
	separated	17	17.06	4.30	14.84	19.27			
TFAM	living together	302	17.61	3.44	17.22	18.00			
	one of them died	105	17.35	3.51	16.67	18.03			

The table 28 indicates mean, standard deviation and F values of parents status in the family (divorced, separated, living together and one of them died) on the scores of juvenile delinquents *on* total of FDS, BFRS and CMDQ ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different parents status of juveniles.

Crime

In order to find out the effect of severity of crime on the variables of the study *FDS, BFRS and CMDQ* & its subscales. The data was divided into six different groups according to their severity of crime such as murderer (n=107), drug smuggling (n=271), terrorism (n=22), kidnapping (n=10), theft (n=44).

Table 29

One way ANOVA for crime-wise differences on FDS sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
Entitlement	murder	107	14.56	8.19	12.99	16.13	.968	.425	.003
	drug smuggling	271	15.34	8.16	14.36	16.32			
	terrorism	22	14.00	8.52	10.22	17.78			
	kidnapping	10	13.10	6.69	8.31	17.89			
	theft	44	16.95	8.50	14.37	19.54			
Discomfort Intolerance	murder	107	14.18	8.16	12.61	15.74	.762	.551	.002
	drug smuggling	271	15.39	8.26	14.41	16.38			
	terrorism	22	14.77	7.66	11.37	18.17			
	kidnapping	10	12.50	5.79	8.35	16.65			
	theft	44	14.23	7.55	11.93	16.52			
Achievement	murder	107	16.01	7.92	14.49	17.53	1.152	.331	.005
	drug smuggling	271	16.92	7.69	16.00	17.84			
	terrorism	22	14.05	8.30	10.37	17.73			

	kidnapping	10	13.90	7.14	8.79	19.01			
	theft	44	16.05	8.00	13.61	18.48			
	murder	107	15.55	8.45	13.93	17.17	.375	.827	.002
	drug smuggling	271	16.28	8.66	15.24	17.32			
Emotional	terrorism	22	14.41	8.72	10.54	18.28			
Intolerance	kidnapping	10	15.10	9.08	8.60	21.60			
	theft	44	15.66	7.85	13.27	18.05			

The table 29 indicates mean, standard deviation and F values of crime wise (murder, drug smuggling, terrorism, kidnapping and theft) on the scores of juvenile delinquents *on FDS sub scales* (p>.01). The results in table also indicate the η values to check the eta square effect size among different parents status of juveniles.

Table 30

One way ANOVA for crime-wise differences on BFRS sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
Cohesion	murder	107	11.35	3.20	10.73	11.96	.815	.516	.003
	drug smuggling	271	10.93	3.29	10.53	11.32			
	terrorism	22	12.00	2.61	10.84	13.16			
	kidnapping	10	11.50	2.71	9.56	13.44			
	theft	44	11.05	3.36	10.02	12.07			
Conflict	murder	107	4.50	1.31	4.24	4.75	.557	.694	.004
	drug smuggling	271	4.31	1.22	4.16	4.45			
	terrorism	22	4.50	1.22	3.96	5.04			
	kidnapping	10	4.20	1.39	3.20	5.20			
	theft	44	4.36	1.12	4.02	4.70			
Expressiveness	murder	107	3.10	3.04	2.52	3.69	.081	.988	.003
	drug smuggling	271	3.19	2.88	2.84	3.53			
	terrorism	22	3.14	2.45	2.05	4.22			

	kidnapping	10	3.10	2.07	1.61	4.59
	theft	44	3.39	2.49	2.63	4.15

The table 30 indicates mean, standard deviation and F values of crime wise (murder, drug smuggling, terrorism, kidnapping and theft) on the scores of juvenile delinquents *on* BFRS sub scales ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different parents status of juveniles.

Table 31

One way ANOVA for crime-wise differences on CMDQ sub scales (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
Somatization	murder	107	5.51	8.83	3.82	7.21	.854	.492	.004
	drug smuggling	271	6.99	10.65	5.72	8.27			
	terrorism	22	3.77	6.22	1.01	6.53			
	kidnapping	10	5.70	10.20	-1.60	13.00			
	Theft	44	6.23	9.18	3.44	9.02			
Anxiety	murder	107	3.74	4.45	2.89	4.59	1.154	.330	
	drug smuggling	271	3.97	4.47	3.44	4.51			
	terrorism	22	3.32	3.53	1.75	4.89			
	kidnapping	10	4.30	4.08	1.38	7.22			
	Theft	44	5.30	4.96	3.79	6.80			
Emotional	murder	107	7.33	8.15	5.76	8.89	1.123	.345	.003
	drug smuggling	271	7.46	7.84	6.53	8.40			
	terrorism	22	6.50	5.90	3.88	9.12			
	kidnapping	10	8.60	7.15	3.48	13.72			

	Theft	44	9.91	8.94	7.19	12.63			
Depression	murder	107	3.78	4.53	2.91	4.65	.576	.680	.005
	drug smuggling	271	3.54	4.59	2.99	4.09			
	terrorism	22	2.64	3.91	.90	4.37			
	kidnapping	10	3.40	3.23	1.08	5.72			
	Theft	44	4.32	4.75	2.87	5.76			
Narcotic Abuse And Dependence	murder	107	4.06	6.19	2.87	5.24	.909	.458	.003
	drug smuggling	271	5.32	7.33	4.44	6.19			
	terrorism	22	3.50	4.88	1.33	5.67			
	kidnapping	10	4.40	6.56	-.30	9.10			
	Theft	44	4.52	6.67	2.49	6.55			
Illness worry and conviction	murder	107	4.12	3.84	3.38	4.86	.547	.701	.004
	drug summing	271	3.87	3.85	3.41	4.33			
	terrorism	22	3.36	3.92	1.62	5.10			
	kidnapping	10	3.10	3.31	.73	5.47			
	Theft	44	4.50	4.28	3.20	5.80			

The table 31 indicates mean, standard deviation and F values of crime wise (murder, drug smuggling, terrorism, kidnapping and theft) on the scores of juvenile delinquents on CMDQ sub scales ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different parents status of juveniles.

Table 32

One way ANOVA for crime-wise differences on total of FDS, BFRS, and CMDQ (N=454)

		n	M	SD	95% Confidence Interval for Mean		F	p	η_2
					Lower Bound	Upper Bound			
TCDM	murder	107	25.27	26.82	20.13	30.41	.592	.669	.003
	drug smuggling	271	28.12	30.41	24.48	31.76			
	terrorism	22	20.59	18.35	12.45	28.73			
	kidnapping	10	27.00	23.91	9.89	44.11			
	Theft	44	30.11	27.87	21.64	38.59			
TFDS	murder	107	60.30	28.28	54.88	65.72	.747	.560	.005
	drug smuggling	271	63.94	28.04	60.58	67.29			
	terrorism	22	57.23	28.07	44.78	69.67			
	kidnapping	10	54.60	23.46	37.81	71.39			
	Theft	44	62.89	26.30	54.89	70.88			
TFAM	murder	107	17.93	3.44	17.27	18.59	1.194	.313	.002
	drug smuggling	271	17.29	3.46	16.88	17.71			
	terrorism	22	18.55	2.77	17.32	19.77			
	kidnapping	10	17.60	3.77	14.90	20.30			
	Theft	44	17.80	3.81	16.64	18.95			

The table 32 indicates mean, standard deviation and F values of crime wise (murder, drug smuggling, terrorism, kidnapping and theft) on the scores of juvenile delinquents total of FDS, BFRS, and CMDQ ($p>.01$). The results in table also indicate the η values to check the eta square effect size among different parents status of juveniles.

Table 33

Mean Standard Deviation & t-values of Juvenile Delinquents with Criminal and Non-criminal Parents on the Scores of FDS and sub scales

Groups	Non-Criminal Parents (n=324)		Criminal Parents (n=130)				
	M	SD	M	SD	t(df)	p	Cohen's d
Discomfort Intolerance	14.46	7.99	15.48	8.26	1.19 (452)	.235	-
Entitlement	13.90	7.75	15.28	8.20	1.63	.228	-
Achievement	15.89	7.63	16.62	7.86	.89	.104	-
Emotional Intolerance	15.17	8.65	16.23	8.47	1.18	.004	.124
Total FDS	59.42	27.39	63.61	27.91	.28	.373	-

Above table 33 shows Mean, SD and t values of FDS and its sub scales. Results show that all sub scales have non-significant differences on FDS and its sub scale among juvenile who have criminal parents. But juvenile who have criminal parents show significant difference on emotional intolerance (M=16.32, SD=8.74) as compared to non-criminal parents (M=15.17, SD=8.65, t=1.18 (452) and p<005.

Table 34

Mean, Standard Deviation & t-values of Juvenile Delinquents with Criminal and Non-criminal Parents on the Scores of CMDQ and sub scales

Groups	Non-Criminal Parents (n=324)		Criminal Parents (n=130)			
	M	SD	M	SD	t(df)	p
SOM	6.10	10.15	6.49	9.85	.66	.195
Anxiety	4.48	4.73	3.84	4.36	.22	.754
Emotions	8.21	8.22	7.43	7.83	.37	.358
Depression	4.47	3.75	4.71	3.58	1.34	.004
Narcotic abuse and dependence	4.65	6.98	4.91	6.87	.94	.728
Illness worry and conviction	3.88	3.92	3.97	3.87	.35	.725
Total CMDQ	27.38	29.46	27.20	28.47	1.45	.727

Above table 34 shows Mean, SD and t values of CMDQ and sub scales. Results show that all sub scales have non-significant differences on CMDQ *and sub scales* among juvenile who have criminal parents. But juvenile who have criminal parents show significant difference on depression (M=4.47, SD=3.75) as compared to non-criminal parents (M= 4.71, SD=3.58, t=1.34 (452) and p<005.

Table 35

Mean, Standard Deviation & t-values of Juvenile Delinquents with Criminal and Non-criminal Parents on the Scores of BFRS and sub scales

Groups	Non-Criminal Parents (n=324)		Criminal Parents (n=130)				
	M	SD	M	SD	t(df)	p	Cohen's d
Cohesion	11.03	3.35	11.13	3.19	.22	.512	-
Conflict	4.30	1.23	4.39	1.24	.05	.002	.072
Expressiveness	3.23	2.94	3.16	2.80	.22	.830	-
Total BRFS	17.50	3.50	17.58	3.47	1.02	.567	-

Above table 35 shows Mean, SD and t values of *BFRS and sub scales*. Results show that all sub scales have non-significant differences on *BFRS and sub scales* among juvenile who have criminal parents. But juvenile who have criminal parents show significant difference on conflict (M=4.39, SD=1.23) as compared to non-criminal parents (M= 4.30, SD=1.24, t=.22 (452) and p<005.

Discussion

The focus of this research was to study the Impact of Family Functioning and Frustration Discomfort on Common Mental Disorders among Juvenile Delinquents; Efficacy of Dialectical Behavior. Juvenile delinquency is the term used to describe the antisocial and criminal behavior exhibited by those under the age of 18 years. Juvenile delinquency is the child and teenage version of crime because once a person enters adulthood; criminal and antisocial behavior is seen as a crime (Young, 2017).

Table 14 showed the frequency and percentage of each demographic variable of the study. The variables were education, status of parents, and nature of the crime and the releasing time from jail. The age category was 15-17, education categories were illiterate, primary, matric, FA and above, parents status was divorced, separated, living, together, one of them died, categories for the nature of crime were murder, drug, smuggling, terrorism and kidnapping, releasing time from jail was more than 3 years and less than 2.5 years.

Table 15 showed the descriptive statistics and reliability of the translated scales. The reliability of the translated scales was moderate to high. To check the normality of the data, Skewness and Kurtosis was calculated. Their results displayed that the data is normal and parametric test can be used for further analysis.

In Table 16, Correlation between BFRS, FDS and CMDQ and its sub-scales can be seen. The results of the table showed that there was a significant correlation among the scales and sub-scales of the present study. Some of the variables are positively correlated and some are negatively correlated. Family relation is negatively correlated with subscales of frustration

discomfort as it is clear that if frustration increases family relations will be low among the juveniles and their families.

In this study, frustration's discomfort significantly and positively moderated between family relationships and common mental health disorders, specifically emotional disorders, and depression. Several studies also investigated the moderating role of frustration discomfort in the relationship between family relation and common mental health disorders (Gu, 2022; Yu & Chao, 2016). The findings suggested that high levels of frustration and discomfort amplified the impact of negative family relationships on the likelihood of developing common mental health disorders, such as anxiety and stress-related conditions (Yıldırım et al., 2022). Individuals with high frustration discomfort experienced heightened emotional reactivity to familial conflicts or stressors, exacerbating mental health symptoms (Manning & Clayton, 2018).

Researchers also examined how frustration and discomfort are associated with family relationships (Daughters et al., 2014) and emotional disorders (Morris et al., 2002), such as mood disorders and emotional dysregulation (Chen et al., 2014). The results indicated that frustration strengthened the link between negative family dynamics and emotional disturbances. Individuals with high frustration discomfort were more susceptible to emotional vulnerabilities in the context of problematic family interactions, leading to increased emotional disorders (Chen et al., 2014; Daughters et al., 2014).

Furthermore, high frustration and discomfort levels appeared to enhance the impact of adverse family environments on the risk of depression (Compas et al., 1993). Adolescents or individuals with high frustration discomfort experienced greater emotional distress in response to familial stressors, contributing to the development or exacerbation of depressive symptoms (Repetti et al., 2002). On the other hand, in the current study, it was also identified that

frustration discomfort as a moderator significantly and negatively predicted the effects of family relationships on mental health disorders, somatic disorders, Illness worry and conviction, and Narcotic abuse and dependence.

Meanwhile, numerous studies also explored the role of family relations, frustration, and discomfort in predicting somatic disorders. The results showed a significant and negative association, suggesting that the combined influence of problematic family relationships and high frustration discomfort heightened the risk of somatic symptom disorders. Individuals experiencing family stressors with elevated frustration discomfort may have been more susceptible to somatic symptoms and health-related concerns (Grunau et al., 1994; Stuart & Noyes, 1999).

However, limited researchers explored the moderation effect of family relations and frustration discomfort on Narcotic abuse and dependence disorders, specifically substance abuse. However, available findings indicated a significant and negative predictive relationship. The interaction of negative family dynamics and high frustration discomfort appeared to increase the risk of substance abuse or addictive behaviors among adolescents or individuals (Shedler & Block, 1990; Swadi, 1999). Similarly, family relations and frustration discomfort effect on Illness worry and a conviction disorder, such as health anxiety, was also limited. Nevertheless, the available evidence suggested a significant and negative predictive association. The combined effect of negative family ties and increased frustration and discomfort has been linked to increased health anxiety or concerns in certain people (Larson & Asmussen, 2017).

In the current study, it was also discovered that family relationships and emotional intolerance had a good and significant effect on anxiety disorders, emotional disorders, and depression. Previous research has consistently found a significant and positive moderating effect,

implying that the interplay of supportive family relationships and lower emotional intolerance is linked to a lower vulnerability to anxiety disorders (Feldman et al., 2009). Individuals with favorable family dynamics and higher emotional tolerance had a lower likelihood of getting anxiety-related conditions (Bolen et al., 2022).

Furthermore, earlier research found a strong and beneficial correlation between supportive familial relationships, lower levels of emotional intolerance and emotional disturbances (Leavy, 1983). People who had better family relationships and a higher emotional tolerance were less prone to develop emotional vulnerabilities and disturbances (Fruzzetti et al., 2005).

Similarly, the literature indicated a significant and positive predictive relationship between family dynamics and lower emotional intolerance correlated with reduced vulnerability to depression (Kuppens et al., 2012). Adolescents experiencing supportive family relationships and displaying higher emotional tolerance were at a decreased risk of developing or experiencing depressive symptoms (Pisani et al., 2013).

According to Whitesell et al., (2013) the interaction of negative family dynamics and higher emotional intolerance increased the vulnerability to somatic symptom disorders (Rabinowitz et al., 2016). Individuals experiencing adverse family relationships combined with elevated emotional intolerance were at a heightened risk for developing somatic symptoms and health-related concerns. Moreover, researchers also examined the interaction of negative family dynamics and higher emotional intolerance appeared to increase the risk of substance abuse or addictive behaviors among adolescents.

Meanwhile, Forbes et al. (2009) findings consistently indicated a significant and positive predictive relationship between positive family dynamics and reduced risk of depression.

Supportive and cohesive family environments have been associated with better emotional well-being and a lower likelihood of developing depressive symptoms in individuals.

Moreover, entitlement, characterized by a sense of unrealistic entitlement or demands for special treatment, has been found to be linked to mental health outcomes, including depression (Rabinowitz et al., 2016). Studies have shown a significant and positive predictive association between entitlement and increased risk of depression. Individuals with higher levels of entitlement were more susceptible to feelings of frustration and dissatisfaction, contributing to the development or exacerbation of depressive symptoms (Evraire & Dozois, 2011).

Additionally, adolescents who experienced supportive family dynamics combined with lower entitlement tendencies were found to have a reduced risk of developing common mental health disorders, such as mood disorders and stress-related conditions, somatic symptom disorders, and anxiety-related conditions, and were less likely to engage in substance abuse or addictive behaviors (Whitesell et al., 2013).

Similarly, the impact of family relations and achievement frustration on depression. The findings consistently demonstrated a significant and positive association between these factors and the likelihood of experiencing depressive symptoms. For instance, individuals who experienced positive family relationships tend to have lower rates of depression compared to those in challenging family environments. Like that, Lindsey et al. (2017) said that achievement frustration, characterized by the experience of setbacks, failures, or unmet expectations in academic, occupational, or personal pursuits, has been linked to depression. Adolescents who experience persistent feelings of frustration in achieving their goals are more susceptible to depressive symptoms.

However, the combined effect of family relations and achievement frustration on depression, and the findings consistently indicated that individuals experiencing unsupportive family dynamics and higher levels of achievement frustration are at a heightened risk of developing depression. The interaction between adverse family relationships and achievement frustration appears to amplify the risk of depressive symptoms, and are more susceptible to developing mental health challenges, including anxiety, depression, somatic disorders, and stress-related disorders. And those adolescents who experienced positive family environments tend to have better mental health outcomes (Gholizadegan et al., 2023).

Meanwhile, in the current study, positive family relations have been found to be accompanied by a lower risk of Narcotic abuse and dependence disorders, such as substance abuse or addictive behaviors. Supportive family environments were found to act as protective factors against engaging in substance abuse or other unhealthy behaviors and play a vital role in reducing the risk of health anxiety (Repetti et al., 2002).

Additionally, discomfort intolerance has been linked to an increased risk of mental health disorders. Individuals who have difficulty tolerating distressing emotions or situations are more susceptible to developing mental health challenges (Lynch et al., 2020). According to a researcher, those adolescents who experienced unsupportive family environments combined with elevated discomfort intolerance are at a heightened risk of developing common mental health disorders, somatic disorders, anxiety disorders, narcotic abuse and dependence disorders, and Illness worry and conviction disorders (Preston & Rew, 2022; Repetti et al., 2002).

In sum, the above discussion of results suggested that frustration discomfort and its factors as a moderator affect the affiliation of family relationships with common mental health

disorders. The interaction between negative family environments and frustration's discomfort appeared to heighten the risk of many common mental health challenges. Moreover, family relations and frustration strongly and negatively predict common mental health disorders, somatic disorders, Narcotic abuse and dependence disorders, and Illness worry and conviction disorders. Positive family dynamics are associated with lower rates of mental and somatic health disorders, while higher levels of frustration increase the vulnerability to these conditions. The combined effect of unsupportive family environments and frustration further heightens the risk of mental and somatic health challenges. These findings underscore the importance of considering the interplay between family relations and individual experiences in understanding mental and somatic health outcomes.

The term "juvenile delinquency" describes the conduct of young people who transgress social and legal norms, ranging from small to significant acts that go against family values and society (Champion, 1992). Young people who intentionally commit crimes take advantage of the judicial system and carry on with their crimes until they reach adulthood. It has been believed that young individuals who have experienced challenging life circumstances such as poverty, dysfunctional families, substance misuse, childhood maltreatment, and shattered families are more likely to become delinquent. Additionally, young people are predisposed to delinquency by an unstable social environment, underdeveloped abilities, and the harmful influence of their peers. The sociocultural elements and their impact on young people's adoption of delinquent behaviour in Pakistan are examined in this essay. Along with information on changes in adolescent delinquency in Pakistan, the report provides historical context for deviant behaviour.

Table 22 showed the ANOVA results for education wise differences on FDS subscales. The subscales were Entitlement, Discomfort Intolerance, Achievement and Emotional Intolerance. It indicated the mean, standard deviation and F values of education wise (illiterate, primary, middle, matric and FA and above) on the juvenile delinquents scores on FDS sub-scales. Table 23 showed the education wise differences on BFRS subscales Cohesion, Conflict and Expressiveness. It showed the mean, standard deviation and F values of education wise (illiterate, primary, middle, matric and FA and above) on juvenile delinquents scores on BFRS subscales. Table 24 showed the education wise differences on CMDQ sub-scales Somatization, Anxiety, Emotional, Depression, Narcotic abuse and dependence and Illness worry and conviction. Mean, standard deviation and F values of education wise can be seen juvenile delinquents scores on CMDQ subscales. All the subscales were non-significantly linked with education. Table 25 described the education wise differences on total of FDS, BFRS and CMDQ.

The aim of the research was to find out the connection between frustration intolerance and academic performance among criminals. 105 criminals were selected as a sample to participate in the study from which 83 were females and 22 were males.

The results of the study determined that the frustration intolerance subscales such as Achievement, Emotional Intolerance and Entitlement all had negative relationship with education (Wilde, 2012).

Researches indicate that criminal behavior can be problematic for children in many ways. This study observed the relationship between family relations and education of the juveniles. Hierarchical linear regression was used to predict the family relations using a sample of 335 juveniles. The findings of the study showed that education and family relations were negatively correlated with each other. Criminal behavior was negatively associated with family relations (Charles, 2018).

In Table 26, one way ANOVA results for parent's status-wise differences on FDS subscales Entitlement, Discomfort Intolerance, Achievement and Emotional Intolerance. The table indicated the mean, standard deviation and F values of parent's status in the family (divorced, separated, living together and one of them died) on the scores of juvenile delinquents on FDS subscales total. It shows that parents status-wise are non-significant with FDS subscales. Table 27 showed the parents status-wise differences on BFRS subscales Cohesion, Conflict and Expressiveness. It indicated the mean, standard deviation and F values of parent's status in family (divorced, separated, living together and one of them died). BFRS subscales had insignificant results with parent's status. In Table 28, parent's status wise differences on CMDQ subscales somatization, anxiety, emotional, depression, Narcotic abuse and dependence.

According to the values given in the table all were negatively correlated with parent's status. In Table 29, parent's status-wise differences on total of FDS, BFRS and CMDQ are displayed. Teenagers' parental status has been linked to a number of risk factors for criminal behavior. However, there aren't many researches that specifically address the connection between parental status and depression among adult offenders. Panel data from the Korea Welfare Panel study that were gathered in 2012 and 2015 were used in a prior study. The study's primary focus was on the relationship between parental status and depression. As a tool, the Center for Epidemiologic Studies Depression Scale, 11 item versions, was employed. There was a multiple regression analysis. The findings of the study indicated that parent's status plays a role in the depression of adult juveniles (Woo, 2012).

Juveniles have a very high chance of being unhealthy. This study concentrated on examining the impact of FOCS intervention on the quality of parent-child relationships, the criminal attitudes of children, and their interest in treatment while examining the integrity of the intervention. A 91-person sample was used in the study, which was done in 15 prisons throughout 2019–20. Prisons that received FOCS during the study period were added to the

intervention group. Prisons that received FOCS later, on the other hand, were added to the control group. The results were measured with parent-report at baseline. September-December 2019 (TO), after intervention (T1) in January-April 2020 and in April-July 2020 at three-months follow up. The main finding was the relationship quality among parent and child and secondary finding was that sometimes due to parents status children indulge in criminal activities. It determined that intervention leaves favorable effects on parent-child relationship quality and it helps the delinquents to overcome their mental issues (Norman, 2022).

In Table 30, output of one way ANOVA for crime-wise differences on FDS subscales Entitlement, Discomfort Intolerance, Achievement and Emotional Intolerance is observed. It showed the mean, standard deviation and F values of crime wise (murder, drug, smuggling, terrorism, kidnapping and theft) on the juvenile delinquents scores on FDS subscales. The results showed that the subscales have insignificant relationship with FDS subscales. In Table 13, crime-wise differences on BFRS subscales Cohesion, Conflict and Expressiveness are shown. Cohesion, Conflict and Expressiveness all subscales have negative relationship with crime. Table 31 showed crime wise differences on CMDQ subscales SOM, Anxiety, Emotional, Depression, Narcotic abuse and dependence. CMDQ subscales are also negatively correlated with crime. Table 32 showed the total of FDS, BFRS and CMDQ scales for crime-wise differences.

Disturbed emotional health can cause maladjustment and inability to reach the desired goals. The aim of the study was to assess the relationship between emotional intolerance and criminal behavior. The sample of the study consisted of 202 from which 101 were convicted offenders while other 101 were matched normal controls. The individuals in offenders group comprised of people convicted for different crimes such as rape, murder and robbery. All the subjects that participated in the study were provided with informed consent.

The findings of the study showed that convicted offenders group gained significantly low scores on all the domains of EI (Singh, 2015).

Table 32 showed the mean, standard deviation and t-values of Juvenile Delinquents with Criminal and Non-Criminal Parents on the scores of FDS and subscales. The subscales were Discomfort Intolerance, Entitlement, Achievement and Emotional Intolerance. Results of the table showed that all the subscales have non-significant differences on FDS in the juveniles who have criminal parents. But juveniles who have criminal parents show significant differences on emotional intolerance as compared to non-criminal parents.

Family psychosocial characteristics in childhood have been linked with children's development into criminal behavior. A previous study explored these relationships examined emotional and psychological problems and highlighted gender specific patterns. The individuals included in the study were who had adverse family factors and individual problems. Using logistic regression gender specific associations with criminality were analyzed. The conclusion of the study determined that all aspects of emotional and psychological problems were linked with criminality for both of the genders. In males these problems seemed to partly mediate these relations but still the associations remained significant. In feminine, positive impact of emotional and psychological problems on the link among family characteristics and criminality was obtained (Klinteberg, 2011)

In Table 33, mean, standard deviation and t values of Juvenile Delinquents with Criminal and Non-Criminal Parents on the scores of CMDQ and subscales were explored. Findings showed that all the subscales have non-significant difference on CMDQ and subscales among juveniles having criminal parents and Non-Criminal Parents. On the other hand, juveniles who had criminal parents showed significant differences on depression in comparison to non-criminals parents. The purpose of the previous study was to see that whether the adult juveniles with incarcerated parents report high level of depression than those who have incarcerated parents. The results of the study showed that adult juveniles who have incarcerated parents show high risks of depression. Further the conclusion stated that a strong parent-child relationship

partially buffer the children from risk (Davis, 2017).

Table 34 showed mean, standard deviation and t values of Juvenile Delinquents with Criminal and Non-Criminal Parents on the scores of BFRS and subscales. Results of the table showed that all the subscales Cohesion, Conflict and Expressiveness have non-significant relationship with BFRS and its subscales. But conflict showed a significant difference with juveniles who had criminal parents. Using Swedish national registries a sample of 1176 was taken for the study. Participants were provided with informed consent. The results of the study displayed those juveniles who currently have criminal parents are at high risk of conflict as compared to juveniles who have noncriminal parents. The juvenile's environment is also a major factor in this (Kendler, 2016).

Conclusion: The tools used by the researcher were BFRS, FDS and CMDQ. Family relations and frustration discomfort strongly and negatively predict common mental health disorders, somatic disorders, Narcotic abuse and dependence disorders, and Illness worry and conviction disorders. Positive family dynamics are associated with lower rates of mental and somatic health disorders, while higher levels of frustration increase the vulnerability to these conditions. The combined effect of unsupportive family environments and frustration further heightens the risk of mental and somatic health challenges. These findings underscore the importance of considering the interplay between family relations and individual experiences in understanding mental and somatic health outcomes. In Pakistan, most of the juvenile population is low educated mostly so the researcher translated DBT and all the scales in Urdu so that the juveniles can easily understand and respond to them.

Limitation and Suggestions

- The study was conducted on the sample of male juveniles in the jail so the future researchers can lead research on the female sample additionally, this will strengthen the reliability of Urdu version of the three scales.
- The data was taken from the barstool jails of Punjab, future researchers could collect data from all barstool; jails of Pakistan for generalizing the findings.
- The translated version of the BFRS, FDS and CMDQ can be used across Pakistani less educated children population for further researches as Urdu is native language of Pakistan. So they can easily understand and grasp the question statements of the scales in Urdu language and feel comfortable in answering them.

Chapter 3

Study III: Translation, Adaptation and Validation of Dialectical Behavior Therapy (DBT) Adolescence Manual

Study III focused on translation and validation of DBT Adolescence manual into Urdu Language establishing its validity and assessment of its effectiveness by administering on juvenile delinquent therefore it was divided into following phases.

Phase I: Translation of the DBT Adolescence manual into Urdu language

Phase II: Adaptation and cross language validation of the DBT Adolescence manual

Phase III: Effectiveness of Urdu translation of the DBT Adolescence manual for juvenile delinquents (n=14)

Phase I: Translation of the DBT Adolescence manual into Urdu language

Objective

2. To translate & adapt the DBT Adolescence manual into Urdu language.

Instruments

The following DBT Adolescence manual was used for the present research.

Dialectical Behavior Therapy (DBT)

DBT was designed to treat individuals of all levels of severity (Linehan & Dimeff, 2001). There are four stages to DBT treatment, each with a unique set of objectives. Moving from behavioral dyscontrol to behavioral control is the primary objective of stage 1 DBT. Stage 1 behaviors include attempts at suicide, cutting, substance misuse, and disordered eating. The second stage of DBT aims to lessen the suffering brought on by negative emotions. Although patients have learned a lot about their emotions and how to control them in Stage 1, they commonly still experience emotional symptoms as a result of lingering effects from prior trauma.

According to Linehan (1993), stage 2 clients live silent lives of desperation. The aim of stage 2 DBT is to increase non-traumatic emotional experiencing while treating PTSD symptoms and emotional avoidance. Stage 3 DBT aims to treat problems associated with typical happiness and dissatisfaction. To help their clients develop a life and deal with everyday problems as they emerge (such as finding happy relationships or career problems), therapists use problem solving, validation, and a dialectical framework. The fourth stage is self-actualization. Stage 4 may include therapy, spiritual guidance, or activities like yoga or mindfulness that foster and strengthen feelings of joy. It should be emphasized that stage 1 DBT is described in the majority of available DBT literature.

Before starting any level of DBT, clients are regarded as being in the pre-treatment phase (Manning, 2006). Several events must take place in order to go from pretreatment to stage one DBT: 1) The client must be educated about the biosocial theory and how it relates to their personal history; 2) The therapist assists the client in choosing treatment objectives that are consistent with their idea of a life worth living; 3) The therapist and client must clearly define any agreements (such as the length of treatment, to work on the treatment relationship when necessary), and most importantly, the client must agree to work on preventing suicide and self-harm; and 4) The client must be an original client.

The incapacity to feel emotions is the main dialectical conflict that exists in the lives of those undergoing stage 1 DBT. People with BPD have discovered that intense emotions cause them to make decisions they subsequently regret. Similar to this, many people have heard that they act too emotionally and dramatically and that they should just cool down. The phenomena of feeling as though one's own emotions are out of control, debilitating, and hazardous is referred to as emotional vulnerability. This experience typically supports dysfunctional habits that people

use to escape or avoid unpleasant emotions (for example, cutting occurs regularly when melancholy is felt to be intolerable). Self-invalidation, which entails disregarding or downplaying feelings, is the reverse of this increased awareness of and sensitivity to emotions (for example, "everyone has problems, I just need to deal with them.") Often people may bounce between these two extremes, unable experience or tolerate emotions.

Mindfulness is a universal experience, but a corrective example may be to listen without attachment or judgment to the sound of a door closing or a set of keys clicking. Examples of distress tolerance frequently highlight the suffering caused by loneliness, challenging family phone calls, or missed visits. Inmates serving lengthy sentences, those who obtain unfavorable court rulings, and those who will spend the rest of their lives behind bars can benefit from radical acceptance, which is the decision to accept a terrible circumstance and one's thoughts about it through body posture and breath. Developing distress tolerance techniques to prevent acting on obsessions or getting bogged down in thoughts (Rosenfeld et al., 2007). To address affective blunting/shutting down as well as conventional emotional lability, we updated emotion management skills. For those with high levels of psychopathic tendencies, modifications have been made, and abilities for boring and manipulating typical emotional experiences have been established (Galietta & Rosenfeld, 2012). Interpersonal effectiveness skills activities to include ones for developing values, real apologies, and resisting the impulse to take advantage of others. In the examples we use for interpersonal effectiveness, issues with authority play a significant role. Prisoners frequently struggle with the conflict between progressing toward their own objectives by avoiding conflict and feeling pressured to engage in combat in order to maintain their dignity or avoid "getting punked." In our model and the majority of correctional DBT

models, additional skills aimed at countering antisocial beliefs—such as "suckers deserve to get taken advantage of"—are present.

In this step Translation of the DBT Adolescence manual were carried out, to determine the juveniles' intervention. Translation method of the scales would be completed in four steps.

Translation

For the translation of the scales the DBT Adolescence manual, five specialists who were fluent in both Urdu and English were contacted. The experts gave brief explanations of the research's factors and goals. Among them two were graduates of International Islamic University, three professional psychologists were chosen. Experts were asked to use concise and straightforward language translation in Urdu and to have an emphasis on conceptual rather than literal translation. The final Urdu translation that is most appropriate has been chosen.

Committee Approach

A committee of five experts (n=5) was formulated to choose the best translation for each item as experts translated the DBT Adolescence manual. This committee was made up of the study's supervisor, clinical psychologists (n = 2), counselors (n = 2), and the researcher herself from the International Islamic University in Islamabad, Bahria University Islamabad and the University of Faisalabad. Each item on the translated the DBT Adolescence manual was thoroughly examined by all committee members for both language use and consistency with the original content. Best Urdu translation was chosen by the experts.

Back Translation

Three specialists (n = 3), from the Department of English of International Islamic University Islamabad (n = 1) and Federal College of Islamabad (n = 2) translated these Urdu translation of the DBT manual into English in order to ensure the DBT Adolescence manual

accuracy. These specialists were native English speakers who had not participated in the translation of the DBT Adolescence manual in the past, thus they were unfamiliar with the vocabulary and grammar of the DBT Adolescence manual 's original English form.

Committee Approach of Back translation

Bilingual specialists (n = 4) were brought together for a group discussion to evaluate the back translation items and choose the best ones. The committee was made up of the study's supervisor, lecturers in Psychology (n = 2) International Islamic University Islamabad, Assistant Professors in the Department of Psychology (n = 2) Bahria University in Islamabad, and the researcher herself from the International Islamic University. All of the committee members agreed that the translated items conveyed the same meaning as the original items or a meaning very similar to it, hence no item needed to be modified in the committee approach of back translation.

Phase II: Adaptation and cross language validation of the DBT Adolescence manual

Objective

1. To determine the cross language validation of Urdu Translation of the DBT Adolescence manual

Sample

For the present study Cross language Validation of the DBT Adolescence manual a sample of (n=2) two clinical psychologists were taken. On psychologist was working in Benazir Bhutto hospital Rawalpindi as clinical psychologist and other one is working as lecturer and wellbeing psychologist in Bariha University Islamabad.

Procedure

For cross language validation of the DBT Adolescence manual was given to two clinical psychologists. They read English and Urdu version both and gave report for its validity, Urdu Translation of the DBT Adolescence manual.

Phase III: Effectiveness of Urdu translation of the DBT Adolescence manual for juvenile delinquents (n=14)

Objective

1. To find out the efficacy of DBT Adolescence manual Urdu version for juveniles in Pakistani jails.

Hypotheses

1. Post scores of Juvenile Delinquents will be low on Frustration discomfort and Common Mental Disorders as compared to their pre scores, after administration of interventions based on DBT Adolescence manual Urdu version.

Sample

The research sample for intervention was comprised of (n=14) male juveniles, who scored moderate to high on FDS and CMDQ. Their age range was from 13-18 years. And their releasing time from the jail was 8 to 6 months.

Operational Definition

Juvenile Delinquency

Generally, anyone who commits a crime or who violates a legal code is called as juvenile. The defining age group juvenile delinquents, is set by local legal statue (typically around 13 to 18 years). Delinquency is a heterogeneous concept, including behaviors as diverse as theft, burglary, robbery, vandalism, violence against persons, drug use, and various kinds of heterosexual and homosexual acts (Farrington, 1992).

According to the current study, juvenile offenders (aged 13 to 18) who commit delinquent acts include selling illicit narcotics, possessing illegal weapons, committing violent crimes against people, or stealing property (Federal Bureau of Investigation, Washington, 2007).

Frustration discomfort

Frustration discomfort is the ability to withstand obstacles and stressful situations. Decreased frustration tolerance among people with stressful life spans frequently exhibit problems with their tolerance. Aggression, impatience, liability, and disinterest are some behavioral signs. Low tolerance for dissatisfaction is a result of erroneous beliefs that have been formed on a personal level (Harrington, 2007).

Common Mental Disorders

Mental disorder**,** any illness with significant psychological or behavioral manifestations that is associated with either a painful or distressing symptom or an impairment in one or more important areas of functioning (APA, 2013).

Instrument

The Frustration Discomfort Scale (FDS)

The 28-item frustration discomfort scale (FDS) (Harrington, 2005a) has four subscales of 7 items each: achievement frustration, entitlement, emotional intolerance, and discomfort intolerance. Alpha coefficients of the subscales ranged from 0.84 to 0.88. On a 5-point Likert-type scale, subjects were asked to score the strength of a belief using the following scoring: Absent (1), mild (2), moderate (3), strong (4), and extremely strong (5).

Common Mental Disorders Questionnaire (CMDQ)

The 38-item questionnaire was created by Christensen, Fink, Toft, Frostholm, Ornbl, and Olesen in 2005 to assist general practitioners in evaluating the mental health of their patients. There are six subscales. The somatization 12-item SCL-SOM subscale measures somatic distress on a scale of 1 to 12. The Anxiety ($SCL\text{-}ANX_4$) subscale measures anxiety with 4 items (items 21–24). The seven-item emotional psychiatric disorders (SCL-8) subscale (22-29) is used to

assess emotional disorders, while the Depression (SCl-DEF_6), which has six items (28-33), is used to assess depression. The two remaining CMDQ subscales, Illness worry and conviction(Whiteley-7) (8 items) and Narcotic abuse and dependence (CAGE, 4 items) measure Narcotic misuse and sickness concern in items 13 through 20 and 34 through 37, respectively.

Responses to CMD-SQ items 1 through 33 were graded on a five-point Likert scale, where 0 corresponded to no symptoms at all, 1 to a few, and 2 to a lot Indicators range from 0 for no symptoms at all to 1 for a small amount, 2 for moderately, 3 for quite a deal, and 4 for extremely. Answers were needed to be dichotomized yes/no on the Narcotic abuse and dependence scale (items 34–37). The patients graded their own general health on the final item, number 38, using a Likert scale with five possible outcomes: Excellent (5 points), Very Good, Good, Fair, and Poor (1 point).

DBT Adolescence Manual (Urdu version)

DBT Adolescence Manual Urdu version was used for the present research. Which consisted of techniques related to Mindfulness, emotion regulation, interpersonal effectiveness and distress tolerance skills, which were drawn from the first edition of the DBT group skills training manual (Linehan, 1993b). The modules were administered in the following sequence:

Mindfulness (2 Sessions): Mindfulness is a core component of DBT, it was covered first. In this sessions discussion regarding confidentiality, program objectives, group member objectives, and other topics were covered during the first meeting. Through the mindfulness module, participants learned strategies for increasing awareness of thoughts, emotions, physical sensations, and activities while avoiding judgment or criticism. With the aid of mindfulness, participants discovered how to identify and classify their present-day emotions.

Emotion Regulation (2 Sessions). By employing emotion regulation strategies, participants try to learn fresh and effective ways to manage strong emotions. The participants gained knowledge on emotional recognition and classification, the purpose of these two sessions were to minimize their sensitivity to strong negative emotions and how to enhance positive feelings, and how to control emotional cravings. Another strategy for addressing emotion avoidance was to teach people to pay attention to their current emotional state.

Distress Tolerance (2 Sessions). Developing distress tolerance skills it helps people to control impulsive conduct that may be caused by an inability to control intense emotions. Through the growth of distress tolerance skills, participants gain coping strategies for tolerating suffering and accepting life as it is in the moment. Participants were taught how to spot the signs of suicidal ideation in addition to crisis-management skills such defusing situations, self-soothing, enhancing the present, and truth acceptance.

Interpersonal Effectiveness (2 Sessions). The goals of interpersonal effectiveness include getting people to accept others opinions, carry out others requests, and fulfill their commitments. The objective is to stop toxic or dysfunctional relationships while also fostering meaningful new connections. Establishing and maintaining equilibrium in relationships is essential, as is striking a balance between change and acceptance. Effective interpersonal abilities must be learned as they are not innate. Emotions often make it difficult to form lasting bonds. Our automatic negative thoughts about ourselves might occasionally make it difficult to start new relationships or end problematic ones.

DBT Adolescence Treatment Stages. There are four stages of DBT. The intensity of the juvenile's actions define the stages, and therapists work with their clients to achieve the objectives of each stage in their progression toward leading a life they believe is worthwhile.

• The juvenile is in Stage 1 when their conduct is out of control and they are miserable. They may try to injure themselves, self-harm, use drugs and Narcotic, or engage in other self-destructive behaviors. When juveniles initially begin DBT therapy, they frequently compare their situation to "being in hell." The objective of Stage 1 is for the juvenile to transition from an uncontrolled state to one of behavioral control.

• In Stage 2, juveniles are in control of their behavior, they are still in pain, often as a result of past trauma and invalidation. They are also experiencing quiet desperation. Juveniles have limited sensory perception. The objective of Stage 2 is to assist the juveniles in moving from a state of quiet desperation to full emotional experiencing.

• Learning how to live, including how to set life objectives, grow in self-respect, and find serenity and satisfaction, is challenging in Stage 3. Regular happiness and misery in the juvenile's life are anticipated.

Procedure

14 juveniles of the treatment group were given DBT interventions. Brief information and introduction was given to the participants about the study, and their consent was obtained for the participation in this study. The respondents were instructed regarding the interventions. Therapist requested to follow and take proper time for the sessions. Each session was in group and duration of the session was 40 minutes. Feedback was obtained in the start of all sessions about the previous session and homework assignments. At completion of DBT intervention, post assessment of study variables was done and a 3-month follow-up assessment for the measuring the effectiveness of DBT for juvenile delinquents.

Results

Table 36

Frequency distribution of juveniles delinquents in intervention study (n=14)

	f	%age
Nature of Crime		
Murder	8	57
Drug smuggling	4	28
Kidnapping	1	7
Terrorism	1	7
Family history of jail		
Father in jail (murder)	2	14
Brother in jail	1	7
First uncle in jail	1	7
Parents marital status		
Broken family (divorced)	3	21
Father died in dispute	2	14
Father died before birth	1	7
Education		
FA	5	35
Matric	6	42
9^{th} standard	3	21

Table 36 shows frequency distribution of 14 juveniles who took intervention. Among them eight committed murder, four were involved in drug smuggling, one was involved in kidnapping a child and one was involved in terrorism. Two Juveniles have the history of criminal father and one

juvenile's brother was in jail because of street crimes, whereas one juvenile's uncle has the history of one year imprisonment because of theft. Three juveniles belonged to broken families by divorce and one juvenile father was shot dead in agricultural dispute in village. And father of one juvenile passed away before his birth. Five juveniles done FA, six have completed their matric and three were in 9th standard in jail school.

Table 37

Comparison of pre-intervention and post intervention of juvenile delinquents on Common Mental Disorder Questionnaire (CMDQ), Frustration Discomfort Scale (FDS) scales

Variables		Groups								Cohen's d
		Pre intervention (n = 14)		Post intervention (n = 14)				95% Confidence Interval		
	k	M	SD	M	SD	t	p	Lower	Upper	
CMDQ	38	47.00	43.30	14.43	14.08	3.87	.002	14.37	50.76	1.01
FDS	28	107.57	31.30	22.93	6.72	11.43	.000	68.64	100.63	3.73

The above table 37 shows the comparison of two groups: pre-intervention and post intervention of juveniles, for the scale of CMDQ, FDS. The result shows that the mean value of CMD Pre intervention score is 47.00 and post intervention 14.43 with standard deviation 43.30 and 14.08 respectively, it indicates that in post intervention the score of CMDQ decrease as compared to Pre intervention. Mean values of both tests had a difference of 32.57, which is very big. In the column under the *p* value label, the significance value of paired sample t-test is given. The pre- intervention and post intervention of juveniles for CMDQ show significance $p \leq .05$, it is p=.002. This value indicates that there is a significant difference between pre- intervention and post intervention of juveniles.

The result further shows that the mean value of FDS Pre intervention score is 107.57 and Post intervention 22.93 with standard deviation 31.30 and 6.72 respectively, it indicates that in Post intervention the score of FDS decrease as compared to Pre intervention. Mean values of both tests had a difference of 84.64. The pre- intervention and post intervention of juveniles for FDS has $p \leq .05$, it is p=.000.

Table 38

Comparison of pre- intervention and post intervention scores of juveniles on Common Mental Disorder Questionnaire sub-scales

Variables		Groups								Cohen's d
		Pre intervention (n = 14)		Post intervention (n = 14)				95% Confidence Interval		
	k	M	SD	M	SD	t	p	Lower	Upper	
Somatization	12	10.21	15.86	4.86	7.89	2.45	.029	.63	10.07	.42
Anxiety	4	6.64	5.53	4.60	4.25	2.88	.013	.66	4.62	.41
Emotional disorder	7	15.14	12.89	7.71	5.28	3.43	.004	2.76	12.09	.75
Depression	6	8.57	9.16	5.07	5.01	3.52	.004	1.35	5.64	.47
Alcohol abuse and dependence	4	8.14	5.61	3.43	1.12	2.69	.018	.95	8.43	1.16
Illness worry and conviction	8	4.50	3.03	2.71	1.67	3.70	.003	.74	2.88	.73

The above table 38 shows the comparison of two groups: pre- intervention and post intervention of juveniles, for the scale of Common Mental Disorders questionnaires sub-scales. The result shows that the mean value of Somatization Pre intervention score is 10.21 and post intervention 4.86 with standard deviation 15.86 and 7.88 respectively, it indicates that in post intervention the score of Somatization decrease as compared to Pre intervention. The *p* value label, the significance value of paired sample t-test is given. The pre- intervention and post intervention of juveniles for Somatization show significance $p \leq .05$, it is p=.029. This value

indicates that there is a significant difference between pre- intervention and post intervention of juveniles.

The result further shows that the mean value of anxiety on the scores of juveniles, in Pre intervention is 6.64 and Post intervention 4.00 with standard deviation 5.53 and 4.25, respectively. It indicates that in Post intervention the score of Anxiety decrease as compared to Pre intervention. The pre- intervention and post intervention of juveniles $p \leq .05$, it is p=.013.

The result also shows that the mean value of Emotional disorder Pre intervention score is 15.14 and Post intervention 7.71 with standard deviation 12.89 and 5.28 respectively, it indicates that in Pre intervention the score of Emotional disorder decreases as compared to Post intervention. The pre- intervention and post intervention of juveniles for Emotional disorder shows significant on $p \leq .05$, it is p=.004.

The result also shows that the mean value of Depression Pre intervention score is 8.57 and Post intervention 5.07 with standard deviation 8.16 and 5.01 respectively, it indicates that in Pre intervention the score of Depression decreases as compared to Post intervention. The pre-intervention and post intervention of juveniles for Emotional disorder shows significant on $p \leq .05$, it is p=.004.

The result also shows that the mean value of Narcotic abuse and dependence Pre intervention score is 8.14 and Post intervention 3.43 with standard deviation 5.61 and 1.12 respectively, it indicates that in Pre intervention the score of Narcotic abuse decreases as compared to Post intervention. The pre- intervention and post intervention of juveniles for Emotional disorder shows significant on $p \leq .05$, it is p=.018.

The result also shows that the mean value of Illness worry and conviction, which indicates the common health anxiety, Pre intervention score, is 4.50 and Post intervention 2.71

with standard deviation 3.03 and 1.67 respectively; it indicates that in Pre intervention the score of Narcotic abuse decreases as compared to Post intervention. The pre- intervention and post intervention of juveniles for Emotional disorder shows significant on $p \leq .05$, it is p=.003.

Table 39

Comparison of pre- intervention and post intervention scores of juveniles on Frustration Discomfort sub-scales

Variables	Groups									Cohen's d
		Pre intervention (n = 14)		Post intervention (n = 14)				95% Confidence Interval		
	k	M	SD	M	SD	t	p	Lower	Upper	
Discomfort intolerance	7	28.07	9.09	14.71	5.23	11.60	.000	10.87	15.84	1.80
Entitlement	7	27.57	6.74	12.57	4.76	11.07	.000	12.07	17.92	.03
Achievement	7	25.14	8.08	11.07	2.70	8.58	.000	10.53	17.61	2.33
Emotional intolerance	7	27.07	9.20	10.07	3.36	10.07	.000	13.35	20.64	2.45

The above table 39 shows the comparison of two groups: pre- intervention and post intervention of juveniles, of Frustration Discomfort sub-scales. The result shows that the mean value of Discomfort intolerance Pre intervention score is 28.07 and post intervention 14.71 with standard deviation 9.09 and 5.23 respectively, it indicates that in post intervention the score of Discomfort intolerance decrease as compared to Pre intervention. In the column under the *p* value label, the significance value of paired sample t-test 11.60 is given. The pre- intervention and post intervention of juveniles for Discomfort intolerance show significance $p \leq .05$, it is p=.000. This value indicates that there is a significant difference between pre- intervention and post intervention of juveniles.

The result further shows that the mean value of Entitlement Pre intervention score is 27.57 and Post intervention 12.57 with standard deviation 6.74 and 4.76 respectively, it indicates

that in Post intervention the score of Entitlement decrease as compared to Pre intervention. The pre- intervention and post intervention of juveniles for Entitlement has $p \leq .05$, it is p=.000, with t values 11.07.

The result also shows that the mean value of Achievement Pre intervention score is 25.14 and Post intervention 11.07 with standard deviation 8.08 and 2.70 respectively, it indicates that in Pre intervention the score of Achievement decreases as compared to Post intervention. The pre- intervention and post intervention of juveniles for Achievement shows significant on $p \leq .05$, it is p=.000, with t value 8.58.

The result also shows that the mean value of Emotional intolerance Pre intervention score is 27.07 and Post intervention 10.07 with standard deviation 9.20 and 3.36 respectively, it indicates that in Pre intervention the score of Emotional intolerance decreases as compared to Post intervention. The pre- intervention and post intervention of juveniles for Emotional intolerance shows significant on $p \leq .05$, it is p=.000, with t value 10.07.

Discussion

The research aimed to explore the Impact of Family Functioning and Frustration Discomfort on Common Mental Disorders among Juvenile Delinquents: Efficacy of Dialectical Behavior Therapy. In the present study, the researcher translated dialectical behavior therapy manual adolescent into Urdu language and applied it on 14 juvenile delinquents in the jail settings. The role of family variables and their relation to delinquency is common to many criminological theories. The families which are very supportive and strong and have both parents at home can make the risk of delinquency less whereas the families that are unstable, neglectful, weak, abusive and unsupportive can increase the risk of delinquency (Church, Wharton & Taylor, 2009). It is estimated that around 20% of juveniles have serious mental disorders. They are referred as emotionally disturbed, getting frustrated. They are prone to commit any crime of particular type (Torbati, 2020).

In Pakistan, DBT based intervention proved helpful juveniles for reduction of their unhelpful behaviors. It helped in six ways, accepting circumstances and make changes, review behaviors and learn healthy patterns of responding, change maladaptive, negative and unhelpful thoughts, develop collaboration skills, receive support. The dialectical behavior therapy manual of adolescent Urdu version proved useful and effective for juveniles for reducing symptoms of common mental health disorders and frustration discomfort and helping to manage them.

According to the findings post intervention scores on CMD decreased as compared to pre intervention scores of juvenile delinquents (n=14). The results further showed that after application of DBT based intervention, the scores of Frustration Discomfort decreased in juvenile delinquents pre scores (table 36).

In table 37, subscales of Common Mental Disorder Questionnaire were taken and the comparison of pre and post intervention assessment scores of juveniles was observed. Dialectical Behavior Therapy (Urdu Version) was administered on 14 juveniles for managing variables somatization, anxiety, emotional disorder, depression, Narcotic abuse and illness and worry. Results indicated significant decreased on somatization because its score decreased in post- score as compared to pre- score. There was a significant positive difference among pre scores and post scores of juveniles. Post score of anxiety decreased in comparison to pre score. The research findings further showed that emotional disorder score also decreased in juveniles. Due to dialectical behavior therapy (Urdu Version) techniques of mindfulness and emotional regulation, symptoms of somatization, anxiety and emotional disorder decreased in juveniles.

An earlier study with 3 months to one-year follow-up looked at dialectical behavior treatment for adolescents exhibiting suicidal and self-destructive behavior as well as borderline symptoms. For a 16–24 week outpatient treatment in a German speaking region, Rathus and Miller (2012)'s modified version of DBT for teenagers for the rehabilitation. The effectiveness of the treatment was assessed using a pretest/posttest comparison and a one-year follow-up using standardized instruments.

Researchers also explored the reduction in frustration discomfort and its factors, which was also consistent with previous studies involving DBT or similar interventions. That strengthens the evidence for the therapy's effectiveness in addressing these specific concerns. For instance, previous research by Frazier and Vela (2014) supported the idea that DBT is effective in reducing frustration and discomfort. That improved coping mechanisms during challenging situations. As DBT's emphasis on distress tolerance and emotion regulation skills training played a significant role in these positive outcomes. These were also aligned with findings from other

studies where DBT had been applied to various populations and shown positive outcomes in managing emotional distress and improving overall well-being (Crossland et al., 2017; Zalewski et al., 2018). Additionally, the observed decrease in mean values from pre-test to post-test and follow-up was seen as evidence of the treatment's impact over time. That showed that psychological interventions often lead to incremental improvements that become more apparent in the post-treatment period and persist in the follow-up phase (Waitz et al., 2021).

According to a study (Schulz, 2011), 53% of inmates who committed crimes met five or more DSM-IV borderline personality disorder criteria. Between the beginning of the therapy and one year after its conclusion, the mean value of the diagnostic criterion significantly dropped from 5.8 to 2.75. 75% of patients were continued in treatment. The effect sizes identified with SCL-90-R and YSR ranged from 0.54 to 2.14. During treatment, non-suicidal self-harming behavior drastically decreased. Before beginning therapy, 8 to 12 patients had made an attempt on their lives. The findings further showed that from the start of therapy to the one-year follow-up, all interventions were well received by the patients and were associated with improvements in a number of areas, including suicidality, emotional deregulation, non-suicidal self-injurious behavior, and depression .

An earlier study explored how well adolescents with clinical signs might control their anger and regulates their emotions using dialectical behavior therapy. The study had a control group that was not equivalent and a quasi-experimental pretest-posttest design. A sample of 24 young people was carefully chosen for the study. Participants were split into experimental and control groups at random. The experimental group participated in ten sessions of group therapy with juvenile delinquents in the jail environment. The State-trait Anger Expression Inventory and the Cognitive Emotional Regulation Questionnaire were used in the previous studies. During the

pretest and posttest phases, the respondents gave their answers to the questions. According to the study's findings, dialectical behavior therapy significantly affects clinical symptoms, as well as anger management and its components as well as emotional regulation and its components (Hassan, 2017).

In Table 38, Frustration Discomfort Scale and its sub-scales were used to see the comparison of pre intervention and post-intervention of 14 juvenile delinquents. The variables were discomfort intolerance, entitlement achievement and emotional intolerance. In the conclusion, it was determined that in post-intervention the discomfort intolerance score decreased as compared to pre-intervention with the help of emotional regulation techniques of DBT (Urdu Version). Paired sample t test was conducted; it was observed that there was a significant difference between pre and post scores of juveniles. Furthermore, the mean values of 14 juvenile delinquents on Entitlement pre scores and post scores showed that the Entitlement score decreased in comparison to pre scores.

The impact of Dialectical Behavior therapy and emotional regulation on distress tolerance and suicide ideation disorder among adolescents juveniles. Using purposive sampling method 45 juveniles were selected and randomly assigned into two groups experimental and control. For data collection Distress Tolerance scale and Suicide Ideation Scale was used. With a control group, the experimental investigation was carried out using a pretest, posttest, and follow-up design. While the control group received no instruction, the experimental group underwent 12 sessions of dialectical behavior therapy and 8 sessions of emotional regulation training. The findings demonstrated that dialectical behavior therapy and emotional regulation training were considerably effective in reducing suicidal ideation and increasing distress tolerance in young people (Kashani, 2020).

Meanwhile, emotional intolerance, a common concern among juveniles, was another aspect addressed by DBT. The study's findings suggested that DBT can reduce emotional intolerance by assisting adolescents in learning how to regulate their emotions (Jørgensen et al., 2021). Adolescents who learned how to recognize, comprehend, and effectively communicate their feelings were better able to handle emotional difficulties (Huntley et al., 2018). DBT also targeted entitlement, a negative attitude characterized by exaggerated expectations for special treatment (Diamond et al., 2021). DBT taught how to communicate assertively without reverting to entitled behaviors by using interpersonal effectiveness skills (Linehan, 2014). DBT thus demonstrated promise in lowering entitlement attitudes and encouraging better communication styles (Miller et al., 2002).

Shelton et al. (2011) claimed that DBT addressed adolescent achievement frustration in addition to emotional difficulties. This type of irritation is brought on by a lack of ability to deal with failures and setbacks. Distress tolerance and mindfulness techniques used in DBT helped developing resilience and a more balanced view of successes and failures, which decreased accomplishment and frustration. Additionally, DBT therapies focus on regulating discomfort intolerance by emphasizing distress tolerance (Rezaie et al., 2021). According to the research, DBT assisted people in raising their threshold for upsetting feelings or circumstances, which reduced discomfort intolerance. Adolescents who received DBT consequently displayed enhanced capacities to successfully manage anguish and discomfort (McMain et al., 2001).

According to Nelson-Gray et al. (2006), DBT has also been successful at improving the emotional control abilities of young participants. Teenagers grew more skilled at handling disagreements and having more positive interactions with family members as they improved their emotional regulation. Therefore, this increase in emotional control resulted in a more

supportive and peaceful home situation (Grandey, 2000). DBT helps adolescents and their families deal with difficult situations more skillfully by treating emotional dysregulation and teaching coping mechanisms (Linehan, 2014). As a result, there were fewer conflicts in the family as a whole, which encouraged more pleasant interactions and strengthened family ties (Welch & Kim, 2012).

In conclusion, it is clear that Pakistan's juvenile justice system draws attention to the urgent issues brought on by discriminatory incidents and the failure to enforce the law. Numerous contributing variables have been discovered by the research, including socioeconomic inequality, inadequate coordination, a lack of legal understanding, and inadequate resource allocation. Juvenile offenders encounter additional challenges due to discrimination based on a variety of criteria. In order to create a fair and efficient juvenile justice system in Pakistan, several issues must be resolved. The suggestions made provide a path forward for addressing the problems found. Important issues that need focus include enhancing legal knowledge, allocating resources more effectively, creating coordination systems, and preventing prejudice. Positive systemic improvements can also be facilitated by strengthening monitoring and assessment procedures, encouraging restorative justice strategies, and involving non-governmental organisations and civil society.

Additionally, McCay et al. (2017) and Groves et al. (2012), dialectical behavior therapy (DBT) has a proven track record of effectively addressing adolescent mental health issues. DBT has been demonstrated to lessen emotional dysregulation and anxiety, with long-term improvements seen during follow-up exams (Fleischhaker et al., 2011). Additionally, it helps young people who are depressed or abusing drugs (Ritschel et al., 2015). Data on DBT's effects on Illness worry and conviction disorders and somatic ailments in teenagers, however, are scant, which calls for more study. In sum up, DBT has the potential to significantly improve teenage mental health disorders, but more thorough research is needed to ascertain its effectiveness

among juveniles.

Limitations and Suggestions

- The present study only included those juvenile delinquents who were there in the jail environment and only male sample was taken for intervention. In future studies can be planned in which the male and female sample can be studied. This will strengthen the reliability and validity of Urdu translated version of DBT for Pakistan juveniles in the jail.
- Sample size was limited to 14 male juveniles from 2 cities future researchers should take the larger sample from all over the Pakistan Barstool jails for generalizing the findings of Urdu translation DBT.
- The present intervention was conducted in the jail environment and limited time slots were allowed by jail administration. In future intervention based studies can be planned with juvenile delinquents after completion of their imprisonment.
- It was also observed that the environment of Pakistani jails were not so conducive for psychological interventions for the juveniles. It is need of time that in Pakistan there should be rehabilitation centers in the barstool jails for the rehabilitation of Pakistani juveniles, so that after releasing from jail they become good citizens for the society.

Implications of study

The Urdu translated version of the DBT adolescence manual can be used across Pakistani juvenile population for future further researches as Urdu is mother tongue of Pakistan. Most of the juveniles in the jails of Pakistan are not highly educated, so they can easily understand. In future researcher in Pakistani jails can use DBT adolescence manual (Urdu version) for management of common mental disorders and frustration discomfort of juveniles, criminals or offenders.

Conclusion

In the study Dialectical behavior therapy manual (Urdu version) was used on participants included 14 juveniles from the jail environment with moderate to high scores of Frustration Discomfort and Common Mental Disorders. The researcher translated Dialectical Behavior Therapy into Urdu and Urdu version was applied on juveniles in jail of Pakistan for the first time. The 12-week DBT intervention included weekly therapy sessions and used a supportive therapeutic approach with the aim of reducing present problems for juvenile delinquents in Pakistani prisons. Prior to and after therapy, participants were assessed using Frustration Discomfort, and Common Mental Disorders questionnaire. This study showed that DBT (Urdu version) based intervention in a condensed 12-week sessions, was helpful for Pakistani juveniles in reducing symptoms of common mental disorders. Following the trial for six months, the intervention group's scores significantly decreased.

Summary of intervention sessions for juveniles (n=14)

DBT adolescents manual (Urdu Version) was administrated in Pakistani jails. There was no previous research assessing the effectiveness of DBT with juveniles in forensic settings in Pakistan. During the session already appointed teacher in the jail helped a lot. Researcher could not visit the jail continuously during the session break of 15 days because of permission issues. Following were the session details of DBT.

Session 1: History taking and description of DBT

The focus of the first session was Rapport building and explaining DBT (Urdu version) counseling program to the juveniles. Rapport building was done through active listening from the juveniles. The purpose of this session was described to juveniles after brief histories were taken that this session was creating comfortable environment between juveniles and the researcher. History taking revealed that most of the juveniles were scores low on family functioning, high on frustration discomfort and common mental disorders as well. Among those 14 juveniles eight committed murder, four were involved in drug smuggling, one was involved in kidnapping a child and one was involved in terrorism. All belonged to low socio-economic class. Two Juveniles have the history of criminal father and one juvenile's brother was in jail because of street crimes, whereas one juvenile's uncle has the history of one year imprisonment because of theft. Three juveniles belonged to broken families by divorce and one juvenile father was shot dead in agricultural dispute in village. And father of one juvenile passed away before his birth. Five juveniles done FA, six have completed their matric and three were in 9th standard in jail school. All juveniles' releasing time was 8 or less than 7 months. All were willing to take DBT sessions and they efficiently completed all the DBT task sheets. Following table show their maladaptive behaviors,

Table 40

Age, gender, crime and maladaptive behaviors of juveniles (n=14)

Participant Assumed no	**Age**	**Gender**	**Crime**	**Maladaptive Behaviors**
Juvenile 1,3,9,13,10,12	17	Male	Murder, drug smuggling	Suicide attempt, cutting, substance use, hitting
Juvenile 2,7,	14	Male	Kidnapping,	Physical aggression, high risk behaviors, Cutting, burning
Juvenile 4,5,8,14	17	Male	Murder	Substance use, depressed
Juvenile 6,11	16	Male	terrorism	Cutting, suicide attempt

Session 2: Description of DBT based intervention program to juvenile Participants

In the start of 2nd session first of all the therapeutic relationship of the researcher was described each juvenile participate in this study, so that they identified their relationship with their specific researcher as a key component of their DBT experience. The therapy relationship was commended by participants as "meaningful," "helpful," "good to have someone to trust," "liked that he was always there," "I felt cared for," and "someone who actually didn't judge me for all my messups." This result was consistent with DBT's emphasis on the importance of a strong therapeutic connection in providing juveniles with successful therapy.

In the 2nd session researcher described all juveniles about the DBT Urdu translation exercise and the manual task sheets. Researcher also gave them surety that all their conversation would be kept confidential and not described to others by their own identity. Juveniles were told

by the researcher that the weekly skills covered each of the DBT modules: Mindfulness, Emotional Regulation, Distress Tolerance, Interpersonal Effectiveness, and the Middle Path. The researcher has already received 40 credit hours of DBT training prior to application of intervention told juvenile that active and honest participation would affect their behavior positively. Protocols were followed regarding their problems and after the completion of the 12-week program, juvenile were offered a chance to repeat the program if extra practice with the skills was needed.

First all, as a researcher asked about their information, a brief family history, social and psychological history, and conducted behavioral observations. It was debriefed by the researcher to juveniles with each of the therapy module of DBT (Urdu version) (Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness, and Middle Path).

Time of every session was 45 minutes, in the last 10 minutes skills were introduced and sheets were filled by the participants. Participants were guided about paying concentration during sessions and participate actively having direct communication with researcher.. Honestly filled the sheets and sheets were already translated into Urdu so that every juvenile could understand that easily. And activities were done on daily basis as homework assignments as described by the researcher during the session. If some juveniles could not understand any of the task or sheet they were allowed to ask freely and directly with the researcher during or in the end of session day.

Session 3: Session 3 was started with the general communication with the juveniles and debriefing about the DBT manual was carried out. Researcher described them about significance of participation in the therapy sessions and it will prove beneficial for behavior modification of juveniles.

The focus of session 3 was on first 7 handouts which consisted on orientation of DBT, all were in Urdu. These were what Dialectical Behavior therapy (DBT) is? It's all related on the aims and purpose of getting DBT and what is the meaning of Dialectical. Goals of skill training, It's about the problem decreasing and good behaviors to increase among the participates. DBT skills training group format which described the 5 main techniques Biosocial theory gave information about the society and environment that juveniles felt, think or sense.

In the end of session therapist asked from the juveniles if there was anything which could not understand and repeated by the therapist before next session. But fortunately no one asked any question.

Session 4: Before starting new technique therapist took feedback of the previous session, which was held a week before. Researcher asked from juveniles to clarify if there is any ambiguity. All juveniles were replied positively and showed willingness to learn and wanted modify themselves. Researcher told them about the Mindfulness in this session. In the start of this session, therapist introduced what is mindfulness through the reading of handouts 1, 2 and 7, which was in Urdu. Therapists also described them if they faced any difficulty to read and understand. After this juveniles were asked to do formal mindfulness practices, which has following steps,

• Counting your breaths. While quietly sitting, count to "one" and take a deep breath in. Then, "two" and let the breath out slowly. Then, "three" and let the breath out slowly.

• Listening to sounds. Sit in stillness and pay close attention to any sounds you can hear, such as your own breathing or the sound of air flowing through vents or fans, etc.

• Looking at something. Pick up something, such a piece of paper or a bird, and pay close attention to it. Use all of your senses to examine the item while concentrating all of your concentration on it.

• Observing Clouds are watching your thoughts. Imagine you resting in a grassy meadow and gazing up at the clouds. Every cloud contains an idea. Consider the thought as it slowly passes by and describe the type of thought it is.

• Concentrating on an idea. Select a meaningful word or a brief phrase to concentrate on, and then repeat it to yourself while paying attention to your breathing. For instance, while inhaling, consider "wise," and while exhaling, consider "mind."

It's the most important session in the therapy which was done in the group. Mindfulness is the way to control the mind about the things with full awareness with open mind and intentional control with focused mind. A group mindfulness practice that showed how various breathing patterns resulted in various bodily feelings and emotions. Participants in this practice became aware of how relaxing it was to take deep breaths. Learning to take deep breaths and observing how their bodies relaxed as a result.

It was also briefed to the juveniles that mindfulness skills to monitor their reactions when they felt their selves becoming upset and their body became tense and it was difficult for them to relax. Whenever they felt like this they started practicing mindfulness and keep their thoughts and bodies relax. Mindfulness involved learning to pay attention to how juveniles expressed their emotions in their body. They learned to notice with the practicing of mindfulness that how their body felt in certain situations.

In the 2nd part of this session therapist described them that there are three types of mind state in every person that is, Reasonable state, Wise state, Emotional state. Through mindfulness

juveniles could observe and describe that in which state they are? After this participate to observe them. After this therapist gave them handouts sheet no 3, which was "Emotional Mind is "hot," controlled by your emotions and compulsions. I frequently: when I'm in an emotional frame of mind. “Reasonable Mind is "cool," and it is governed by reasoning, reality, and logic. When I am in a rational state of mind, I usually:" "Wise Mind contains both reason and emotion; it is the wisdom within each person and the state of mind to access when you need to make a crucial decision or to avoid behaving impulsively. In the Urdu version, I tend to. After session 4, this document was filled out with the help of the therapist.

Session 5: In session 5, therapist did practice of mindfulness technique to juveniles. After that researcher advised them to do it by their own. After this practice 2 to 3 times, handout sheets of mindfulness 4 and 8 given to the juveniles, asked then to fill it. In this handout sheets juveniles have to fill the Practice Exercise: Observing Yourself in Each State of Mind, Practice Exercise: Mindfulness “What” and “How” Skills. Both sheets answers were described in the following table collectively;

Emotional Mind: 1 example of Emotional Mind this week was (please describe your emotions, thoughts, behaviors):	1. “I was angry when remembered my crime and related people”. 2. “I wanted to hit the wall when I heard that the other person involved in the crime was released from the jail.” 3. “After watching jail bars, I wanted to yell out”.
Reasonable Mind: 1 example of Reasonable Mind this week was (please	After applying mindfulness technique 1. “I tried to control my emotions

describe your emotions, thoughts, behaviors):	after thinking of bad people, and did breathing exercise. I hold my emotions through reasonable mind that they are not present here and it's useless to be angry". 2. "I did not hit the wall after controlling my emotion and breathing led to different sensations and emotions in my body".
Wise Mind: 1 example of Wise Mind this week was (please describe your emotions, thoughts, behaviors):	1. "I did not think of drugs as they are harmful for health and tried to divert my attentions working in the jail compound".

In the end of session researcher asked juveniles, if they want more practice therapist could do with them. But everyone was satisfied with the session, so therapist ended up session.

Session 6-7:

In the session 6, first researcher asked from juveniles about the previous session and after getting positive feedback researcher moved towards the new technique. Before moving to new technique, researcher asked juveniles to practice mindfulness in their mind. Then researcher introduced the Distress Tolerance handouts 1, 2, 7, and 15 in Urdu for coping with their frustration, anxiety, and depression problems. Skills for tolerating painful events and emotions when juveniles could not make things better right away and wanted to make things worse. There were different sub techniques in the Distress Tolerance. But therapist preferred 3 handouts which were, Handout 3 Crisis Survival Skills: Distract with "Wise Mind ACCEPTS", Handout 7 Crisis Survival Skills: IMPROVE the Moment and Handout 15 Accepting Reality: Turning the Mind.

In Handout 3 Crisis Survival Skills: Distract with “Wise Mind ACCEPTS” therapist practiced the juveniles following aspects,

Activities include cleaning your area, exercising, reading a book, and playing cricket or hokey either alone or with others at the time of playing. Contributing: Help someone out (do something pleasant for them). In this situation, help a friend out, do something nice for someone else, or do whatever to make people happy. Comparisons: Think about others who have it worse than you. Compare your current state to a moment when you were performing poorly. Consider those who are coping the same way or less well than you. Emotions: Create different emotions. Try to involve in some productive activity when you are unhappy; go to jail compound and working as gardener, read books. Pushing away: Temporarily put the traumatic event, like the crimes, out of your mind. Building an imaginary wall between you and the issue will help you mentally distance yourself from it. Put the suffering in a box and place it on a shelf. Replace your current thoughts. Read, solve word or numerical problems, and mentally count numbers. Increase other sensations and perform push-ups and sit-ups. Session ended here as time was over and next handouts were discussed and done by the juveniles in the session 7.

In the start of session 7 feedback of last session 6 was taken. Researcher asked from the juveniles that if they had any difficulties in practicing the last technique and handouts then shared it. After discussion next techniques of Distress Tolerance with the help of Handout 7 Crisis Survival Skills: IMPROVE the Moment therapist practiced these steps to juveniles,

Imagery: Imagine things going well; visualize success; visualize acquiescing. Imagine having painful feelings flow out of you like water through a conduit. Meaning: Give the suffering some reason, meaning, or worth. Create drawings on paper. Prayer: During your prayers, let your heart to be open and ask for courage to handle the suffering you are currently

experiencing. Try to relax your muscles by tensing and relaxing each major muscle group, working your way down from the forehead. One thing to remember in the moment is to give your current task your undivided attention. Be aware of your body's sensations or movements when you walk, clean, or consume food. Give yourself a quick break. Read a magazine or newspaper while going for a little walk. Encourage oneself by being positive. Say to you repeatedly, "I can handle it," "I'll get through this," "It won't last forever," and "I'm doing the best I can."

After practicing these techniques therapist end up session by giving them homework of handouts no 4, 8, and 18 sheets in Urdu, they have to do practice of these 3 skills and after that fill these three handouts during the week break before next session.

Session 8:

Before starting the session 8 researcher asked from juveniles regarding session 7 of last week. Asked about their whole week experiences and inquired about their assigned homework of filling the handouts no 4, 8, and 18 sheets in Urdu, after practicing the pervious techniques of Distress Tolerance. Juveniles were reported that they successfully used distraction skills by engaging in a calming activity to distract them from negative thoughts. All said that they prayed to Allah and seek for His help for stopping criminal activities and thoughts. Four juveniles described that they accepted the reality that they had negative thoughts and deeds in the past that is why they committed crime like murder and drug smuggling. The therapist requested that juveniles give a brief account of the stressful situation(s) you encountered and the techniques you employed. Juveniles said that they were successfully diverted from their negative thoughts by engaging in a relaxing activity. When they sensed themselves growing irritated or wanting to act negatively, they used distress tolerance abilities of imagery. They felt more at ease when they

had to practice the ability to envision them somewhere else or to think of anything positive or humorous.

One of the juvenile gave researcher detailed example of how he was able to turn his mind away from negativity, by practicing distraction, imagery, and acceptance skills: “When I am furious I feel like I am going to pop off at all those people who were there at the time of committing crime, so I try to go to my relax place, which is tree plantation site in the jail. I mean it’s just my best place. I actually have a picture I drew from DBT on my barrack wall, the Murree hills. I look at that in which my family. Another juvenile described that learning distress tolerance skills had helped him develop more adaptive coping mechanisms for difficult emotions. He said, "I learned to recognize what my triggers were and then to replace the destructive behaviors with more, uh, appropriate ones."

Another juvenile explained to the therapist that since the DBT program, he has found healthier ways to respond to distressing situations. Although he said, "Well, for me I never cut or anything," he had a history of self-harming behaviors. He described head-bashing and hitting walls till his hands bled in the past. He claimed that his typical response to upsetting circumstances was to "freak-out," which includes acting violently and aggressively against other people and/or causing property damage. He claimed that DBT assisted him in less occurrences.

Acceptance → Acceptance AND Change = MIDDLE PATH → Change

Researcher gave the examples that if someone is doing the best he can AND he need to do better, try harder, and be more motivated to change. He can do this AND it’s going to be hard.

This viewpoint assists in illuminating the journey toward the middle path by assisting you to: Widen your thinking and perspectives on the world. "Unstick" confrontations and standoffs. Be more personable and adaptable. Steer clear of assuming and blaming.

The researcher also discussed how to employ behavior change skills to improve desired behaviors and decrease undesirable ones (in ourselves and others). Reinforcement, which can be either positive or negative, is a method of boosting the behaviors. The ways to reduce or stop behaviors through extinction and punishment were also discussed by the therapist.

After practicing these techniques therapist end up session by giving them homework of handouts no 12, 14 and 16 sheets in Urdu, they have to do practice of these 3 skills and after that fill these three handouts during the week break before next session.

Session 9-10:

Before starting the session 9 therapist asked from juveniles regarding session 8 of last week. Asked about their whole week experiences and inquired about their assigned homework of filling the handouts no 12, 14 and 16 sheets in Urdu, after practicing the pervious techniques of walking the Middle Path.

Researcher asked their experience regarding this technique. Six Juveniles especially who were taking drugs described that behavior change handouts were very effective for them. It's hard to stop, as the drugs really help and it kept them away from all that worries but what I really need to do is clear my mind and just accept that it'll be there. And with the help of punishment technique, they could control their behavior and shaped their behavior positively.

After getting feedback and knowing about the filled handouts, researcher asked juveniles to move further for the next technique, which was Emotion Regulation. Researcher described them that how to Take Charge of Your Emotions. It was explained to them that teenagers frequently struggle to control strong emotions like anger, shame, melancholy, or worry. Having trouble controlling these emotions, this frequently results in undesirable behaviors that have an

impact on both you and people around you. Anxious, uncomfortable emotions are frequently not resolved by problematic habits.

Along with this Emotion Regulation Handout 13 Wise Mind Values and Priorities List was also described to the juveniles. Understand the emotions that you experience, Reduce emotional vulnerability and stop unwanted emotions from starting in the first place, Decrease the frequency of unwanted emotions, Decrease emotional suffering; stop or reduce unwanted emotions once they start.

After practicing these above techniques researcher handover all juveniles Emotion Regulation Handout 3 which consisted of the Short List of Emotions, in which they have to write names for emotions they frequently experience. Session ended here as time was over and next handouts were discussed and done by the juveniles in the session 10.

In the start of session 10 feedback of last session 9 was taken. Researcher asked from the juveniles that if they had any difficulties in practicing the last technique and handouts then shared it. After discussion, the researcher defined Emotion Regulation Handout 9 to the juveniles. Practice them, mindful positive things and unmindful negative thought and worries. Provide them Emotion Regulation Handout 10 Pleasant Activities List, it was already translated into Urdu.

After practicing these techniques researcher ended up session by giving them homework of handouts no 12, 14, and 21 sheets in Urdu, they have to practice these 3 skills and after that fill these three handouts during the week break before next session.

Session 11-12:

Before starting the session 11, researcher asked juveniles regarding session 10 of last week. Researcher asked about their whole week experiences and inquired about their assigned

homework of filling the handouts no 12, 14, and 21 sheets in Urdu, after practicing the pervious techniques of Emotion Regulation. Juveniles were reported that they successfully used Emotion Regulation skills to identify their emotions and understand the purpose of their emotions.

One of juveniles' stated, "I guess DBT taught me how to learn more about my emotions." He admitted that in the past, he had trouble recognizing his feelings or would just choose to ignore them because they were too painful. He acquired the ability to recognize disappointment in therapy. Then, he was able to comprehend how this feeling contributed to his despair. "Um, it's just that like, I felt like people disappointed me," he said in his explanation. I believe that I put too much pressure on other people, which cause me to react negatively when they harm me.

Another juvenile discussed problems regulating his emotions, especially anger. He described his anger: "I hold it in. Until I get really mad." He claimed that he often suppresses his emotions until he is about to lose it. He gave an example: When the wrong person approaches and says something I don't like, I explode up and conduct crime. People can make me angry, but I suppress that anger. I kind of pass out after that, and I'm not really sure what occurs. He displayed contempt for discussing emotions when the therapist questioned him about his ability to control his emotions. It's messed up Life, he remarked. However, crying about it and wishing it would go away won't make anything different. He liked practicing emotion regulation techniques in group therapy to conversing. He offered a case study when the group was studying about employing a wise mind.

Another juvenile acquired the ability to move away from negative thoughts and feelings and turn toward positive ones. By using these techniques, he changed his perspective on life and decided against a life of crime. "Uh, yeah, I guess I changed how I see myself," he reported. In the confines of the prison, I'm not any longer hopeless. As I prepare to return home after this

lengthy sentence, I notice a difference in myself and my emotions, and I perceive things more positively. These abilities aid him in controlling his emotional responses to traumatic life situations. He told me using skills had increased his sense of control over his life in the jail. Session ended here as time was over and next handouts were discussed and done by the juveniles in the session 11.

In the start of session 12 feedback of last session 11 was taken. Researcher asked from the juveniles that if they had any difficulties in practicing the last technique and handouts then shared it. After discussion the researcher moved further Interpersonal Effectiveness technique. First of all therapist described them what Is Your Goal and Priority? Keeping and maintaining healthy relationships (GIVE Skills), Getting somebody to do what you want (DEAR MAN Skills), Maintaining Your Self-Respect (FAST Skills). What Stops You from Achieving Your Goals? I. Lack of skill, II. Worry thoughts, III. Emotions, IV. Can't decide, V. Environment. Building and Maintaining Positive Relationships: GIVE Skills.

Juveniles were berified that developing interpersonal effectiveness abilities will assist them to have better connections with others. Maintaining Your Self-Respect, Interpersonal Effectiveness Handout 7, says: Have FAST Skills. Fair: Be fair to both the other person and yourself. (no) Don't over-apologize for your actions, your request, or simply for being you. (If you've done someone wrong, don't apologize enough.) Maintain your values: Keep your thoughts and ideals to yourself. Don't compromise in order to acquire what you want, fit in, or avoid being told "no." (Please see Emotion Regulation Handout 13, "Wise Mind Values and Priorities List.") (Be) Honest: Do not lie. If you are not helpless, don't act like it. Don't exaggerate or invent justifications.

Juveniles were told to learn Self-respect which would helpful in building self-respect situation within the society, which enhanced motivation in a person. After practicing this exercise, juveniles were asked to fill the Urdu translated handouts 7.

Another important skill of Interpersonal Effectiveness i-e Handout 12 Practice Exercise: Using Skills at the Same Time was practiced. In this skill juveniles were asked to choose a situation during the week that required more than one interpersonal effectiveness skill. Then tried to understand that what were your priorities? (Check all that apply.) Build/maintain relationship Get what you want, say "no," or be taken seriously Build/maintain self-respect. After the session homework was given including handouts 7 and 12 to the juveniles for practicing.

Session 13:

In the start of the session the juveniles gave feedback of the previous session. One of the juvenile's described that with the help of Interpersonal effectiveness he has the learning of expressing his needs more effectively with in the jail environment, set personal limits, and improved his relationships through validation with the other juveniles as well as the jail staff. It is possible that he has improved personal relationships in his life by having better control over his emotions and behaviors in the jail and outside the jail.

Another juvenile's discussed that with the help of Interpersonal effectiveness he applied the interpersonal effectiveness skills with his group in the jail. He told the therapist that he had a hard time standing up for himself, especially with his barrack peers. By practicing skills this with the therapist and doing homework and practicing the handouts, he was able to assert himself and maintain self-respect.

One of the young people revealed that DBT taught him interpersonal effectiveness techniques that made it simpler for him to interact with his fellow inmates and the jail officials.

He observed that the ability of active listening, which instructs youth to respond to the speaker with vocal input and body language like eye contact, is beneficial. He talked about how he learned how to maintain relationships and how to validate the other party in a relationship. He also acquired self-validation of his own thoughts, feelings, and values through the study of interpersonal effectiveness techniques. When the therapist questioned from the juvenile about his DBT experience, he replied, "Well, to be honest, I would say that learning to accept who I am and learning skills with others was most definitely what stood out in my mind."

In the end of this session juveniles were asked about anything they wanted to ask or share. None of them had showed any ambiguity. Therapists end up the session here, with relaxation training.

Session 14: Discussing outcomes of Urdu translated DBT sessions with juveniles and benefits

The purpose of last session was to discuss the outcomes of Urdu translation of DBT after session's completion with the juveniles in Pakistani jails. As a group, juveniles reported feeling more connected to others, less emotionally volatile, and generally more capable to handle challenges in the jail. They also shared that they feel happy and less disappointed when their family members come to meet them. Otherwise two juveniles were reported to the therapist that they do not want to meet their family members. They felt frustration when their parents or siblings came for meeting prior talking this intervention.

Additionally, juvenile described being better able to handle situations that in the past would have led to arguments that could have been physical or verbal in nature. In this therapy, young patients were in charge of documenting how they used particular abilities that were taught over the week in between group meetings. Techniques of DBT (Urdu version) played a

significant role in juveniles' life. Juveniles gave a healthy feedback and they showed willingness for the follow-up. Researcher said that there will be a follow up visit after 1 week.

Discussion of intervention

This study aimed to see the efficacy of DBT (Urdu version) on juvenile deliquents. Concentrating on the entire DBT (Urdu version) experience of the young participants, including observations regarding therapy modalities, skill modules, and recommendations for improvement. All of the study's participants mentioned skills group therapy as an important aspect of their DBT experiences. The participants in studies with DBT (Urdu version) groups felt the group therapy component to be normalizing, and this finding was similar to that finding (Koerner & Linehan, 2000; Safer et al., 2009). Several young participants felt relieved after discussing their personal issues with the group. These juveniles described DBT focused group therapy as a special source of social, emotional, and behavioral support. After undergoing DBT, participants indicated that they received emotional support from group members when they were unable to do so from other people in their lives.

Conclusion

Although there is growing evidence that dialectical behavior therapy (DBT) in Urdu is an effective treatment for juveniles. The current study's goal was to fill this knowledge gap by application of the DBT treatment modules and skills. In this study, juveniles reported an overall positive experience with the practice of techniques of DBT (Urdu version) and discussed positive outcomes like decreased frustration behaviors, and common mental disorders like anxiety, stress, and depression. Moreover, they have experienced improved capacity for coping with distress, increased mindfulness and emotion regulation, and healthier interpersonal relationships.

Over All Discussion of the Study

The present study focused on Impact of Family Functioning and Frustration Discomfort on Common Mental Disorders among Juvenile Delinquents; Efficacy of Dialectical Behavior Therapy. For this purpose present research was divided into 3 studies phases. These were as follows;

Study I: Translation, Adaptation and Validation of the Brief Family Relationship Scale (BFRS), the Frustration Discomfort Scale (FDS) and Common Mental Disorders Questionnaire (CMDQ)

Study II: Main Study

Study III: Translation, Adaptation, Validation and intervention of Dialectical Behavior Therapy (DBT) Adolescence Manual

Study I: Translation, Adaptation and Validation of the BFRS, FDS and CMDQ. Urdu language was conducted for the purpose of the instrument understandable for the juvenile population. Researcher need to administer this instrument on Pakistani juvenile population, so that target population could understand Urdu language more easily and feel comfortable in responding the items properly in Urdu language. The instrument was being translated by following all the steps of translation, described by Brislin (1986). Scale translation involved the forward translation by bilingual experts and committee approach, backward translation by different bilingual experts (not those who translated the forward part) and the committee approach by same experts. Parallel versions of translation involved several bilingual experts who translated the same questionnaire independently.

The important step of translation phase is to determine the cross language validity of the translated scale by analyzing a comparison of translated Urdu version with the original English

language version of the scale. In order to validate the scale, both English and Urdu versions of the scale were administered on a sample of 40 school students from Islamabad. Two groups of students were administered twice with Urdu-English and Urdu-Urdu sequence and then these two groups were further divided into four subgroups of 10 student's individuals each. Test-retest reliabilities and correlation of these groups; Urdu-English, Urdu-Urdu, English-English and English-Urdu, the results indicated significant positive relationship between the two versions of scale. Urdu-Urdu correlation is highly positive and frustration discomfort scale Urdu translation version showed more comprehendible to students.

The main aim of this study was to assess the psychometric properties of the scales BFRS, FDS and CMDQ among Juvenile Delinquents. The tools included Common Mental Disorder Questionnaire (CMDQ) and its subscales, Brief Family Relationship Scale (BFRS) and sub-scales, Frustration Discomfort Scale (FDS) and its sub-scales. In Pakistan, most of the juvenile delinquents are not highly educated, so the researcher translated all the scales in Urdu language for comprehension of delinquents so they can easily understand and respond to each item. The subsequent goal was to find out Alpha reliability coefficients of Urdu versions. The original scales in English version have been widely used and translated in several languages. The inter scale correlation showed that all the subscales were unequivocally related with each other. Convergent validity and construct reliability of translated scales showed that the validity and reliability of the Urdu version of these scales was good. The Urdu version of scales was reliable. The CFA model of common mental disorders, Family Relationship Scale and frustration discomfort showed that all indicators were within the range and best fit for analysis.

It was concluded with the help of this research that both versions of BFRS, FDS and CMDQ have uniformity in conceptual meaning of the scale in Pakistani adolescent population. It also showed that the Urdu vocabulary words used in the scale are simple, easy to understand, appropriately giving the meaning of the sentence, conveying the concept to the population in Pakistan. Cross language validity reflect that Urdu version of BFRS, FDS and CMDQ could appear to be valid, reliable and Pakistani culture fair.

Study II: Main Study, in this phase of study was Common Mental Disorder Questionnaire, its subscales, Brief Family Relationship Scale, its subscales were translated in Urdu and these scales were effectively used on Pakistani juvenile population. For the better understanding of the scales as mostly juvenile population in the Pakistani jails are less educated. It was observed in the findings that the Urdu version of scales had good validity and it was reliable. The results were run on CFA and the CFA models also indicated the scales good reliability and validity. In future researchers can do studies on FDS, CMDQ and BFRS in different dimension as it has now Urdu translation. Especially on those populations which cannot easily understand English in Pakistan. These Urdu version scales can also help in diagnosis, when utilized alongside other evaluation tools so that right appraisal and powerful treatment plan can be utilized for the female and male juveniles and those offenders which are there in schools.

Correlation between BFRS, FDS and CMDQ and its sub-scales can be seen. The results of the table showed that there was a significant correlation among the scales and sub-scales of the present study. Some of the variables are positively correlated and some are negatively correlated. Family relation is negatively correlated with subscales of frustration discomfort as it

is clear that if frustration increases family relations will be low among the juveniles and their families.

In the current study, frustration's discomfort as a moderator significantly and positively predicted the effect of family relationships on common mental health disorders, emotional disorders, and depression. On the other hand, in the current study, it was also identified that frustration discomfort as a moderator significantly and negatively predicted the effects of family relationships on mental health disorders, somatic disorders, Narcotic abuse and dependence, and Illness worry and conviction disorders. Similarly, current study also has investigated the impact of family relations and achievement frustration on depression. The findings consistently demonstrated a significant and positive association between these factors and the likelihood of experiencing depressive symptoms.

ANOVA results for education wise differences on FDS subscales. The subscales were Entitlement, Discomfort Intolerance, Achievement and Emotional Intolerance. It indicates the mean, standard deviation and F values of education wise (illiterate, primary, middle, matric and FA and above) on the juvenile delinquents scores on FDS sub-scales. Education wise differences on BFRS subscales Cohesion, Conflict and Expressiveness, CMDQ sub-scales SOM, Anxiety, Emotional, Depression, Narcotic abuse and dependence and Illness worry and conviction.

One way ANOVA results for parent's status-wise (divorced, separated, living together and one of them died) differences on FDS subscales Entitlement, Discomfort Intolerance, Achievement and Emotional Intolerance, CMDQ subscale SOM, anxiety, emotional, depression, Narcotic abuse and dependence, SQ. and BFRS subscales Cohesion, Conflict and Expressiveness insignificant results with parent's status.

Juvenile Delinquents with Criminal and Non-Criminal Parents on the scores of FDS and subscales. The subscales were Discomfort Intolerance, Entitlement, Achievement and Emotional Intolerance, CMDQ and subscales. Juveniles who had criminal parents showed significant differences on depression in comparison to non-criminals parents.

Study III: Translation, Adaptation, Validation and intervention of Dialectical Behavior Therapy (DBT) Adolescence Manual, researcher applied Dialectical Behavior Therapy on 14 juveniles. The tools used by the researcher were Common Mental Disorder Questionnaire (CMDQ), Frustration Discomfort Scale (FDS) and Brief Family Relationship Scale (BFRS). In Pakistan, most of the juvenile population is illiterate so the researcher translated DBT in Urdu so that the juveniles can easily understand and respond to them. The findings indicated that the therapy applied had positive effects on them. The Urdu version of the scales also showed good reliability and validity. Furthermore, it showed that juveniles experience various mental problems.

In the end as a researcher it has concluded that relevant parties, such as governmental bodies, law enforcement agencies, the judiciary, social welfare departments, civil society organisations, and the general public, must work together to successfully execute these proposals. This process requires the supply of sufficient resources, capacity-building programs, and policy changes. Pakistan may promote a juvenile justice system that protects the rights of young offenders, guarantees their rehabilitation, and eases their reintegration into society by tackling the issues of prejudice and non-implementation of legislation. A more equitable and inclusive society will ultimately result from a reformed juvenile justice system, allowing all young people to reach their full potential.

Limitation and Suggestions

- The study was conducted on the sample of male juveniles in the jail so the future researchers can conduct research on the female sample additionally, this will strengthen there liability of Urdu version of the three scales.
- The data was taken from the juvenile jails of Punjab, future researchers could collect data from all juvenile jails of Pakistan for generalizing the findings.
- This study included the translation of three scales into Urdu translation for assessment of frustration, family relations and common mental disorders on the juvenile population; other than these measures can be used for translation to get maximum data related to juveniles in the Pakistani jails.
- The translated version of the BFRS, FDS and CMDQ can be used across Pakistani less educated children population for further researches as Urdu is native language of Pakistan. So they can easily understand and grasp the question statements of the scales in Urdu language and feel comfortable in answering them.
- Despite the fact that juvenile delinquency is becoming a bigger problem in Pakistan, research on female juvenile offenders seems to be less common than that on male offenders. Cultural and societal conventions that may affect how female delinquency is viewed and dealt with, as well as possible biases in data collecting, could be some of the reasons for this discrepancy in studies. Present research also lacks of this consideration. For future research perspectives female sample should be addressed.

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