Level of Coping Patterns among Parents of Children and Adolescents with Mental Illness: A Cross-Sectional Study

By

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This thesis is submitted in total fulfilment of the requirements for the subject RESEARCH 2 & 3 and partial fulfilment of the requirements for the degree of

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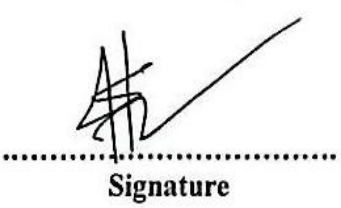

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Statement of Authorship

Except where it is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for any other degree or seminar. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any other degree in any other tertiary institution. The ethical issue of the study has been strictly considered and protected. In case of dissemination of the findings of this project for future publication, the research supervisor will be highly concerned, and it will be duly acknowledged as an undergraduate thesis.

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Dedication

This thesis is dedicated to my beloved husband Sabbir Hossain Akash in recognition of his love, patience, support and endless encouragement. I'm very much thankful to him for standing beside me through every challenge, cheering me on in every moment of doubt, and believing in me even when I struggled to believe in myself. This achievement is as much his as it is mine.

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List of Abbreviations

ASD	Autism Spectrum Disorder
ADHD	Attention Deficit Hyper Activity Disorder
AOTA	American Occupational Therapy Association
BHPI	Bangladesh Health Professions Institute
CRP	Centre for Rehabilitation of the Paralysed
CHIP	Child Health Inventory for Parents
CE	Child Edition
DD	Developmental Disabilities
FQoL	Family Quality of Life
FMSF	Family Management Style Framework
IRB	Institutional Review Board
ID	Intellectual Disability
NDD	Neurodevelopmental Disorders
NHMRC	National Health and Medical Research Council
NIMH	National Institute of Mental Health & Hospital
OT	Occupational Therapy
PIP	Paediatric Inventory for Parents
QoF	Quality of Life
WHO	World Health Organization

Abstract

Background: Parents of children and adolescents with mental illness frequently experience emotional, psychological, and social stressors that affect their coping capacity. Understanding these coping patterns is essential for developing effective support interventions.

Objective: To assess the level of coping patterns among parents and to identify sociodemographic and associated factors influencing these coping patterns.

Methods: A cross-sectional study was conducted among 120 parents of children and adolescents aged 7-17 years diagnosed with mental illnesses. Data was collected using a structured questionnaire incorporating sociodemographic characteristics and the Coping Health Inventory for Parents (CHIP). Data was analysed using SPSS version 20. Descriptive statistics, parametric and nonparametric tests, and multiple linear regression analyses was performed to determine associations and predictors of coping patterns.

Results: Coping Pattern I (Family integration, Cooperation and an Optimistic definition of the situation) was rated as extremely helpful by 79.2% (n=95) of parents, Coping Pattern II (Maintaining social support, Self-esteem and psychological stability) was rated moderately helpful by 64.2% (n=77) of parents, while Coping Pattern III (Understanding the healthcare situation through communication with other parents and Consultation with the health care-team) showed mixed levels of helpfulness. 29.2% (n=35) of the participants thought that Coping Pattern III was extremely helpful, 43.3% (n=52) was moderately helpful, 27.5% (n=33) was minimally helpful for them. Parent

age (*P*=.018), relationship to child (*P*=.004), marital status (*P*=.001; .004), educational qualification (*P*=.012; .001), family type (*P*=.045), child age *(P*=.012), number of children (*P*=.036), and child schooling status (*P*=.002) was significant predictors across different coping patterns.

Conclusion: The findings of this study demonstrate that Coping Pattern I (family integration, cooperation, and an optimistic definition of the situation) constitute the most effective and frequently utilized coping strategy among parents of children and adolescents with mental illness in Bangladesh. This reflects the strong influence of collectivist family structures and cultural reliance on intra-family support in coping with long-term mental health challenges. Conversely, variations observed across Coping Pattern II (maintaining social support, self-esteem and psychological stability) and Coping Pattern III (understanding the health care situation through communication with other parents and consultation with the health care-team) indicate gaps in social support utilization and healthcare communication, particularly among mothers, low-income families, and parents with limited education. These results underscore the necessity of family-centred, culturally responsive mental health services that strengthen parental education, promote social support networks, and improve collaboration between families and healthcare professionals. Integrating structured caregiver support within occupational therapy and mental health services is essential to enhance parental resilience, optimize family functioning, and ultimately improve outcomes for children and adolescents with mental illness.

Keywords: Parents, Coping Patterns, Child and Adolescents, Mental illness.

CHAPTER I: INTRODUCTION

1.1 Background

Mental illness in children and adolescents is a growing global concern, with approximately 10–20% of children and adolescents worldwide experiencing mental health disorders (WHO, 2021). Worldwide, 8% of children and 15% of adolescents experience a mental disorder, but the majority of them do not seek help or receive care. Suicide is the third leading cause of death in 15-29 years old (WHO, August 2024). In Bangladesh 13.6% Children and Adolescents aged 7 – 17 years experiences mental health disorders (National Mental Health Survey, Bangladesh, 2019). Conditions such as autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), intellectual disability (ID), depressive disorder, anxiety disorder and conduct disorder can significantly impact a child's daily functioning and development. Parental coping plays a crucial role in managing these conditions, influencing both the child's well-being and the family's overall mental health. However, the stress and emotional burden on parents of children and adolescents with mental illness often go unmeasured, leading to gaps in providing adequate support and interventions (Johnston et al., 2022).

Research indicates that parents of children with mental illness experience higher levels of psychological distress, financial strain, and social isolation compared to parents of typically developing children (Davis & Carter, 2008). Studies suggest that coping mechanisms, such as problem-focused coping and emotional support, significantly affect parental resilience (Lazarus & Folkman, 1984). Existing research also highlights that structured-assessments, such as the Child Health Inventory for Parents (CHIP), provide a standardized approach to measuring parental coping and

stress levels. However, limited studies have explored the effectiveness of CHIP in evaluating coping strategies across different cultural and socioeconomic settings.

Recent studies emphasize that parental coping mechanisms vary based on demographic factors such as socioeconomic status, education level, and cultural background. Emerging research suggests that tailored interventions, such as mindfulness programs and peer support groups, can enhance parental coping and reduce stress-related health issues (Brown & Patel, 2022). Despite these advancements, there remains a critical gap in measuring and analysing parental coping strategies in diverse populations using validated tools like CHIP. This study aims to address this gap by systematically assessing how parents cope with their child's mental illness and identifying key areas for intervention.

The primary aim of this study is to measure level of coping patterns among parents of children and adolescents with mental illness using the Child Health Inventory for Parents (CHIP). By identifying specific coping patterns, the study seeks to provide insights into the psychological and social support needs of these parents. The findings will contribute to developing targeted intervention strategies that improve parental well-being and enhance the overall management of childhood mental health disorders. Furthermore, the study's outcomes can guide policymakers and healthcare professionals in designing family-centred mental health programs, ultimately fostering a more supportive environment for affected families.

1.2 Justification of the study

To the best of my knowledge, no study reported the parental coping of children and adolescents with mental illness by using the Child Health Inventory for Parents (CHIP) scale in Bangladesh. Parental coping plays a critical role in managing childhood mental illness, impacting both the child's development and the overall family dynamic.

However, research on measuring parental coping using the Child Health Inventory for Parents (CHIP), remains limited, particularly in diverse cultural settings. This study is significant as it bridges this gap by providing evidence-based insights into how parents adapt to the challenges of caring for a child with mental illness.

Occupational therapists work with families to develop adaptive strategies, improve daily functioning, and reduce caregiver stress (American Occupational Therapy Association [AOTA], 2020). By identifying coping patterns, this research can contribute to family-centred OT interventions that promote resilience and reduce burnout among caregivers.

This study expands the existing literature on parental coping by utilizing CHIP to measure stress, adaptation, and coping strategies. The findings can inform future research on mental health interventions tailored to family needs. From societal perspective, the study underscores the emotional, financial, and psychological burden parents face when raising a child with mental illness. By bringing awareness to these challenges, the research can advocate for increased mental health resources, parental support programs, and community-based interventions.

At the policymaking level, the study provides empirical data that can inform policymakers about the necessity of integrating family-centred mental health programs into national health policies. Policymakers can use these insights to allocate resources more effectively and implement policies that ensure parents receive adequate mental health support (World Health Organization [WHO], 2021).

It highlights the importance of family-centred interventions in occupational therapy, emphasizing the need for holistic approaches that consider both the child and their caregivers. Occupational therapists can use CHIP data to tailor intervention plans that address parental stress and coping challenges, ultimately improving therapeutic

outcomes. The study provides specific insights into coping mechanisms that can guide occupational therapists in developing targeted interventions, such as structured caregiver training, stress management workshops, and home-based therapy programs. The findings can be used to create new OT programs focused on enhancing parental coping, thereby strengthening parent-child relationships and improving overall family well-being.

The study's impact extends beyond academia and clinical practice. By identifying coping strategies and stressors, it fosters a better understanding of how to support parents effectively. Occupational therapists, psychologists, educators, and policymakers can all benefit from the study's findings, using them to enhance support networks for families dealing with childhood mental illness.

1.3 Operational Definition

1.3.1 Parental Coping Pattern

Parental coping pattern is operationally defined as the extent and manner in which parents use coping strategies to handle the stress associated with caring for a child or adolescent with mental illness, as measured by the total and subscale scores of the Coping Health Inventory for Parents (CHIP) scale. The CHIP identifies three coping patterns.

1.3.1.1 Coping Patterns I: Family Integration, Cooperation, and Optimism (Efforts to maintain family stability, unity, and positive outlook).

1.3.1.2 Coping Patterns II: Maintaining Social Support, Self-esteem & Psychological Stability (Seeking emotional support, maintaining personal well-being, and staying psychologically balanced).

1.3.1.3 Coping Patterns III: Understanding the Medical Situation Through Communication (Learning about the illness, communicating with health professionals, and connecting with other parents).

Higher scores in each subscale indicate stronger coping patterns, while lower scores indicate weaker coping patterns. (Mccubbin et al., n.d.)

1.3.2 Mental Illness

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),"Mental illness / mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning." Mental disorders are typically associated with distress, disability, or a significant impairment in social, occupational, or other important areas of life. (American Psychiatric Association, 2013)

1.4 Aim of the study

To find out the level of parental coping pattern among parents of children and adolescents with mental illness.

CHAPTER II: LITERATURE REVIEW

In this literature review chapter, a comprehensive synthesis of existing research on parental coping strategies, stress, and family well-being in the context of mental illness among children and adolescents is presented. The review draws on a variety of scholarly databases, including PubMed, PsycINFO, Scopus, and Google Scholar, which were used to identify relevant studies published over the past 10-12 years. The selected studies encompass diverse methodologies, ranging from quantitative surveys and cross-sectional analyses to qualitative interviews and case studies. By synthesizing findings from various global contexts such as those from India, Saudi Arabia, Greece, and other countries, this review aims to provide a broad understanding of the factors that influence parental coping mechanisms. It also highlights the gaps in literature, particularly regarding the application of the Coping Health Inventory for Parents (CHIP) scale in Bangladesh, which remains underexplored. Through this synthesis, this review not only integrates existing theoretical perspectives but also underscores the need for culturally sensitive approaches to enhance family well-being in the face of childhood mental health challenges.

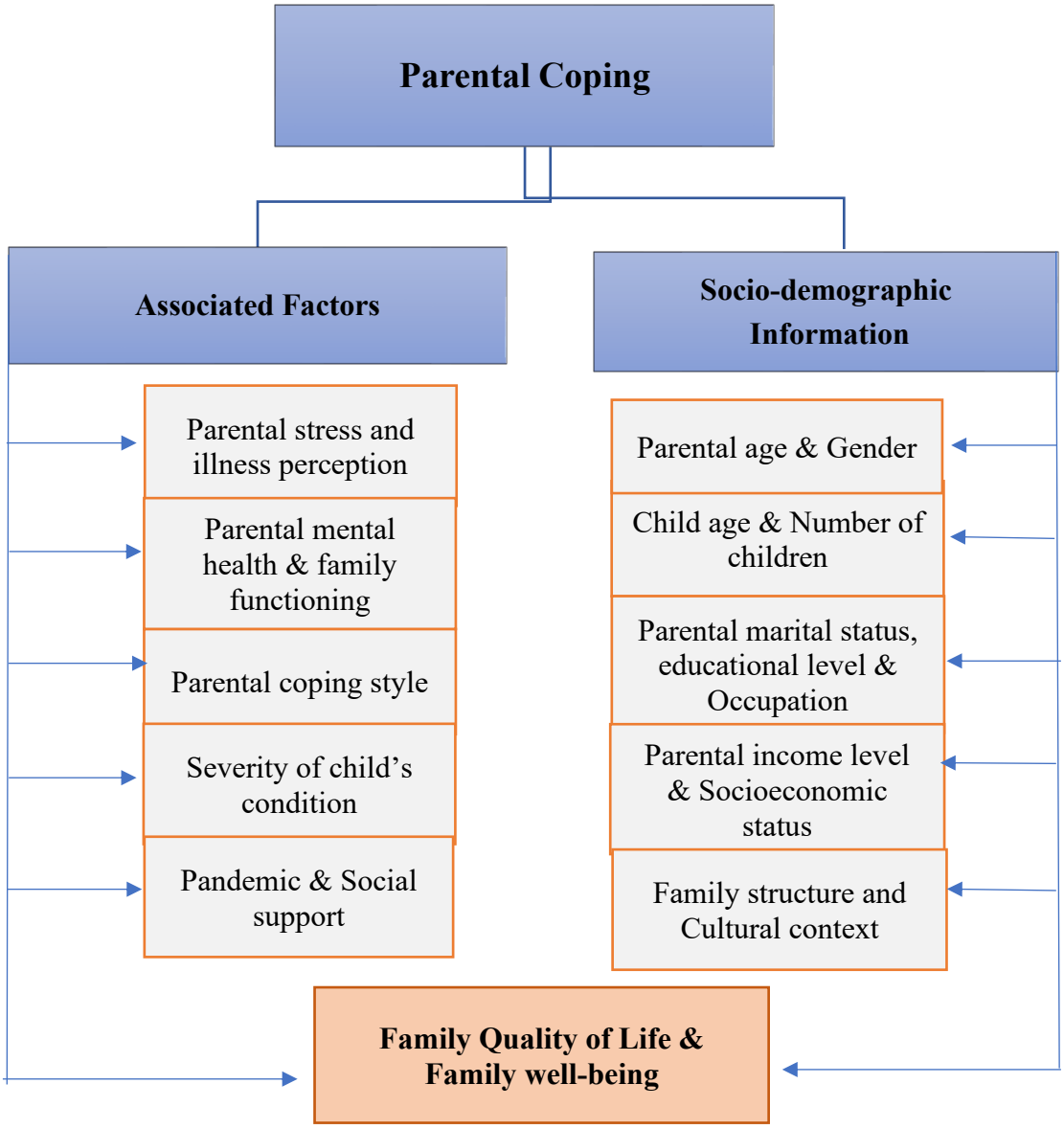
The process of developing the literature review figure from the literature matrix involved systematically organizing and synthesizing key themes and findings from the selected studies. Initially, each article was analyzed (Lohar et al., 2023) to identify core concepts related to parental coping strategies, stress, family functioning, and socio-demographic factors. The literature matrix served as a foundational tool, categorizing each study based on its research focus, methods, results, and gaps.

While reviewing the literature, it was apparent that the field of mental-illness has generated more interest over the past several years. Many facets of mental-illness have

been investigated including the stress and coping abilities of parents who have a child with mental-illness and the daily struggles they face. When investigating the coping strategies used by parents who have a child with mental-illness (e.g., ASD, ADHD, Anxiety Disorder, Depressive Disorder, ID, Conduct Disorder), it is essential that a thorough investigation done.

Figure 2.1:

Associated factors and Socio-demographic influences on parental coping and Family Quality of Life & Family well-being.



2.1 Parental Coping

Parental coping represents how parents manage emotional, psychological, and practical demands while raising a child with mental illness. Coping responses vary based on internal resources and external supports and significantly influence both parental well-being and child outcomes (Lohar et al., 2023);Papadopoulos et al., 2023).

2.1.1 Associated Factors

2.1.1.1 Parental Stress and Illness Perception: Parental stress is closely linked to parents' perception of their child's illness. Specifically, higher parental stress, related to the core symptoms of mental illness (e.g., autism spectrum disorder), is associated with lower Family Quality of Life (FQoL). Conversely, greater perceived control over treatment positively correlates with improved family well-being.

A cross-sectional study was conducted in Greece, recruiting participants from speech therapy centres, occupational therapy centres, and a General Children's Hospital, involving 53 mothers of children diagnosed with ASD aged 31–49 years. The study highlights that perceptions of ASD severity significantly influence stress levels, consequently impacting family dynamics(Papadopoulos et al., 2023)**.**

Another cross-sectional study was conducted in Tezpur, Assam, India, involving 100 biological parents to assess the stress and coping mechanisms of parents with children seeking treatment from a tertiary care mental health institute. The important finding is that high stress commonly observed among parents of children with mental illness and chronic stress without support leads to burnout, here parental stress mean score was 45.72 ± 8.25 indicating high stress , affecting parenting quality and emotional availability (Lohar et al., 2023).

2.1.1.2 Parental Mental Health & Family Functioning: Poor parental mental health is directly associated with lower family functioning and decreased Family

Quality of Life. Families where parents experience mental illness (e.g., depression, anxiety) generally report significantly lower family well-being and poorer mental health outcomes for their children (Sell et al., 2021)(Melchior, 2019). Additionally, lower family functioning directly correlates with increased parental distress, emphasizing the reciprocal relationship between parental mental health and family dynamics (Reed, 2023).

In Germany, a study that published in the journal named Frontiers in Psychiatry reported that parents with depression, anxiety, or other mental health concerns are at risk of using maladaptive coping, which negatively impacts family dynamics and child outcomes (Sell et al., 2021). Another Cross-sectional observational study aims to Compare parental health-related quality of life (HRQoL) to Canadian population norms using the SF-36, examine associations between family functioning and parental physical and mental HRQoL shows that families with low cohesion, adaptability, and communication experience poorer quality of life and more dysfunctional coping patterns (Reed et al., 2023).

2.1.1.3 Parental Coping Style: Parental coping styles play a crucial role in managing stress related to children's mental health conditions. Positive coping strategies, such as positive reappraisal, active problem-solving, and emotional support-seeking, are frequently associated with lower stress and better family outcomes. Lohar (2023) demonstrated that coping mechanisms vary significantly by gender, with mothers often using emotion-focused coping, while fathers lean towards problem-focused strategies. Similarly, Sell (2021) found positive coping, particularly religiosity and meaning-making, was associated with fewer mental health symptoms in children.

A study by Alostaz J. was conducted in United States to examine whether adaptive parental coping moderates the relationship between child autism symptoms

and externalizing problems and parents' reactions to their children's negative emotions reports that positive coping (e.g., active planning, cognitive reappraisal) leads to better outcomes and avoidance-based coping may offer temporary relief but worsens stress over time (Alostaz et al., 2022).

2.1.1.4 Severity of Child's Condition: The more severe or disruptive the child's symptoms, the more stress the parents face, requiring more intensive coping efforts (Papadopoulos et al., 2023). A quantitative cross-sectional study was conducted in Saudi Arabia using online questionnaires distributed via social media (Twitter, Snapchat, WhatsApp), including 425 parents to measure burnout and anxiety among parents of children with neurodevelopmental disorders (NDDs) compared to parents of typically developing children. This study demonstrated that the severity of the child's condition strongly affects parental coping and family well-being, also increased severity of neurodevelopmental disorders (NDDs), like ADHD, strongly correlates with higher anxiety and burnout in parents. The comparison between parents of typically developing children and those with severe disorders clearly indicates significantly elevated parental distress levels associated with more severe symptoms(Alostaz et al., 2022).

2.1.1.5 Pandemic & Social Support: Lack of social support contributes to isolation and burnout among parents with chronic health conditions. In 2022, a study conducted in Israel to identify changes in family coping-strategy profiles among parents pre- and during the first COVID-19 lockdown. To analyse interactions between the clusters of coping strategies pre-COVID with family quality of life (FQOL) during the first lockdown. This study reported that the COVID-19 pandemic has markedly influenced family coping strategies. Families who employed positive cognitive appraisal during the pandemic generally maintained or even improved their Family Quality of Life. On the other hand, families lacking sufficient social support

experienced noticeable declines in emotional well-being and family interactions, highlighting the critical role social support systems play during crisis situations. Events like COVID-19 have significantly altered family coping dynamics, pushing many toward emotion-focused or avoidance strategies and affecting FQoL. Strong networks of emotional, instrumental, and informational support reduce parental anxiety and buffer the impact of stress (Fogel et al., 2022).

2.1.2 Socio-demographic Information

2.1.2.1 Parental Age & Gender: Parental age and gender significantly influence coping strategies. Older parents generally exhibit better problem-solving skills and emotional stability compared to younger parents, who might prefer emotion-focused coping mechanisms. The study by Lohar (2023) identified clear associations between parental age, gender, and coping styles older fathers frequently engage in positive reappraisal, whereas mothers of various ages predominantly utilize distancing and acceptance.

A Comparative analysis of coping styles and strategies was conducted in Spain and Singapore to explore the styles and strategies of coping with stress among parents of children with developmental disabilities (DD) compared to parents of children with typical development (TD), including 270 parents (167 parents of children with DD, 103 parents of children with TD). The study reports that younger parents are more likely to engage in problem-focused or task-oriented coping (Bujnowska et al., 2021).

Another study of Saudi Arabia shows that mothers, especially, report higher stress and anxiety compared to fathers, particularly when managing conditions like ADHD or ASD, age also influences perceived control and adaptability in stressful situations (Alrahili, 2023).

2.1.2.2 Child Age & Number of Children: The child's age and the number of

children in the family notably impact coping behaviors. A quantitative study cross-sectional study conducted in Sweden at 46 psychiatric units across five Swedish regions, including 87 children from 63 families aged 8–17 years to investigate the mental health and family context of children. The study reports that younger children (8–10 years old) tend to be associated with higher parental stress and mental health problems compared to older children (Alrahili, 2023).

On the other hand a study conducted in Serbia to evaluate the characteristics of family functioning with mentally ill children and adolescents reports that families with more children face greater caregiving demands, which may overwhelm coping abilities (Jelkić et al., 2018). So the study insisted that, the birth order of children influences coping styles; for example, parents use more structured problem-solving approaches with first-born or single children compared to larger families**.**

2.1.2.3 Parental Marital Status, Educational Level & Occupation: Parental marital status, educational background, and occupation significantly affect their coping capacities and family quality of life. Divorced mothers typically report lower FQoL compared to those in stable marriages due to reduced social and emotional support systems (Papadopoulos et al., 2023). Moreover, higher educational attainment among parents consistently correlates with more effective coping mechanisms, particularly in structured problem-solving and emotional management strategies, higher education is linked to greater use of planful problem-solving and positive reappraisal coping strategies (Lohar et al., 2023).

2.1.2.4 Parental Income Level & Socioeconomic Status: Higher parental income and socioeconomic status are strongly associated with better family coping outcomes and enhanced Family Quality of Life. Studies consistently find that higher SES is associated with improved access to resources, lower stress, and better overall

coping and FQoL, lower SES families face more stressors and have limited access to support (Papadopoulos et al., 2023). Conversely, lower socioeconomic status is commonly linked with increased parental stress, limited coping resources, and poorer family functioning (Jelkić et al., 2018).

2.1.2.5 Family Structure and Cultural Context: Family structure and cultural context significantly influence coping behaviors and family functioning. Extended or supportive family structures typically provide a stronger social support network, enhancing parental coping and family well-being. Furthermore, cultural differences strongly impact coping strategies, highlighting the importance of culturally sensitive coping frameworks.

For instance, A cross-sectional study was conducted a children's hospital in Poland, including 459 parents aged 30–59 years that aim to validated the Coping Health Inventory for Parents (CHIP), revealing culturally distinct coping styles emphasizing family support systems. This study reports that cultural norms influence perceptions of mental illness and appropriate coping strategies(Bąk & Zarzycka, 2022).

Another study conducted in Spain, to synthesize current knowledge about the association between parents' emotional intelligence (EI) and psychological, developmental, and mental health-related variables of their children. The study shows that collectivist cultures may emphasize family support, while individualist cultures may stress independence (González et al., 2021).

2.1.3 Family Quality of Life (FQoL)

FQoL is both an outcome and a feedback mechanism for coping. It reflects the family's emotional well-being, social functioning, and satisfaction with life. Effective coping supported by favorable demographic and psychosocial conditions leads to enhanced

FQoL, while poor coping leads to distress, conflict, and reduced functionality (Sell et al., 2021).

Each item in this literature review figure is intricately connected, demonstrating clear relationships between socio-demographic factors, parental coping strategies, and family quality of life. Specifically, factors like parental stress, coping styles, and the severity of the child's condition directly influence family outcomes, whereas socio-demographic elements such as parental age, marital status, and socioeconomic status provide context that shapes these coping behaviors. Overall, understanding these interconnections underscores the necessity of holistic, culturally sensitive interventions to enhance parental coping and family well-being in contexts involving childhood mental health challenges.

CHAPTER III: METHODS AND MATERIAl'S

3.1 Study Question, Aim & Objectives

3.1.1 Study question

What is the level of parental coping pattern among parents of children and adolescents with mental illness?

3.1.2 Aim

To find out the level of parental coping pattern among parents of children and adolescents with mental illness.

3.1.3 Objectives

- To assess the level of coping pattern of family integration, cooperation, and an optimistic definition of the situation among parents.
- To identify the level of coping pattern of social support, self-esteem, and psychological stability among parents.
- To understand the level of coping pattern of the health care situation through communication with other parents and consultation with the health care team.
- To find out the associated factors of parental coping patterns.
- To find out the sociodemographic information.

3.2 Study design

3.2.1 Study Method

This study was followed a quantitative method because it involves a standardized instrument (CHIP) that collects numerical data on parental coping. The CHIP is a structured, standardized questionnaire designed to measure parental coping and well-

being in relation to their child's health condition. It generates quantifiable data that can be statistically analysed to identify coping patterns among parents. A quantitative approach ensures reliability and validity by using structured survey responses rather than subjective narratives.

The CHIP tool has been validated in prior research, making it a reliable instrument for measuring coping behaviours in parents. (McCubbin et al., 1983; Gothwal et al.,2015; Toledano- Toledano et al., 2020)

This study introduces CHIP-CE (Child Edition) as a standardized tool to assess children's health and well-being from a parental perspective. It measures functional health, including physical, emotional, and social aspects, which influence parental coping strategies. The tool was tested for reliability and validity, confirming its effectiveness in assessing children's health outcomes and how parents perceive their child's well-being. (Riley et al.,1998)

Expands on CHIP to create a version for adolescents, further validating the framework in measuring health-related quality of life from both parent and adolescent perspectives. Highlights how parents' perceptions of their child's health condition influence their coping mechanisms, decision-making, and stress management. Supports the use of CHIP as a quantitative measure to assess how parents adapt to their child's mental and physical health conditions. (Starfield et al.,1999)

3.2.2 Study Approach

This quantitative study employed a cross-sectional survey design to assess parental coping among parents of children with mental illness using the Child Health Inventory for Parents (CHIP). The design enabled the measurement of coping strategies at a single point in time and facilitated the examination of associations between parental coping

and selected demographic and psychosocial factors. The cross-sectional approach was chosen for its efficiency, feasibility, and suitability for standardized survey-based data collection, while acknowledging its limitation in establishing causal relationships (Sedgwick, 2014; Vogt & Johnson, 2015).

3.3 Study Setting and Period

3.3.1 Study setting

Data was collected from NIMH (National Institute of Mental Health & Hospital), Rehabilitation Centres (CRP Paediatric unit, CRP Rabia-Noor Mental Health Day Centre, CRP-Mental Health Day Centre), Special Schools (William and Marie Taylor School, Prottasha Centre for Autism Care, Smiling Children Special School) in Dhaka.

3.3.2 Study Period

The study period was from June 2025 to December 2025, and the data collection period was from 02 August 2025 to 15 September 2025.

3.4 Study Participants

3.4.1 Study Population

Parents of children and adolescents diagnosed with this six form of mental illness such as Autism-Spectrum Disorder (ASD), Attention-Deficit/Hyperactivity Disorder (ADHD), Intellectual Disability, Depressive Disorder, Anxiety Disorders, Conduct Disorder. [DSM-5, 2013, p. 20, 31, 155, 189, 470].

3.4.2 Sample Size

The study sample refers to the subset of the study population selected for data collection. The sample size and selection process will depend on Cochran's formula, the sample size was calculated for a confidence level of 95%, a margin of error of 5%.

Here, Z= the standard normal deviate usually set at 1.96 for Confidence Interval level = 95%;

Population proportion p= 13.6%= 0.136; As the prevalence of children and adolescents with mental illness are 13.6% (NMHS, 2019).

q= (1-p) = 0.864; d= 5% =0.05;

Sample size, $n = Z^2 pq / d^2 = Z^2 p (1-p) / d^2$

$= (1.96)^2$ o.136 x 0.864 / $(0.05)^2 = 180.56 \sim 181$;

Adding 10% non-response data to the actual sample size = 181+18 = 199;

According to the equation the sample size was 199 participants.

3.4.3 Sampling Techniques

This study used a convenience sampling technique, where participants were selected based on their availability and willingness to participate during the data collection period. Convenience sampling was suitable for this study because parents of children and adolescents with mental illness are often difficult to reach due to caregiving responsibilities, emotional stress, and time constraints related to treatment and hospital visits. Recruiting parents who were readily accessible at hospitals, rehabilitation centres, and special schools allowed the researcher to collect data efficiently within the limited time and resources of an undergraduate research project.

Convenience sampling is widely used in health and mental health research, especially in clinical settings where the study population is readily available and meets

specific inclusion criteria (Etikan et al., 2016). In this study, all participants met clearly defined inclusion and exclusion criteria, which helped ensure that the sample was relevant to the research objectives. Although convenience sampling may limit the generalizability of findings, recruiting participants from multiple settings helped increase sample diversity and strengthen the credibility of the results.

3.4.4 Inclusion and Exclusion Criteria

3.4.4.1 Inclusion Criteria:

- Parents of children and adolescents who were diagnosed with a mental illness before age 15 years, and whose current age was between 7 to 17 years, was included in the study.
- Parents of children and adolescent who were willing to take part in the study and provide informed consent.

3.4.4.2 Exclusion Criteria:

- Parents of children and adolescents who has been diagnosed with a mental illness for less than six months was excluded from the study.
- Parents with severe cognitive impairments or with other mental disorder was excluded from the study to prevent questionnaire complication.

3.5 Ethical considerations

3.5.1 Ethical Clearance

Ethical approval was obtained from the Institutional Review Board (IRB) at the Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI). The IRB form number is CRP-BHPI/IRB/07/2025/1089 (see in details appendix-A).

Permission was also obtained from the Head of the Occupational Therapy department, BHPI, to collect data from the study setting. The study followed ethical guidelines set forth by the World Medical Association (World Medical Association, 2022).

3.5.2 Informed Consent (Information Sheet, Consent Form, Withdrawal Form)

Informed consent is an ethical and legal principle requiring medical interventions to be performed only after participants are fully informed about the purpose, nature, consequences, and risks (Guraya et al., 2014). The student researcher shared participants with an information sheet explaining the aim, objective, and purpose of the study during data collection. The participants expressed their willingness to take part in the study and to have their data with written consent.

3.5.5.1 Participant Explanatory Statement: The Participant Information Sheet provides comprehensive information about the study, aids potential participants in deciding to participate, and offers contact details. (See appendix D)

3.5.5.2 Consent Form: The student researchers emphasize that research participation should be voluntary, informed by sufficient information and understanding often proposed research and its implications (NHMRC,2023). (See Appendix E).

3.5.5.3 Withdrawal Form: Throughout this study, individuals were free to choose, whether to participate or not. They were also allowed to withdraw participation from the study within 2 weeks from the time of interview. (See Appendix F)

3.5.3 Unequal Relationship

The student researcher was preventing unequal relationship from affecting participant selection, ensuring fairness and unbiasedness. The student researcher gathered data

using a standardized questionnaire, and the participants was willing to completed. This approach eliminated potential bias, ensuring a balanced power relationship.

3.5.4 Risk and Beneficence

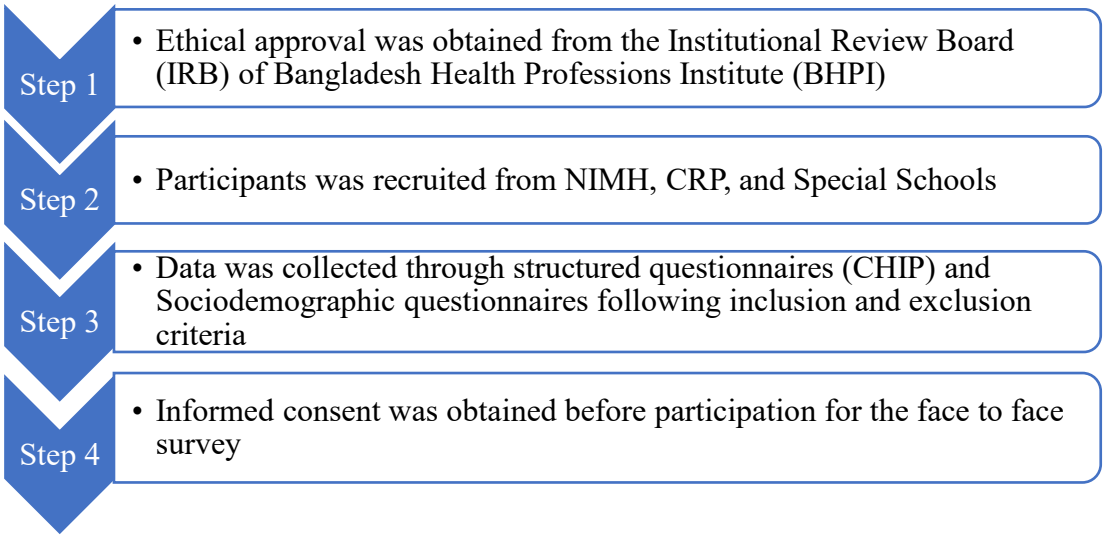
Participation in this study did not involve risk and beneficence. There was no monetary or any other benefit involved in this study. According to the NHMRC 2023, guidelines the researcher was clearly explaining the absence of physical, social, or environmental risks in the study, ensuring informed consent and upholding ethical conduct standards.

3.5.5 Confidentiality

The student researcher was deeply committed to maintaining the confidentiality of the participants' information. The participant's information was shared only with the supervisors, as explicitly mentioned in the information sheet. Additionally, any identifying information about the participants was not disclosed for future use, including report writing, publications, conferences, media, or any written or verbal discussions. The participants were clearly informed about confidentiality through the information sheet.

3.6 Data Collection Process

3.6.1 Participant Recruitment Process



3.6.2 Data Collection Method

Data was collected by face-to-face survey by using CHIP questionnaires.

3.6.3 Data Collection Instrument

The Coping Health Inventory for Parents (CHIP) is a self-report instrument developed to assess how parents manage family life when caring for a child with a serious or chronic illness. It consists of 45 specific behaviours that parents might use to cope with their child's condition. Parents rate each behaviour on a Likert-type scale ranging from 0 (not helpful) to 3 (extremely helpful). If a coping behaviour is not used, parents indicate whether it's by choice or because it's not applicable to their situation. [mccubbinresilience.org]

The CHIP is divided into three subscales:

- Maintaining Family Integration, Cooperation, and an Optimistic Definition of the Situation: This subscale includes 19 behaviours aimed at strengthening family life and fostering a positive outlook.
- Maintaining Social Support, Self-Esteem, and Psychological Stability: Comprising 18 items, this subscale focuses on developing relationships, enhancing self-worth, and managing psychological pressures.
- Understanding the Health Care Situation Through Communication with Other Parents and Consultation with the Health Care Team: This subscale contains 8 behaviours directed at building relationships with healthcare professionals and other parents to better understand the illness and manage home care-treatments.

Each subscale has demonstrated good internal consistency, with Cronbach's alpha coefficients of 0.79, 0.79, and 0.71, respectively. The primary purpose of the CHIP is to measure a family's coping strategies when faced with a child's serious or chronic illness. It helps identify which behaviours parents find helpful in managing family life under

these challenging circumstances. This information can guide interventions to support families in enhancing their coping mechanisms. The CHIP has been widely used in studies involving children with chronic illnesses and disabilities, providing valuable insights into parental coping patterns. (McCubbin, H.I., McCubbin, M.A., Patterson, J.M., Cauble, A.E., Wilson, L.R., & Warwick, W. 1983).

- **Demographic Variables** includes parent age, parent gender, marital status, relationship to the child, educational level, employment status, monthly income, religion, family type, place of residence, number of family member, number of children, child age, child gender, diagnosis, duration of illness, treatment status, schooling status, distance of nearest health facilities.
- **Measurement variables** of CHIP include the three subscales.

3.6.4 Field Test

The student researcher, with the help of the supervisor and a mental health professional expert in formal Bengali writing, translated the questionnaire into Bengali, which is the native language of Bangladesh. To identify potential problems with the questionnaire, it was pretested with one respondent who was similar to the study population. After pretesting, the questionnaire was finalized with the necessary corrections for the study.

3.7 Data Management and Analysis

Data management, which refers to the systematic method of handling, organizing, and guaranteeing the quality and accessibility of data during the study period and its lifecycle, is an essential and integral component of quantitative cross-sectional research, as well as any other type of research. This typically includes various stages from data creation to disposal. Effectively managing data assets, preserving data integrity, conducting analyses, and providing quick, safe access to produced information are the

objectives of research data management. In this instance, following careful data management planning, the procedure began with gathering data through face-to-face surveys using a well-crafted and structured data collection questionnaire. In order to further the cause, the data was processed, cleansed, and loaded into Statistical Package for Social Science (SPSS) version 20. This required looking for, locating, and fixing any problems, duplicate entries, inconsistent data, etc. Following that, appropriate data storage on Google Cloud was made sure of, allowing the data to be conveniently accessible, safe, and structured when needed.

Researcher used descriptive statistics analysis to calculate means, standard deviations and frequency distributions. After the revision of the data set and checking the normality nonparametric tests like T-test and ANOVA test are done for Coping Pattern II (Maintaining social support, Self-esteem and psychological stability), Mann Whitney U test & Kruskal Wallis test are done for Coping Pattern I (Family integration, Cooperation and an Optimistic definition of the situation) and Coping Pattern III (Understanding the healthcare situation through communication with other parents and Consultation with the health care-team) and also multiple linear regression analyses was used to determine associations and predictors. Once the analysis was finished, it is crucial to involve appropriate individuals in the data sharing process, such as supervisors in order to ensure data quality and researchers to guarantee data sharing while maintaining 22 privacy and ethical compliance. And it is necessary to disseminate the findings and insights gained from the data analysis and that is why it was written and presented through tables and reports for the purpose of conveying information effectively. The data preservation and archiving stage of data management is now centered on storing the data in a secure and accessible manner because data has evolved into information and is important for future reference. After ten years, data that is no

longer needed or relevant will be safely deleted or destroyed to safeguard privacy in accordance with established laws and regulations.

3.8 Quality Control and Quality Assurance

The study ensured the highest level of data quality and safety by strictly adhering to the five steps of data cycle management. 120 participants actively participated in this study. The surveys were conducted in a paper document format with areas set aside for answers, along with informed consent and withdrawal forms. Every response of the participants and data was maintained confidentiality. Every document was photocopied for further preservation in order to increase security. Both the data gathering procedure and the ensuing data input were carried out with fairness. All data was originally saved in the SPSS. Furthermore, copies of the data were safely kept in the personal laptop which was highly secured. There was a strong focus on making sure the data was used responsibly, and strict precautions was made to avoid any unwanted access. Throughout the investigation, the data was kept in their original condition; neither alteration nor exploitation took place. As they anticipate its significance for future research projects, the supervisor and the researcher both urge for comprehensive preservation. Realizing that the data will only be useful for a short time once the study period is over, the data utilized in this research will be properly disposed of after its assessment is over.

CHAPTER IV: RESULTS

A cross-sectional study was conducted on the level of parental coping patterns among parents of child and adolescents with mental illness. This chapter presents the study's findings in tables and figures, with comparison of helpfulness levels across coping patterns and association and influence of different variables on coping patterns.

4. 1 Sociodemographic characteristic

Table 4.1:

Distribution of Sociodemographic Characteristics of the parents

Variable	Category	n=120	Percentage (%)
Age	22-42 years	88	73.3
	43-63 years	32	26.7
	Median = 37 years, SD (±7.634), Minimum= 22 years, Maximum= 62 years		
Gender	Male	26	21.7
	Female	94	78.3
Marital status	Married	111	92.5
	Separated/ Divorced	6	5.0
	Widowed	3	2.5
Relationship to the child	Mother	94	78.3
	Father	26	21.7
Educational qualification	No formal education	7	5.8
	Primary	27	22.5
	Secondary	29	24.2

	Higher Secondary	29	24.2
	Graduate	5	4.2
	Postgraduate or above	23	19.2
Occupation	Housewife	82	68.3
	Service holder	17	14.2
	Business	10	8.3
	Farmer	2	1.7
	Others	9	7.5
Monthly income	< 29000 Tk	67	55.8
	29000 or above 29000 Tk	53	44.2
	Median = 25000 BDT, SD (±30896.643), Minimum= 3000 BDT, Maximum= 200000 BDT		
Religion	Islam	116	96.7
	Hinduism	4	3.3

Table 4.1 portrays an overview of the sociodemographic details of parents of child and adolescents with mental illness. The study involved 120 participants, with 21.7% (n=26) being male and 78.3% (n=94) being female, this suggests that caregiving responsibilities are predominantly undertaken by mothers. The average ages of participating parents ranged from 22 to 62 years, with a median age of 37 years with a standard deviation of ±7.634. Most of the parents, 73.3%(n=88) were within the 22–42-year age group, indicating that the majority of caregivers were relatively young to middle-aged adults. A majority of the participants were married 92.5% (n=111), 5% (n=6) were Separated/divorced, 2.5% (n=3) were widowed. 78.3% (n=94) of the total respondents, were mothers and 21.7% (n=26) were fathers. This further reinforces the central caregiving role of mothers in child disability management. Regarding education,

24.2% (n=29) had completed secondary and higher secondary education, 22.5% (n=27) had completed primary education, 19.2% (n=23) held postgraduate or higher degrees and only 5.8%(n=7) had no formal education. The majority of the parents were housewives 68.3% (n=82), followed by service holders 14.2% (n=17) and business owners 8.3% (n=10), a very small percentage were farmers 1.7% (n=2) and engaged in other occupations 7.5% (n=9), this reflects that most mothers were full-time homemakers. The average monthly family income was 25000 BDT., with a standard deviation of ±30896.643. Furthermore, 55.8% (n=67) of the participants reported a monthly family income <29000 BDT and 44.2% (n=53) of the participants reports a monthly family income 29000 or above 29000 BDT, indicating substantial income variation and the presence of both low- and middle-income households. Most families were Muslim 96.7% (116), with a small representation of Hindu families 3.3% (n=4), reflecting the typical religious distribution of the region.

Table 4.2:

Distribution of Sociodemographic Characteristics of the Family

Variable	**Category**	**n=120**	**Percentage (%)**
Family type	Nuclear	95	79.2
	Joint	25	20.8
Place of residence	Urban	25	20.8
	Semi-urban	47	39.2
	Rural	48	40.0
Number of Family members	< 5 persons	89	74.2
	5 or above 5 persons	31	25.8
	1-3 children	111	92.5

Number of Children	4-6 children	9	7.5
Other member with chronic illness/ disability	Yes	10	8.3
	No	110	91.7
Specify illness/ disability	ADHD	3	2.5
	Amputation	1	.8
	ID	5	4.2
	OCD	1	.8

The data in Table 4.2 outlines key details about family information of the participants, such as the majority lived in nuclear families 79.2% (n=95), whereas 20.8%(n=25) lived in joint families. Among the participants, 20.8% (n=25) urban, 39.2% (n=47) semi-urban and 40% (n=48) lived across rural areas, with rural and semi-urban populations forming the majority, this demonstrates wide geographic representation. Most families 74.2% (n=89) had fewer than five members, indicating relatively small household sizes. A vast majority 92.5% (n=111) had 1–3 children, while only 7.5% (n=9) had 4–6 children, reflecting a trend toward smaller family units. Only 8.3% of families had another member with a chronic illness/disability.

Table 4.3:

Distribution of Sociodemographic Characteristics of the child's health and disability

Variable	**Category**	**n=120**	**Percentage (%)**
Age	7-12 years	64	53.3
	13-18 years	56	46.7
	Median = 12 years, SD (±3.258), Minimum= 7 years, Maximum= 17 years		

Gender	Male	86	71.7
	Female	34	28.3
Diagnosis	ASD	29	24.2
	ADHD	33	27.5
	ID	53	44.2
	Anxiety Disorder	8	6.7
	Depressive Disorder	12	10.0
	Conduct Disorder	10	8.3
Duration of illness	< 7 years	94	78.3
	7 or above 7 years	26	21.7
	Median = 5 years, SD (±3.0731), Minimum= .6 years, Maximum= 13 years		
Current treatment/ interventions	Medication	104	86.7
	Physio therapy	2	1.7
	Occupational therapy	57	47.5
	Speech therapy	29	24.2
	Counselling	39	32.5
	Educational support	5	4.2
Current treatment setting	Government hospital	88	73.9
	NGO clinic	10	8.4
	Private hospital	35	29.4
	Others	4	3.3
Current schooling status	Not enrolled	43	35.8
	Regular school	40	33.3
	Special school	29	24.2
	Madrasa	8	6.7

Government disability card or support service	Yes	26	21.7
	No	94	78.3
Hospitalization for this condition last year	Yes	28	23.3
	No	92	76.7
Number of hospitalization times	< 2 times	26	21.7
	2 or above 2 times	2	1.7
Nearest health facility from home	< 10 km	112	93.3
	10 or above 10 km	8	6.7
	Median = 2 km, SD (±5.706), Minimum= 1km, Maximum= 35 km		

Table 4.3 displays the child's health and disabilities information's. The average ages of the child and adolescents ranged from 7 to 17 years, with a median age of 12 years with a standard deviation of ±3.258. Most of them were male 71.7% (n=86), while 28.3% (n=34) were female. The Children presented with diverse mental health conditions such as Intellectual disability 44.2% (n=53), ADHD 27.5% (n=33), ASD 24.2% (n=29), Depressive disorder 10% (n=12), Conduct disorder 8.3% (n=10), Anxiety-disorder 6.7% (n=8), where ID, ADHD, and ASD were the most frequent diagnoses. Most children 78.3% (n=94) had been diagnosed for less than 7 years, with a median duration of 5 years and the duration ranged between 0.6 and 13 years. Among of the children were receiving multiple interventions 86.7% (n=104) were using Medication, 47.5% (n=57) were receiving Occupational therapy, 32.5% (n=39) were receiving Counselling, 24.2% (n=29) were receiving Speech therapy, 4.2% (n=5) were receiving educational support and 1.7% (n=2) were receiving Physiotherapy (1.7%), this indicates a reliance

on pharmacological and multidisciplinary therapeutic care. Most families received treatment from government hospitals 73.9% (n=88), followed by Private hospitals 29.4% (n=35), 8.4% (n=10) NGO clinics and 3.3% (n=4) other settings, indicating that many families utilized more than one service location. Furthermore, a considerable proportion of children were not enrolled in school 35.8% (n=43) and others attended: 33.3% (n=40) of them Regular schools, 24.2% (n=29) of them Special schools, 6.7% (n=8) of them Madrasas, 0.8% (n=1) of them Home-based education, this highlights significant educational challenges among children with disabilities. Only 21.7% (n=26) had a government disability card or received support services and the majority 78.3% (n=94) lacked formal disability certification. About 23.3% (n=28) had been hospitalized in the past year for their condition, although only 1.7% (n=2) required hospitalization two or more times. Among of the respondents most families 93.3% (n=112) lived within 10 km of a health facility, with a median distance of 2 km, only 6.7% (n=8) reported distances of ≥10 km, indicating generally good geographic accessibility.

4.2: Overview of Helpfulness Levels Across Coping Patterns

Figure 4.1

Level of helpfulness for Coping Pattern I: Family integration, Cooperation and an Optimistic definition of the situation.

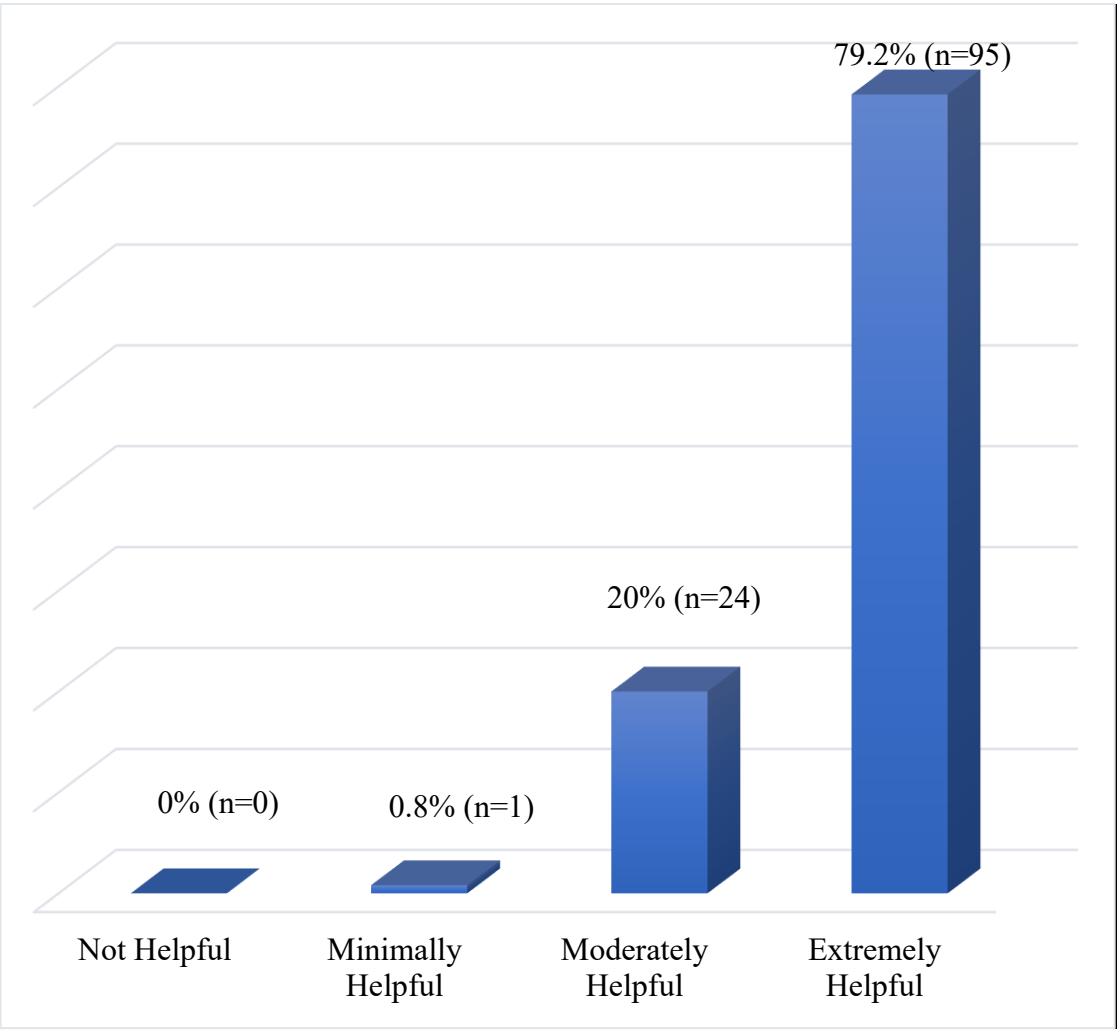


Figure 4.1 portrays that 79.2 % (n=95) of the participants thought that coping pattern I (Family integration, Cooperation and an Optimistic definition of the situation) was extremely helpful, 20% (n=24) was moderately helpful, 0.8% (n=1) was minimally helpful for them, but no one reported that coping pattern I (Family integration, Cooperation and an Optimistic definition of the situation) was not helpful for them.

Figure 4.2

Level of helpfulness for Coping Pattern II: Maintaining social support, Self-esteem and psychological stability.

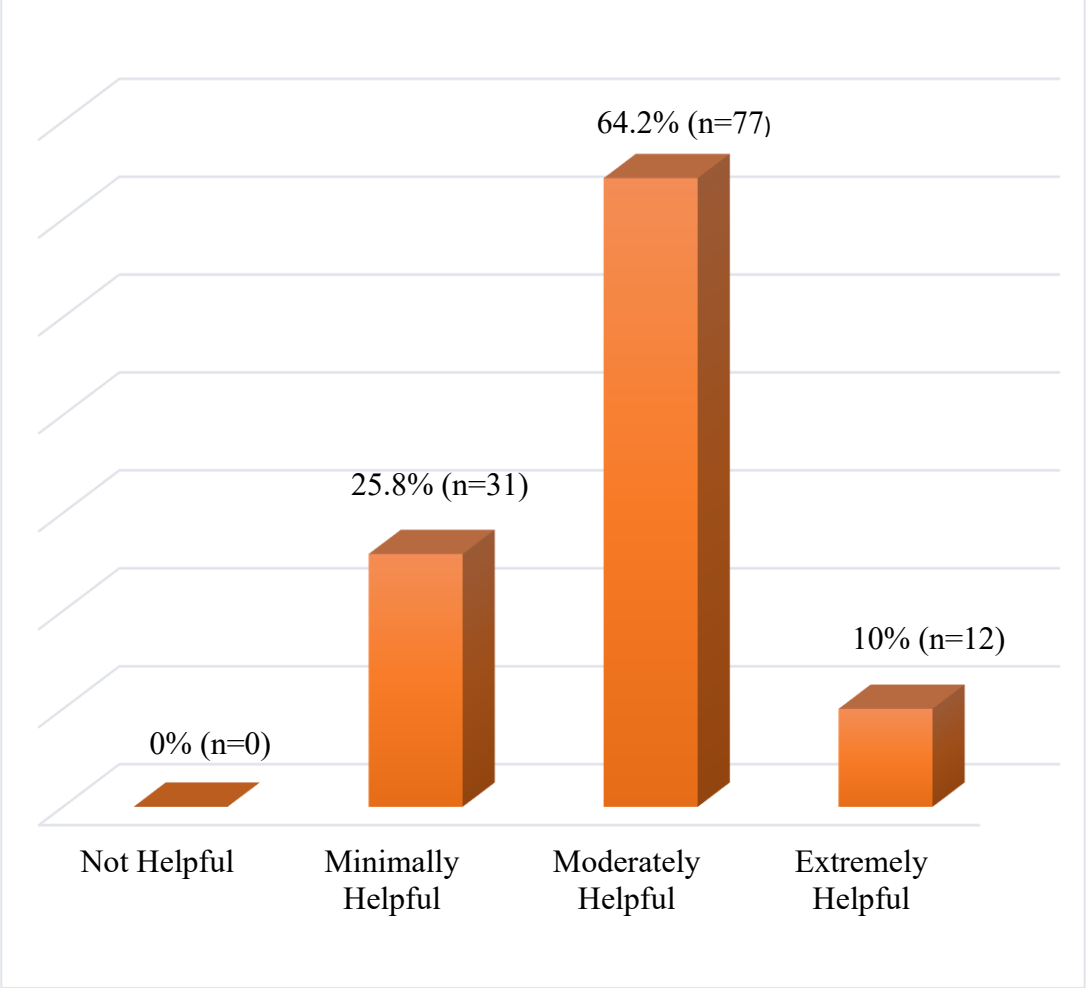


Figure 4.2 shows that 10 % (n=12) of the participants thought that Coping Pattern II (Maintaining social support, Self-esteem and psychological stability) was extremely helpful, 64.2% (n=77) was moderately helpful, 25.8% (n=31) was minimally helpful for them, but no one reported that coping pattern II (Maintaining social support, Self-esteem and psychological stability) was not helpful for them.

Figure 4.3

Level of helpfulness for Coping Pattern III: Understanding the healthcare situation through communication with other parents and Consultation with the health care-team.

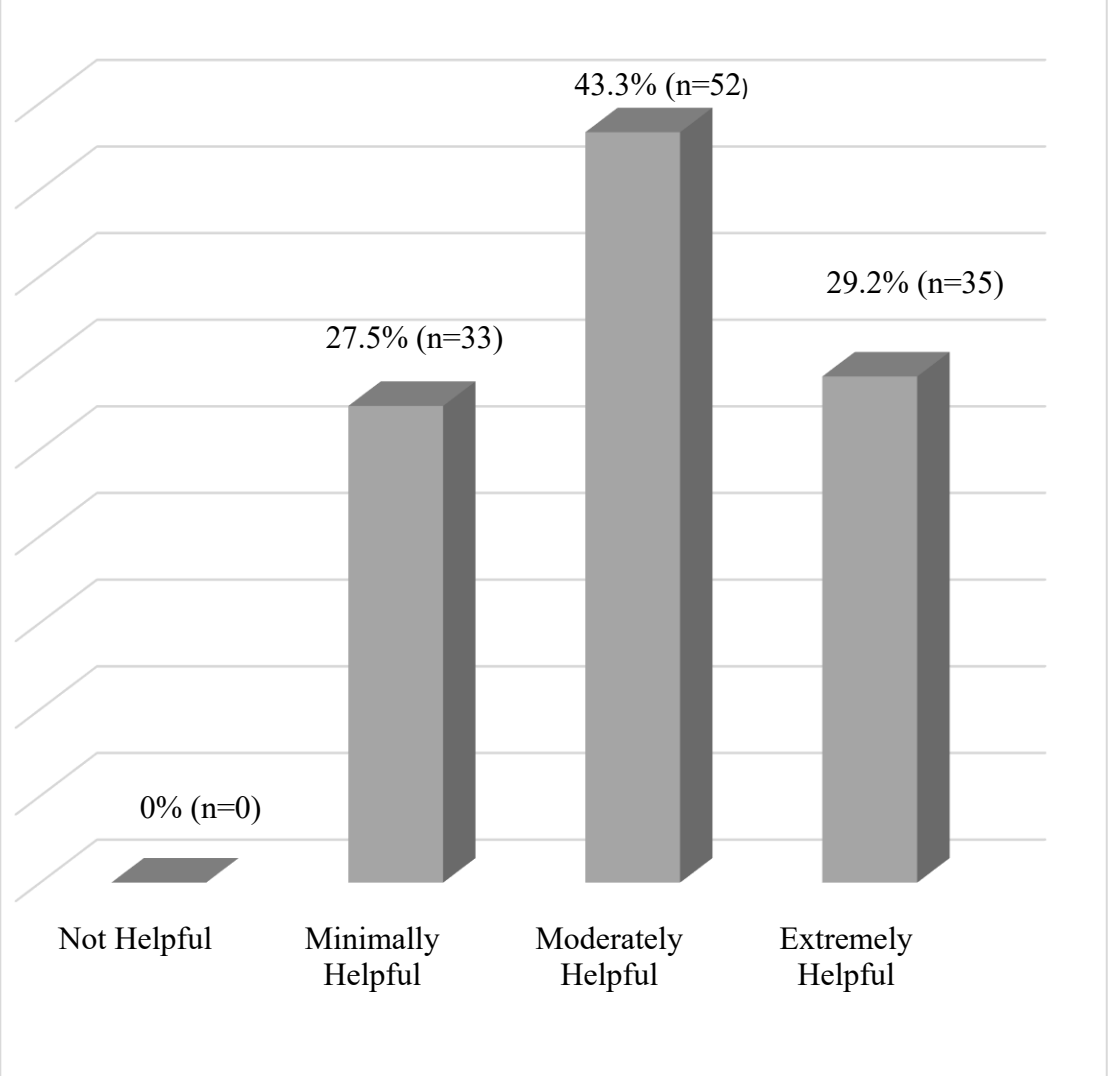
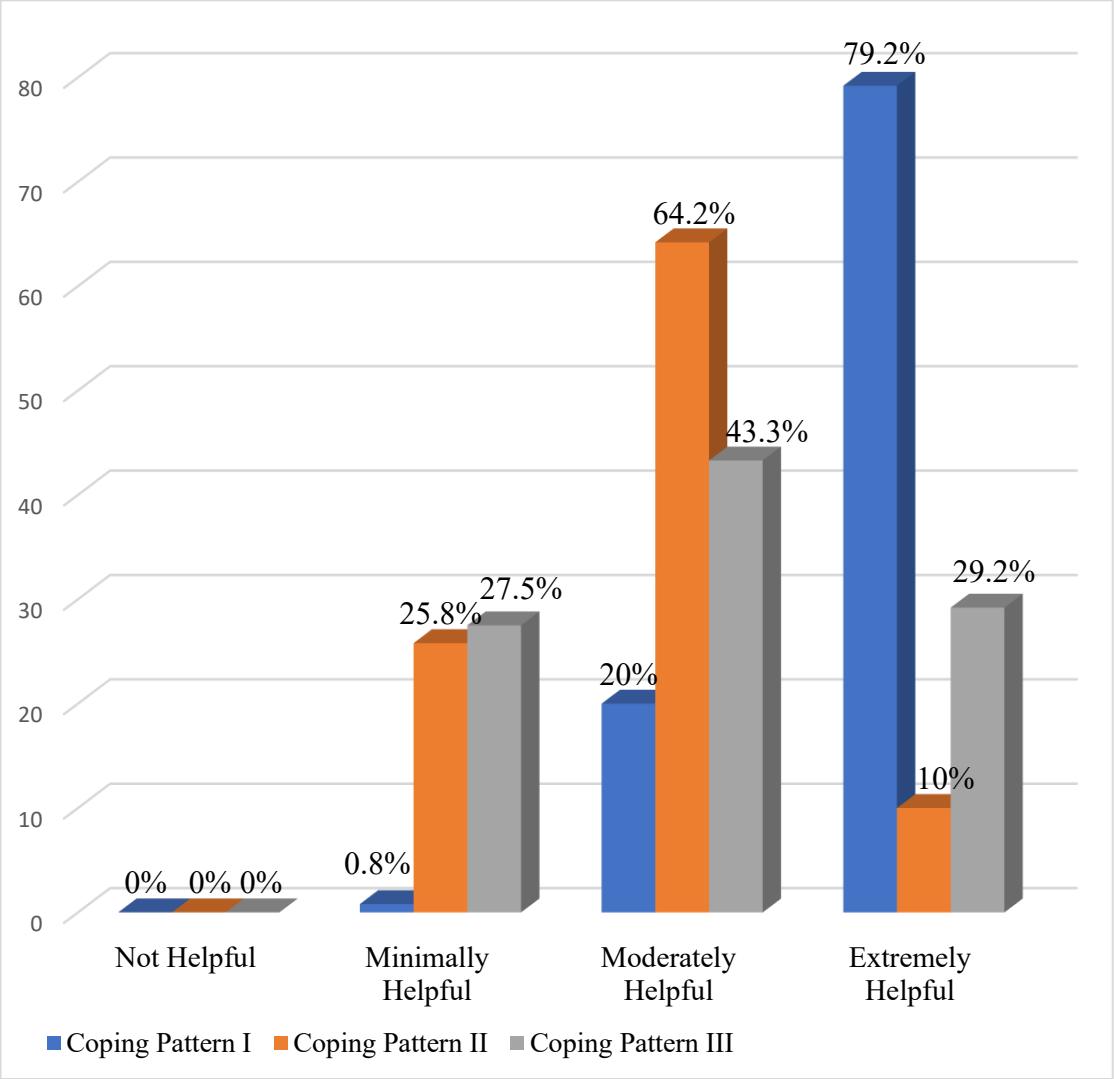


Figure 4.3 displays that 29.2% (n=35) of the participants thought that Coping Pattern III (Understanding the healthcare situation through communication with other parents and Consultation with the health care-team) was extremely helpful, 43.3% (n=52) was moderately helpful, 27.5% (n=33) was minimally helpful for them, but no one reported that coping pattern III (Understanding the healthcare situation through communication with other parents and Consultation with the health care-team.) was not helpful for them.

Figure:4.4

Comparison of Helpfulness Levels Across Coping Patterns



Note:

Coping Pattern I: Family integration, Cooperation and an Optimistic definition of the situation.

Coping Pattern II: Maintaining social support, Self-esteem and psychological stability.

Coping Pattern III: Understanding the healthcare situation through communication with other parents and Consultation with the health care-team.

Figure 4.4 displays the distribution of perceived helpfulness across the three coping patterns of the CHIP scale revealed notable variations. None of the coping patterns were rated as "Not Helpful," indicating that all strategies provided at least some degree of benefit to parents. A minimal proportion of participants (0.8%, n=1) rated Coping

Pattern I as “Minimally Helpful,” whereas substantially higher percentages rated Coping Pattern II (25.8%, n=31) and Coping Pattern III (27.5%, n=33) within this category. In contrast, a larger proportion of parents rated the strategies as “Moderately Helpful,” with Coping Pattern II receiving the highest proportion (64.2%, n=77), followed by Coping Pattern III (43.3%, n=52) and Coping Pattern I (20%, n=24). The most prominent finding emerged in the “Extremely Helpful” category, where Coping Pattern I demonstrated the highest rating (79.2%, n=95), compared to Coping Pattern III (29.2%, n=35) and Coping Pattern II (10%, n=12).

4.3: Overview of Impact of different variables on Coping Patterns

Table 4.4:

Association of different variables with Coping Pattern I: Family Integration, Cooperation, and An Optimistic Definition of the Situation (Mann Whitney U Test)

Family Integration, Cooperation, and An Optimistic Definition of the Situation					
Variable		**Frequencies (n)**	**Mean rank**	**Z-value (Mann Whitney test)**	**P-value**
Parent age	22-42 years	88	55.96	-2.374	.018
	43-63 years	32	72.98		

Table 4.5:

Association of different variables with Coping Pattern I: Family Integration, Cooperation, an Optimistic Definition of the Situation ((Kruskal-Wallis Test)

Family Integration, Cooperation, and An Optimistic Definition of the Situation				
Variable	**Frequencies (n)**	**Mean rank**	**χ^2**	**P-value**

Marital status	Married	111	64.01	15.298	.001
	Separated / Divorced	6	13.58		
	Widowed	3	24.50		
Educational Qualification	No Formal Education	7	34.79	14.610	.012
	Primary	27	58.52		
	Secondary	29	56.12		
	Higher Secondary	29	56.45		
	Graduate	5	52.90		
	Post graduate or above	23	82.93		

Table 4.4 & Table 4.5 shows the mean rank of parent age, marital status, educational qualifications that has an association with Coping Pattern I (Family Integration, Cooperation, and An Optimistic Definition of the Situation) where P values are .018, .001, .012 which was statistically significant (P <0.05).

Table 4.6:

Association of different variables with Coping Pattern II: Maintaining social support, Self-esteem and psychological stability

Maintaining social support, Self-esteem and psychological stability						
Variable		**Frequencies (n)**	**Mean**	**SD**	**ANOVA-test**	**P-value**
Marital states	Married	111	46.81	15.702	5.917	.004
	Separated/ Divorced	6	24.38	16.077		

	Widowed	3	48.77	9.503		
Educational Qualification	No Formal Education	7	29.10	17.591	8.479	.001
	Primary	27	41.77	15.368		
	Secondary	29	43.42	11.162		
	Higher Secondary	29	44.19	15.890		
	Graduate	5	40.00	14.018		
	Post graduate or above	23	61.59	12.808		

Table 4.6 presents the group rank of marital status and educational qualification that has an association Coping Pattern II (Maintaining social support, Self-esteem and psychological stability) where P values are .004, .001 which was statistically significant (P <0.05).

Table 4.7:

Association of different variables with Coping Pattern III: Understanding the healthcare situation through communication with other parents and Consultation with the health care-team. (Mann Whitney U Test)

Understanding the healthcare situation through communication with other parents and Consultation with the health care-team

Variable		Frequencies (n)	Mean rank	Z-value	P-value
Parent gender	Male	26	42.90	-2.919	.004
	Female	94	65.37		
Relationship to child	Mother	94	65.37	-2.919	.004
	Father	26	42.90		
Type of Family	Nuclear	95	57.25	-2.000	.045

	Joint	25	72.86		
Number of children	1-3 child	111	62.40	-2.101	.036
	4-6 child	9	37.11		
Child age	7-12 years	64	67.95	-2.511	.012
	13-18 years	56	51.99		

Table 4.8:

Association of different variables with Coping Pattern III: Understanding the healthcare situation through communication with other parents and Consultation with the health care-team. (Kruskal-Wallis Test)

Understanding the healthcare situation through communication with other parents and Consultation with the health care-team					
Variable		**Frequencies (n)**	**Mean rank**	χ^2	**P-value**
Educational Qualification	No Formal Education	7	14.07	30.451	.001
	Primary	27	46.28		
	Secondary	29	59.59		
	Higher Secondary	29	65.41		
	Graduate	5	59.90		
	Post graduate or above	23	86.41		
Place of residence	Urban	25	62.66	6.920	.031
	Semi-urban	47	69.32		
	Rural	48	50.74		
Current schooling status	Not enrolled	43	51.14	14.438	.002
	Regular school	40	55.81		
	Special school	29	81.45		
	Madrasa	8	58.31		

Table 4.7 & Table 4.8 shows the group rank of parent gender, relationship to child, family type, number of children, child age, educational qualification, place of residence, current schooling status that has an association with Coping Pattern III (Understanding the healthcare situation through communication with other parents and Consultation with the health care-team.) where P values are .004, .004, .045, .036, .012, .001, .031, .002 which was statistically significant ($P< 0.05$)

4.4: Overview of Linear regression Model Analysis

Table 4.9:

Linear regression analysis of Coping Pattern I: Family Integration, Cooperation, and An Optimistic Definition of the Situation.

		Coping Pattern I			
Predictors		**Unadjusted**		**Adjusted**	
		B (95% CI)	**P value**	**B (95% CI)**	**P value**
Parent Age	22-42 years	Reference			
	43-63 years	3.763 (.972; 6.554)	.009	2.867 (.370; 5.365)	.025
Marital Status	Married	Reference			
	Separated / Divorced	-15.797 (-20.879; -10.716)	.001	-14.207 (-19.191; -9.224)	.001
	Widowed	-2.539 (-7.268; 2.190)	.290	-2.283 (-6.860; 2.294)	.325
Educational Qualification	No Formal Education	Reference			
	Primary	4.414 (-1.251; 10.078)	.125	3.912 (-1.096; -8.920)	.125
	Secondary	3.189 (-.560; 6.938)	.095	3.657 (.342; 6.972)	.031
	Higher Secondary	2.044 (-.768; 4.856)	.153	1.816 (-.671; 4.303)	.151
	Graduate	1.594 (-1.534; 4.722)	.315	1.438 (-1.345; 4.220)	.308
	Post graduate or above	3.118 (1.197; 5.040)	.002	2.614 (.929; 4.299)	.003

Table 4.9 presenting the linear regression model analysis, where the unadjusted unstandardized coefficient (B) is showing how much Coping Pattern I (Family Integration, Cooperation, and An Optimistic Definition of the Situation) is influenced by parent age, marital status and educational qualification. Here 43-63 years age group parents showing coping pattern I is 3.763 times more helpful than 22-42 years age group parents which is statically significant where P value is .009.

On the other hand, widowed parents are showing Coping Pattern I is 2.539 times less helpful which is not statistically significant, and separated or divorced parents showing 15.797 times less helpful than the married parents which is statically significant where P value is .001.

In contrast, primary level educated parents showing Coping Pattern I is 4.414 times, secondary level educated parents showing 3.189 times, higher secondary level educated parents showing 2.044 times and graduated parents showing 1.594 times more helpful which is not statically significant and the post graduate or above level educated parents showing 3.118 times more helpful than the parents who had no formal education which is statically significant where P value is .002.

In the adjusted model also Parent age, Marital status, Educational Qualification (secondary, post graduate or above) are statistically significant. So, from the Adjusted and Unadjusted model indicating that parent age, parental marital status and educational qualification has greater influence in explaining the Copping Pattern I .

Table 4.10:

*Linear regression analysis of Coping Pattern II: Maintaining social support, Self-esteem and psychological stability***.**

		Coping Pattern II			
Predictors		**Unadjusted**		**Adjusted**	
		B (95% CI)	**P value**	**B (95% CI)**	**P value**
Marital Status	Married	Reference			
	Separated/Divorced	-11.833 (-18.277; -5.389)	.001	-9.616 (-15.386; -3.847)	.001
	Widowed	1.474 (-4.523; 7.471)	.627	2.191 (-3.161; 7.544)	.419
Educational Qualification	No Formal Education	Reference			
	Primary	6.335 (.374; 12.295)	.037	5.317 (-.436; 11.070)	.070
	Secondary	4.774 (.829; 8.720)	.018	4.446 (.652; 8.240)	.022
	Higher Secondary	3.772 (.813; 6.731)	.013	3.138 (.269; 6.007)	.032
	Graduate	2.180 (-1.112; 5.472)	.192	1.630 (-1.546; 4.807)	.311
	Post graduate or above	5.416 (3.393; 7.438)	.001	4.958 (2.998; 6.918)	.001

Table 4.10 presenting the linear regression model analysis, where the unadjusted unstandardized coefficient (B) is showing how much Coping Pattern II (Maintaining social support, Self-esteem and psychological stability) is influenced by parents' marital status and

educational qualification. This time widowed parents showing that coping pattern II is 1.474 times more helpful which is not statically significant and separated or divorced parents are showing 11.833 times less helpful than the married parents which is statistically significant where P value is .001.

On the other hand, primary level educated parents showing coping pattern II is 6.335 times, secondary level educated parents showing 4.774 times, higher secondary level educated parents showing 3.772 times, post graduate or above level educated parents showing 5.416 times more helpful which is statically significant where P values are .037, .018, .013, .001, and the graduated parents showing 2.180 times more helpful than the parents who had no formal education which is not statically significant.

In contrast the adjusted model also showing that parents Marital Status (separated/ divorced) and Educational Qualification (Secondary, higher secondary, post graduate or above) are statistically significant. So, from the Adjusted and Unadjusted model indicating that parental educational qualifications and parental marital status have equal influence in explaining the Copping Pattern II.

Table 4.11:

Linear regression analysis of Coping Pattern III: Understanding the healthcare situation through communication with other parents and Consultation with the health care-team.

		Coping Pattern III			
Predictors		**Unadjusted**		**Adjusted**	
		B (95% CI)	**P value**	**B (95% CI)**	**P value**
Relationship to child	Mother	Reference			
	Father	-7.593 (-12.474; -2.713)	.003	-4.566 (-9.299; .168)	.059
Type of Family	Nuclear	Reference			
	Joint	5.272 (.216; 10.328)	.041	1.140 (-3.566; 5.846)	.632
Number of children	1-3 child	Reference			
	4-6 child	-8.721 (-16.495; -.947)	.028	-3.297 (-10.557; 3.963)	.370
Child age	7-12 years	Reference			
	13-18 years	-5.004 (-9.092; -.915)	.017	-.321 (-4.452; 3.810)	.878
	No Formal Education	Reference			

Educational Qualification	Primary	11.618 (3.155; 20.081)	.008	10.859 (1.913; 19.805)	.018
	Secondary	10.605 (5.003; 16.206)	.001	9.572 (3.584; 15.560)	.002
	Higher Secondary	8.816 (4.614; 13.017)	.001	7.782 (2.954; 12.609)	.002
	Graduate	6.190 (1.517; 10.864)	.010	5.733 (.651; 10.815)	.027
	Post graduate or above	8.299 (5.428; 11.170)	.001	7.472 (4.099; 10.845)	.001
Place of residence	Urban	Reference			
	Semi-urban	2.512 (-3.009; 8.034)	.369	-1.124 (-6.683; 4.436)	.689
	Rural	-2.485 (-6.152; 1.182)	.182	.706 (-2.900; 4.312)	.699
Current schooling status	Not enrolled	Reference			
	Regular school	1.586 (-3.168; 6.340)	.510	-3.416 (-8.333; 1.501)	.171
	Special school	6.724 (3.257; 10.191)	.001	2.838 (-1.078; 6.753)	.154
	Madrasa	1.235 (-2.931; 5.402)	.558	-.564 (-4.588; 3.460)	.782

Table 4.11 presenting the linear regression model analysis, where the unstandardized coefficient (B) is showing how much Coping III (Understanding the healthcare situation through communication with other parents and Consultation with the health care-team) is influenced

by relationship to child, family type, number of children, child age, educational Qualification, place of residence and current schooling status. Here fathers are showing that coping pattern III is 7.593 times less helpful than mothers which is statistically significant where P value is .003. Also, joint families showing that coping pattern III is 5.272 times more helpful than nuclear families which is statistically significant where P value is.041.

In addition, 4-6 child in the families showing that coping pattern III is 8.721 times less helpful than 1-3 child in the families which is statistically significant where P value is .028. Also, 13-18 years age child in the families showing that coping pattern III is 5.004 times less helpful than 7-12 years child in the families which is statistically significant where P value is .017.

In contrast, primary level educated parents showing coping pattern III is 11.618 times, secondary level educated parents showing 10.605 times, higher secondary level educated parents showing 8.816 times, graduated parents showing 6.190 times and the post graduate or above level educated parents showing 8.299 times more helpful than the parents who had no formal education which is statically significant where P values are .008, .001, .001, .010, .001.

The families who are living in rural areas showing coping pattern III is 2.485times less helpful and families who are living in semi urban areas showing 2.512 times more helpful than families who are living in urban areas which is not statically significant. Finally, the regular school going child's parents are showing that coping pattern III is 1.586 times, madrasa going child's parents showing 1.235 times more helpful which is not statically significant but special school going child's parents are showing 6.724 times more helpful than the parents whose children are not enrolled in any school that is also statically significant where P value is .001.

Here the adjusted model showing that only parents Educational Qualification (primary, secondary, higher secondary, graduate and post graduate or above) is statistically significant. So, from the Adjusted and Unadjusted model indicating that parental educational qualifications have the most influence in explaining the Copping Pattern II than other predictors.

CHAPTER V: DISCUSSION

This study assessed the level of coping patterns of parents of children and adolescents with mental illness using the Coping Health Inventory for Parents (CHIP) scale and explored how various sociodemographic and child-related associated factors influenced these coping mechanisms. Data was collected through face-to-face interviews where 120 parents were participated, so the response rate was 60.30% of the total sample size. However, achieving this percentage was challenging due to short data collecting period. The findings of this study provide an important understanding of the unique challenges faced by Bangladeshi parents and how their coping strategies align with previous literature.

The present study found that Coping Pattern I (Family Integration, Cooperation, and an Optimistic Definition of the Situation) was the most helpful strategy, with 79.2% of parents rating it as extremely helpful. This finding is consistent with multiple studies indicating that family cohesion, emotional bonding, and collective problem-solving are strong protective factors for families raising children with developmental or mental disorders (McCubbin & McCubbin,1996; Heiman, 2021). Cultural norms in South Asian contexts often emphasize family unity, shared responsibility, and collective caregiving, which may enhance the perceived usefulness of this coping pattern.

Younger parents reported significantly lower use of this pattern compared to older parents. Previous studies have similarly shown that older parents often cope more effectively due to greater emotional maturity and long-term adaptation to caregiving demands (Hastings, 2002). Additionally, separated/divorced parents reported significantly lower coping scores, reflecting literature indicating that lack of partner support and single-parent stress reduces coping resources (Benson, P.R. 2014).

Higher educational attainment significantly enhanced the helpfulness of this coping pattern. Consistent with earlier research, educated parents may have better problem-solving skills, higher health literacy, and improved access to information and services, which strengthen positive reframing and family integration strategies (Rajan & Romate, n.d. 2021).

Coping Pattern II (Maintaining Social Support, Self-Esteem, and Psychological Stability) was rated as moderately helpful by most parents (64.2%) but was the least likely to be rated extremely helpful (10%). This aligns with previous South Asian studies that report limited use of social support networks due to stigma, fear of judgment, and social isolation associated with mental illness (Islam & Sharif, 2018). Even though social support is widely recognized in global literature as a major protective factor (Peer & Hillman, 2014), cultural stigma often inhibits parents from actively seeking emotional or community support. Also, marital status significantly influenced this coping pattern, with separated/divorced parents reporting much lower scores. Similar findings in other studies demonstrate that the absence of spousal support can reduce self-esteem and increase psychological vulnerability (Weiss et al., 2015).

Education again played a strong role. Parents with higher education (secondary, higher secondary, and postgraduate) reported significantly higher coping levels. International research also confirms that educated parents tend to access support groups, counselling, and community services more frequently (Brown et al., 2019), contributing to greater psychological stability.

Coping Pattern III (Understanding the Healthcare Situation Through Communication and Consultation) received mixed responses, with 29.2% finding it extremely helpful and 43.3% moderately helpful. This reflects the importance parents place on interacting with healthcare providers and other parents. Earlier studies using

the CHIP scale have similarly found that communication with professionals enhances parental confidence, reduces uncertainty, and improves decision-making (McCubbin et al., 1983; Johnston & Mash, 2001). Mothers used this coping pattern significantly more than fathers, consistent with previous evidence showing that mothers attend more therapy sessions, engage more with professionals, and participate in parent support meetings (Ling & Fung, 2020). Joint families also demonstrated higher use of this pattern, a finding that echoes literature where extended families offer additional emotional and informational support (Rane & Potdar, 2019).

Education showed the strongest effect on this coping pattern among all variables. The more educated the parent, the greater the perceived helpfulness. Studies consistently show that education improves health system navigation, understanding of treatment options, and engagement in therapy (Ajuwon & Brown, 2012). Children attending special schools had significantly higher parental coping scores. This supports previous research stating that special education centers offer structured guidance, multidisciplinary support, and parent networking opportunities that directly enhance parental coping (Kirk & Gallagher, 2015).

Linear regression analyses confirmed the influence of sociodemographic variables on coping. In all three coping patterns, education emerged as a consistently significant predictor, highlighting the critical role of parental knowledge, awareness, and problem-solving capacity in coping with the challenges of raising a child with mental illness. Marital status and family structure also played substantial roles, reinforcing the importance of strong social and spousal support systems.

Overall, the findings of this study is that family cohesion is a high-impact coping strategy, mothers bear the primary caregiving burden and therefore use more coping strategies, social support is helpful but often underutilized in stigmatized contexts,

education consistently strengthens coping across all CHIP patterns, parents of children enrolled in special schools cope better due to increased professional contact, reliance on government hospitals was high (73.9%) is indicating financial constraints or trust in public service, income variation was wide and poverty may limit service utilization and coping. These factors highlight cultural, structural, and socio-economic influences on coping patterns that are especially relevant for low- and middle-income countries like Bangladesh.

CHAPTER VI: CONCLUSION

6.1 Strength and Limitation

6.1.1 Strength

- The data collection from participants and the data entry process was non-biased.
- The study utilized the Coping Health Inventory for Parents (CHIP), a widely recognized and validated instrument, ensuring reliability of findings related to parental coping.
- The study employed both nonparametric tests and multivariate regression analysis, which strengthened the identification of significant predictors and improved the robustness of findings.
- For data safety and validation, all the data used in this study will be destroyed.
- With 120 parents from various sociodemographic backgrounds, the study achieved sufficient representation from urban, semi-urban, and rural areas, enhancing the generalizability within similar contexts in Bangladesh.
- This is one of the few studies in Bangladesh that examines parental coping in relation to childhood mental illness, contributing important local evidence to a field with limited national literature.

6.1.2 Limitation

Some limitations of this study are:

- Participants were recruited from selected rehabilitation center, hospitals or clinics, which may exclude parents who do not access formal health services and therefore limits broader generalizability.
- The findings from Cross-sectional design reflect a single point in time, limiting

the ability to draw causal relationships or understand changes in coping over time.

- All information was collected through parent reports, which may introduce recall bias or social desirability bias.
- Factors such as severity of the child's illness, parental mental health, family stress levels, and availability of extended support systems were not assessed, though they may significantly influence coping.

6.2 Practice Implication

6.2.1 Recommendation for future practice

- Enhancing family-cantered mental health support: Since family integration was the strongest coping pattern, mental health programs should focus on strengthening family relationships through family counselling, psychoeducation, and structured support interventions.
- Targeted support for mothers and single parents: Mothers and separated/divorced parents showed lower coping levels in certain patterns. Tailored support such as parent training, peer groups, and stress-management programs is needed for these high-risk groups.
- Promotion of parental education and awareness programs: Education emerged as the strongest predictor of coping across all patterns. Health systems should provide regular workshops, counselling sessions, and printed or digital educational materials for parents.
- Expanding access to multidisciplinary services: Children attending special schools or receiving therapy showed better parental coping. Expanding special

education centres, occupational therapy and counselling services would greatly improve coping outcomes.

- Reducing stigma through community-based awareness: Social stigma often inhibits parents from seeking support. Community-level campaigns, parents' groups, and collaboration with schools can reduce stigma and improve help-seeking behaviour.
- Strengthening healthcare communication: Parents benefit significantly from communication with healthcare providers. Training for professionals in family counselling, empathy-based communication, and parent engagement is essential.

6.2.2 Recommendation for future research

- Future research should evaluate coping changes over time to understand long-term adaptation and the impact of therapeutic interventions.
- Studies should assess parental mental health, stress, depression, and anxiety, as these factors significantly influence coping.
- Comparing coping between parents of children with mental illness, chronic physical illness, and neurodevelopmental disorders may provide deeper insights.
- In-depth interviews or focus groups can reveal richer insights about parental experiences, cultural influences, and coping challenges.
- Testing parent training programs, counselling modules, or support groups can identify effective strategies to improve coping.

6.3 Conclusion

This study explored the level of coping patterns of parents of children and adolescents with mental illness using the CHIP scale and identified significant sociodemographic and child-related predictors. The findings revealed that Coping Pattern I (Family Integration, Cooperation, and Optimism) was the most effective and widely used strategy among parents in Bangladesh. Educational attainment, marital stability, family structure, and the child's schooling status were significant factors that shaped coping behavior.

The study highlights that parental coping is deeply influenced by both individual and contextual factors. Mothers, younger parents, separated/divorced parents, and families with limited educational or financial resources are more vulnerable and require focused support. Strengthening family-centered care, improving healthcare communication, promoting parent education, and expanding access to specialized services are essential to improving parental well-being.

Overall, the study contributes valuable evidence to the limited literature on parental coping in Bangladesh and underscores the need for more comprehensive support systems to empower families raising children with mental illness.

CHAPTER VII: REFERENCE

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APPENDICES

Appendix A: Ethical Approval Letter

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

BANGLADESH HEALTH PROFESSIONS INSTITUTE

Ref: CRP-BHPI/IRB/07/2025/1089 Date: 21.07.2025

To
Elmin Akter
4th Year B.Sc. in Occupational Therapy
Session: 2020-2021, Student ID: **122200402**
BHPI, CRP, Savar, Dhaka-1343

Subject: Approval of the thesis proposal Level of Parental Coping among Parents of Children and Adolescents with Mental Illness by ethics committee.

Dear Elmin Akter,
Congratulations.
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above mentioned dissertation, with yourself, as the principal investigator and Md. Saddam Hossain Assistant Professor, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as thesis supervisor. The Following documents have been reviewed and approved:

SL No.	Name of the Documents
1	Research Proposal
2	Coping Health Inventory for Parents (CHIP) Scale (English & Bangla)
3	Information sheet & consent form.

The purpose of the study is to find out the level of parental coping among parents of children and adolescents with mental illness. The study involves use of a Coping Health Inventory for Parents (CHIP) Scale to find out the level of parental coping among parents of children and adolescents with mental illness that may take 30 to 35 minutes to answer the questionnaire and there is no likelihood of any harm to the participants. There is no benefit to the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 8:30 AM on 17 June, 2025 at BHPI (50th IRB Meeting).

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

Best regard,

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

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

Appendix B: Permission Letter for Scale

Queries regarding permission and scoring of Child Health Inventory for Parents

Inbox
Search for all messages with label Inbox
Remove label Inbox from this conversation

E

Elmin Hossain Zoana <elminhossainzoana07@gmail.com> Wed 29 Jan, 11:22

to mccubbinresilience

Dear Sir,

I hope you are well. I am Elmin Akter, a student in the final year of a B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (an academic institute of CRP) in Bangladesh. In our course curriculum, we have to undertake undergraduate research. I am passionate about researching time use, and my research title is "Measuring parental coping of children with mental illness of any age". I want to use the Child Health Inventory for Parents you and your team developed in this research. Therefore, I have a few questions about the questionnaire. I would appreciate it if you could guide me with my following queries:

1. How can I get permission to use this questionnaire?

2. What is the licensing system or procedure?

3. Do I need to pay for using this questionnaire?

4. What is the scoring system for the questionnaire?

5. Can I translate it into Bengali by keeping the original meaning unchanged? Because the native language of my participants is Bengali, it will be helpful for the survey.

Your response to my queries will be beneficial to me. I have copied this email to my supervisor, Arifa Jahan Ema, Lecturer in Occupational Therapy and Course Coordinator of MSc in Occupational Therapy of BHPI.

I look forward to hearing from you! Thank you very much!

Regards,

Elmin Akter

4th year student

B.Sc. in Occupational therapy

Sessions: 2020-21

Bangladesh Health Professions Institute,

CRP, Chapain, Savar, Dhaka-1343

Phone No: 01886074766

Jason Sievers <jasievers@gmail.com> Wed 29 Jan, 18:52

to me

Elmin --

You have our permission to use the Coping Health Inventory for Parents measure for your research free of charge. You can find the measure at https://www.mccubbinresilience.org/measures.html and all of its information.

Respectfully,

Laurie "Lali" McCubbin, PhD

Jason A. Sievers, PhD

Hamilton I. McCubbin, PhD (retired)

Resilience, Adaptation and Well-Being Project

Email: mccubbinresilience@gmail.com

Website: www.mccubbinresilience.org

Appendix C: Permission Letters for Data Collection

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)
CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 02/08/2025

To
The Principal,
William and Marie Taylor School- CRP,
Chapain, Savar, Dhaka-1343, Bangladesh.

Subject: Regarding permission for data collection for undergraduate research.

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is "Level of Parental Coping among Parents of Children and Adolescents with Mental Illness" with myself & Md. Saddam Hossain, Assistant Professor, Department of Occupational Therapy, BHPI, as my thesis supervisor. The purpose of the study is to find out the level of parental coping among parents of children and adolescents with mental illness and I have to use Coping Health Inventory for Parents (CHIP) Scale. In order to fulfill the objective of this study, I would like to collect data from parents of children with mental illness (ASD, ADHD, ID, Anxiety, Depression, Conduct Disorder) who are currently studying at William and Marie Taylor School-CRP and the data collection period is from 02/08/2025 to 15/09/2025. I assure you that collected information that will be used solely for academic purpose and confidentiality will be maintain in accordance with ethical guideline. Your permission and support would be invaluable in facilitating the successful completion of my research.

So, I therefore, pray and hope that you would be kind enough to grant me permission to collect data for my study and oblige thereby.

Permitted for Data collection from WMTS.

2-8-25
MD. ABDULLAH AL ZUBAYER
Principal
William and Marie Taylor School
CRP, Savar, Dhaka-1343

Sincerely yours,

Elmin Akter
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200402
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the thesis supervisor	Signature, Head of the Department
Md. Saddam Hossain Assistant Professor Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343	Prof. Sk. Monirujzzaman Professor & Head Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter.

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)
CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 02/08/2025

To
The head of the Pediatric Department,
Centre for the Rehabilitation of Paralyzed
CRP-Chapain, Savar, Dhaka-1343

Subject: Regarding permission for data collection for undergraduate research.

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is "Level of Parental Coping among Parents of Children and Adolescents with Mental Illness" with myself & Md. Saddam Hossain, Assistant Professor, Department of Occupational Therapy, BHPI, as my thesis supervisor. The purpose of the study is to find out the level of parental coping among parents of children and adolescents with mental illness and I have to use Coping Health Inventory for Parents (CHIP) Scale. In order to fulfill the objective of this study, I would like to collect data from parents of children with mental illness (ASD, ADHD, ID) who are currently receiving treatment from Pediatric Department - CRP and the data collection period is from 02/08/2025 to 15/09/2025. I assure you that collected information that will be used solely for academic purpose and confidentiality will be maintain in accordance with ethical guideline. Your permission and support would be invaluable in facilitating the successful completion of my research.

So, I therefore, pray and hope that you would be kind enough to grant me permission to collect data for my study and oblige thereby.

She will collect data from this Department. please help her. Thanks
2-8-25

Sincerely yours,
Elmin
Elmin Akter
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200402
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Hosneara Pervee
Head of Department
Department of Paediatri
CRP, Savar, Dhaka

Recommendation from the thesis supervisor	Signature, Head of the Department
Md. Saddam Hossain Assistant Professor Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343	Prof. Sk. Moniruzzaman Professor & Head Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter.

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 02/08/2025

To
The Project Manager,
Meaningful Social Access for Persons with Mental Health Needs
CRP, Chapain, Savar, Dhaka-1343

Subject: Regarding permission for data collection for undergraduate research.

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is **"Level of Parental Coping among Parents of Children and Adolescents with Mental Illness"** with myself & Md. Saddam Hossain, Assistant Professor, Department of Occupational Therapy, BHPI, as my thesis supervisor. The purpose of the study is to find out the level of parental coping among parents of children and adolescents with mental illness and I have to use Coping Health Inventory for Parents (CHIP) Scale. In order to fulfill the objective of this study, I would like to collect data from parents of children with mental illness (ASD, ADHD, ID, Anxiety, Depression, Conduct Disorder) who are currently receiving treatment from Rabia Noor Mental Health Day Centre and the data collection period is from 02/08/2025 to 15/09/2025. I assure you that collected information that will be used solely for academic purpose and confidentiality will be maintain in accordance with ethical guideline. Your permission and support would be invaluable in facilitating the successful completion of my research.

So, I therefore, pray and hope that you would be kind enough to grant me permission to collect data for my study and oblige thereby.

Sincerely yours,
Elmin
Elmin Akter
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200402
BHPI, CRP, Savar, Dhaka-1343

Application is granted for data collection and it is strongly advised to maintain ethical standards and confidentiality in accordance with code of ethics related to the Psychosocial areas.

Rdemn (2219)
02.08.2025

Recommendation from the thesis supervisor	Signature, Head of the Department
Md. Saddam Hossain Assistant Professor Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343	Prof. Sk. Moniruzzaman Professor & Head Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter.

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 02/08/2025

To
The Deputy General Manager,
CRP-Mirpur,
Plot A/5; Block A, Mirpur 14,
Dhaka-1206

Subject: Regarding permission for data collection for undergraduate research.

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is "Level of Parental Coping among Parents of Children and Adolescents with Mental Illness" with myself & Md. Saddam Hossain, Assistant Professor, Department of Occupational Therapy, BHPI, as my thesis supervisor. The purpose of the study is to find out the level of parental coping among parents of children and adolescents with mental illness and I have to use Coping Health Inventory for Parents (CHIP) Scale. In order to fulfill the objective of this study, I would like to collect data from parents of children with mental illness (ASD, ADHD, ID, Anxiety, Depression, Conduct Disorder) Conduct Disorder who are currently receiving treatment from Mental Health Day Centre and the data collection period is from 02/08/2025 to 15/09/2025. I assure you that collected information that will be used solely for academic purpose and confidentiality will be maintain in accordance with ethical guideline. Your permission and support would be invaluable in facilitating the successful completion of my research.

So, I therefore, pray and hope that you would be kind enough to grant me permission to collect data for my study and oblige thereby.

Sincerely yours,

Elmin Akter
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200402
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

In-charge Paediatric Unit
Affn. In-charge, OT Dept
Please allow the student from to collect data from Paediatric Unit
17-08-25

Recommendation from the thesis supervisor	Signature, Head of the Department
Md. Saddam Hossain Assistant Professor Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343	02/8 Prof. Sk. Moniruzzaman Professor & Head Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter.

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালক ও অধ্যাপকের কার্যালয়
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট ও হাসপাতাল
শের-ই-বাংলা নগর, ঢাকা- ১২০৭

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/২৫৮৭ তারিখঃ ২৪/৮/২৫

বরাবর

এসকে মনিরুজ্জামান
অধ্যাপক এন্ড প্রধান
অকুপেশনাল থেরাপি বিভাগ
পক্ষাঘাতগ্রস্তদের পূনর্বাসন কেন্দ্র (সিআরপি)
চাপাইন, সাভার, ঢাকা।

বিষয় : গবেষনা সংক্রান্ত তথ্য (ডাটা) সংগ্রহের অনুমতি প্রদান প্রসঙ্গে।

উপরোক্ত বিষয়ের আলোকে বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), ঢাকা এর বিএসসি চতুর্থ বর্ষের শিক্ষার্থী কে জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, শেরে বাংলা নগর, ঢাকায় "Level of Parental Coping among Parents of Children and Adolescents with Mental Illness" বিষয়ক গবেষনা সংক্রান্ত থিসিসের তথ্য উপাত্ত (ডাটা) সংগ্রহের জন্য অনুমতি প্রদান করা হলো।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা।

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/ তারিখঃ

অনুলিপি অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহনের জন্য প্রেরন করা হলো ঃ-

১। সহযোগী অধ্যাপক, চাইল্ড, এডলোসেন্ট এন্ড ফ্যামিলি সাইকিয়াট্রি বিভাগ, এনআইএমএইচ, ঢাকা।।
২। সহযোগী অধ্যাপক, জেরিয়াট্রিক এন্ড অর্গানিক সাইকিয়াট্রি, এনআইএমএইচ, ঢাকা।
৩। ড. মোঃ জহির উদ্দিন, সহকারী অধ্যাপক, ক্লিনিক্যাল সাইকোলজি, এনআইএমএইচ, ঢাকা।
৪। মোঃ জামাল হোসেন, সাইকিয়াট্রিক সোসাল ওয়ার্কার, এনআইএমএইচ, ঢাকা।
৫। রেসিডেন্ট সাইকিয়াট্রিস্ট, এনআইএমএইচ, ঢাকা।
৬। প্রশাসনিক কর্মকর্তা, এনআইএমএইচ, ঢাকা।
৭। পরিচালক মহোদয়ের ব্যক্তিগত সহকারী, জাতীয় মানসিক স্বাস্থ্য ইনষ্টিটিউট, ঢাকা।
৮। সহকারী লাইব্রেরিয়ান, এনআইএমএইচ, ঢাকা।
৯। অফিস কপি।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা

Student Office Order-286

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 02/08/2025

To
To The Principal,
Prottasha Centre for Autism Care.
Dogormora, CRP Road, Savar, Dhaka-1343

Subject: Regarding permission for data collection for undergraduate research.

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is "**Level of Parental Coping among Parents of Children and Adolescents with Mental Illness**" with myself & Md. Saddam Hossain, Assistant Professor, Department of Occupational Therapy, BHPI, as my thesis supervisor. The purpose of the study is to find out the level of parental coping among parents of children and adolescents with mental illness and I have to use Coping Health Inventory for Parents (CHIP) Scale. In order to fulfill the objective of this study, I would like to collect data from parents of children with mental illness (ASD, ADHD, ID, Anxiety, Depression, Conduct Disorder) who are currently who are currently receiving care at Prottasha Centre for Autism Care and the data collection period is from 02/08/2025 to 15/09/2025. I assure you that collected information that will be used solely for academic purpose and confidentiality will be maintain in accordance with ethical guideline. Your permission and support would be invaluable in facilitating the successful completion of my research.

So, I therefore, pray and hope that you would be kind enough to grant me permission to collect data for my study and oblige thereby.

Sincerely yours,

Elmin Akter
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200402
BHPI, CRP, Savar, Dhaka-1343

Kawsar Ahmed
Vice Principal
Prottasha Centre for Autism Care

Recommendation from the Head of the Department:

Recommendation from the thesis supervisor	Signature, Head of the Department
Md. Saddam Hossain Assistant Professor Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343	Prof. Sk. Moniruzzaman Professor & Head Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter.

Appendix D: Information Sheet [English & Bangla Version]

PARTICIPANT EXPLANATORY STATEMENT

Research Title: Level of Parental Coping among Parents of Children and Adolescents with Mental Illness.

Student Investigator	**Elmin Akter** 4th Year, B. Sc. in Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka- 1343 Call: +8801886074766 Email: elminhossainzoana07@gmail.com
Principal Investigator	**Md. Saddam Hossain** Assistant Professor Department of Occupational Therapy Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka- 1343 Call: +8801766494605 Email: saddamot6@gmail.com

This information sheet is for you to keep.

What is the purpose of this research?

Parenting a child with a mental health condition can be emotionally and physically demanding. By understanding how parents cope, this study aims to contribute to the development of improved psychological support, educational programs, and intervention strategies tailored to the needs of families. You are invited to participate in this study, which aims to explore how parents cope with the challenges of raising a child

with a mental illness. We will use the Coping Health Inventory for Parents (CHIP) tool, a widely used questionnaire designed to assess different coping strategies. If you agree to participate, you will be asked to complete a questionnaire about your experiences and coping strategies. Your responses will remain confidential, and participation is voluntary.

What does the research involve?

Please read this explanatory statement in full before deciding whether you are interested in participating in this research. If you would like further information regarding any aspect of this research, you are encouraged to contact the researchers via the phone number or email addresses listed above. If you agree to participate, you will be asked to: Complete a Questionnaire – You will fill out a survey that includes questions about your experiences, coping strategies, and sources of support. This includes age, gender, relationship to the child, and basic details about the child's condition. This helps us understand different coping patterns in various family situations. This should take approximately 30-35 minutes. The survey will be conducted online or in-person, depending on your preference. All responses will remain confidential and anonymous to ensure privacy.

Why were you chosen for this research?

You have been invited to participate in this study because you are a parent of a child or adolescent diagnosed with a mental health condition. Your participation is valuable because every parent's experience is unique, and your insights will help researchers develop better support systems for families facing similar challenges.

Source of funding

The research has been carried out on a self-funded basis.

Consenting to participate in the project and withdrawing from the research

If you agree to participate in this research, you will need to sign the accompanying consent form and provide it to the researcher at the time of the interview. Participating in this research is voluntary and you are under no obligation to consent to participate. However, if you do consent to participate, you may withdraw from further participation at any stage up until the data are analysed. There will be no negative consequences if you choose to withdraw. You are also able to refuse to answer any questions with no negative consequences.

Possible benefits and risks to participants

Participation in this research may not yield direct benefit, but your participation will help improve support systems for parents in similar situations by contributing to research on effective coping strategies.

The research is designed with low risk, but potential psychological discomfort may occur due to sharing experiences. If it arises during the interview, the student researcher will minimize it in the following way:

- You will be given a reminder that the participation is voluntary, you can withdraw from it anytime you want.
- The researcher will offer break during interview if the discomforts impact the interview. Additionally, the researcher will discuss about re-scheduling the interview if you prefer to continue later.

Confidentiality

The study will maintain confidentiality of all participant details, with their name not disclosed in any published documentation. A unique code will be used for de-identification after interviews, ensuring anonymous data analysis. The original survey questionnaire, featuring the participant's name, will only be accessible to the

researchers, ensuring high privacy and security.

Storage of data

The data collected will be stored in a password-protected computer and cloud system, accessible only to the researchers, and physical copies will be kept in locked filing cabinets at the Centre for the Rehabilitation of the Paralysed (CRP) for strict confidentiality.

Results

Results from the survey and other data collected as part of this research will be aggregated, analyzed and written in a descriptive report. Summaries of some aspects of the results of this study may be published in a scientific journal or at conference proceedings. You may request a summary of the project results by emailing any of the project investigators using the above contact details.

Complaints

If you have any concerns or complaints about the research's conduct, you are welcome to contact the supervisor.

Md. Saddam Hossain

Assistant Professor

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI), CRP

Call: +8801766494605

Email: saddamot6@gmail.com

Thank you,

Elmin Akter

অংশগ্রহণকারীর জন্য ব্যাখ্যামূলক বিবৃতি

গবেষণার শিরোনাম: মানসিক অসুস্থতায় আক্রান্ত শিশু ও কিশোর-কিশোরীদের পিতামাতার মানিয়ে নেওয়ার সক্ষমতার মাত্রা পরিমাপ।

ছাত্রী গবেষক

ইলমিন আক্তার

৪র্থ বর্ষ, বিএসসি ইন অকুপেশনাল থেরাপি

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই)

সিআরপি, সাভার, ঢাকা-১৩৪৩

ফোন: +৮৮০১৮৮৬০৭৪৭৬৬

ইমেইল: elminhossainzoana07@gmail.com

প্রধান গবেষক

মো. সাদ্দাম হোসাইন

সহযোগী অধ্যাপক

অকুপেশনাল থেরাপি বিভাগ

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি

ফোন: +৮৮০১৭৬৬৪৯৪৬০৫

ইমেইল: saddamot6@gmail.com

এই তথ্যপত্রটি আপনার কাছে রাখার জন্য।

এই গবেষণার উদ্দেশ্য কী?

মনের অসুস্থতায় আক্রান্ত সন্তান লালনপালন করা মানসিক ও শারীরিকভাবে কষ্টকর হতে পারে। পিতামাতারা কীভাবে এসব চ্যালেঞ্জ মোকাবিলা করেন তা বোঝার মাধ্যমে, এই গবেষণাটি মানসিক সহায়তা, শিক্ষামূলক প্রোগ্রাম এবং হস্তক্ষেপ কৌশলগুলোর উন্নয়নে সহায়ক হবে। আপনাকে এই গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানানো হচ্ছে, যার উদ্দেশ্য হলো সন্তানদের মানসিক অসুস্থতার চ্যালেঞ্জ মোকাবেলায়

পিতামাতার অভিজ্ঞতা ও কৌশল অন্বেষণ করা। আমরা "Coping Health Inventory for Parents (CHIP)" নামক একটি বহুল ব্যবহৃত প্রশ্নাবলী ব্যবহার করব যা বিভিন্ন মোকাবেলা কৌশল মূল্যায়নের জন্য ব্যবহৃত হয়। যদি আপনি অংশগ্রহণে সম্মতি দেন, তবে আপনাকে একটি প্রশ্নাবলী পূরণ করতে বলা হবে যেখানে আপনার অভিজ্ঞতা ও কৌশল সম্পর্কিত প্রশ্ন থাকবে। আপনার উত্তর গোপন রাখা হবে এবং অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাধীন।

গবেষণায় কী অন্তর্ভুক্ত রয়েছে?

অনুগ্রহ করে এই ব্যাখ্যামূলক বিবৃতিটি সম্পূর্ণরূপে পড়ে দেখুন, এরপর সিদ্ধান্ত নিন আপনি এই গবেষণায় অংশগ্রহণে আগ্রহী কি না। যদি এই গবেষণার কোনো বিষয়ে আরও তথ্য জানতে চান, তাহলে উপরোক্ত নাম্বার বা ইমেইলের মাধ্যমে গবেষকদের সাথে যোগাযোগ করতে পারেন।

যদি আপনি অংশগ্রহণে সম্মতি দেন, তাহলে আপনাকে যা করতে হবে:

একটি প্রশ্নাবলী পূরণ করা – আপনাকে একটি প্রশ্নাবলী পূরণ করতে বলা হবে যাতে আপনার অভিজ্ঞতা, মোকাবেলার কৌশল ও সহায়তার উৎস সম্পর্কে প্রশ্ন থাকবে। এতে আপনার বয়স, লিঙ্গ, সন্তানের সঙ্গে সম্পর্ক, এবং সন্তানের সমস্যার কিছু মৌলিক তথ্য জিজ্ঞাসা করা হবে। এতে আমাদের বিভিন্ন পারিবারিক প্রেক্ষাপটে কৌশলগত পার্থক্য বুঝতে সহায়তা করবে। সময় লাগবে আনুমানিক ৩০-৪০ মিনিট। এই প্রশ্নাবলী অনলাইন বা আপনার পছন্দ অনুযায়ী সরাসরি নেওয়া যেতে পারে। আপনার সকল উত্তর গোপন ও বেনাম থাকবে।

আপনাকে কেন এই গবেষণার জন্য বেছে নেওয়া হয়েছে?

আপনাকে এই গবেষণার জন্য আমন্ত্রণ জানানো হয়েছে কারণ আপনি একজন পিতামাতা বা প্রধান অভিভাবক যাঁর সন্তান মানসিক স্বাস্থ্য সমস্যায় ভুগছে। আপনার অংশগ্রহণ গুরুত্বপূর্ণ কারণ প্রতিটি পিতামাতার অভিজ্ঞতা অনন্য এবং আপনার অভিজ্ঞতা অন্য পরিবারগুলোর জন্য উন্নত সহায়তা পদ্ধতি বিকাশে সহায়ক হবে।

তহবিলের উৎস

এই গবেষণা স্ব-অর্থায়নে পরিচালিত হচ্ছে।

গবেষণায় সম্মতি দেওয়া ও প্রত্যাহারের অধিকার

যদি আপনি গবেষণায় অংশগ্রহণে সম্মতি দেন, তাহলে আপনাকে একটি সম্মতি ফর্মে স্বাক্ষর করতে হবে এবং তা সাক্ষাৎকারের সময় গবেষকের কাছে জমা দিতে হবে।

এই গবেষণায় অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাধীন এবং আপনি সম্মতি না দিলেও কোনও সমস্যা নেই। তবে আপনি যদি সম্মতি দেন, এরপরও আপনি যে কোনও সময় অংশগ্রহণ প্রত্যাহার করতে পারেন যতক্ষণ না তথ্য বিশ্লেষণ শুরু হয়েছে। প্রত্যাহারে কোনো নেতিবাচক পরিণতি হবে না। আপনি চাইলে কোনো প্রশ্নের উত্তর দিতে না বলতেও পারেন, এর জন্য কোনো সমস্যা হবে না।

অংশগ্রহণকারীর সম্ভাব্য উপকার ও ঝুঁকি

এই গবেষণায় সরাসরি উপকার না থাকলেও এটি মানসিক অসুস্থ সন্তানের পিতামাতার সহায়তা ব্যবস্থার উন্নয়নে সহায়ক হবে।এই গবেষণাটি নিম্নঝুঁকিপূর্ণভাবে ডিজাইন করা হয়েছে, তবে অভিজ্ঞতা ভাগাভাগির সময় সামান্য মানসিক অস্বস্তি হতে পারে। যদি তা ঘটে, তাহলে গবেষক তা নিম্নোক্তভাবে মোকাবেলা করবেন:

আপনাকে মনে করিয়ে দেওয়া হবে যে অংশগ্রহণ স্বেচ্ছাধীন এবং আপনি যেকোনো সময় অংশগ্রহণ থেকে সরে যেতে পারেন।

যদি অস্বস্তি সাক্ষাৎকারে প্রভাব ফেলে, তাহলে গবেষক আপনাকে বিরতির সুযোগ দেবেন। প্রয়োজনে সাক্ষাৎকার পুনঃনির্ধারণ করে পরবর্তী সময়ে চালিয়ে নেওয়ার বিষয়েও আলোচনা করবেন।

গোপনীয়তা

সকল অংশগ্রহণকারীর পরিচয় গোপন রাখা হবে এবং কোন প্রকাশিত তথ্য বা নথিতে নাম উল্লেখ করা হবে না। প্রতিটি অংশগ্রহণকারীকে একটি নির্দিষ্ট কোড বরাদ্দ দেওয়া

হবে যাতে নামহীনভাবে তথ্য বিশ্লেষণ করা যায়। মূল প্রশ্নাবলী যেখানে আপনার নাম থাকবে তা কেবল গবেষকদের কাছে থাকবে এবং সুরক্ষিত অবস্থায় সংরক্ষিত থাকবে।

তথ্য সংরক্ষণ

তথ্য একটি পাসওয়ার্ড-প্রটেক্টেড কম্পিউটার ও ক্লাউডে সংরক্ষণ করা হবে যা কেবল গবেষকগণ ব্যবহার করতে পারবেন। প্রিন্ট কপি সিআরপির লক করা ফাইল কেবিনেটে রাখা হবে যাতে গোপনীয়তা বজায় থাকে।

ফলাফল

এই গবেষণা থেকে সংগৃহীত তথ্য বিশ্লেষণ করে একটি বর্ণনামূলক প্রতিবেদন তৈরি করা হবে। কিছু ফলাফল বৈজ্ঞানিক জার্নাল বা সম্মেলনে উপস্থাপন করা হতে পারে। আপনি চাইলে গবেষণার সংক্ষিপ্ত ফলাফল অনুরোধ করে উপরোক্ত ইমেইল ঠিকানায় যোগাযোগ করতে পারেন।

অভিযোগ

যদি আপনি এই গবেষণার পরিচালনা নিয়ে কোনো অভিযোগ বা উদ্বেগ অনুভব করেন, তাহলে আপনি গবেষণা তত্ত্বাবধায়ককে যোগাযোগ করতে পারেন।

মো. সাদ্দাম হোসাইন

সহযোগী অধ্যাপক

অকুপেশনাল থেরাপি বিভাগ

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি

ফোন: +৮৮০১৭৬৬৪৯৪৬০৫

ইমেইল: saddamot6@gmail.com

ধন্যবাদান্তে,

ইলমিন আক্তার

Appendix E: Consent Form [English & Bangla Version]

CONSENT FORM

Research Title: Level of Parental Coping among Parents of Children and Adolescents with Mental Illness.

Student investigator: Elmin Akter

Please tick into the right-side box to confirm:

I confirm that I have read and understand the information sheet for the above study	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	
I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason, without medical or legal rights being affected.	
I understand that relevant sections of any medical notes and data collected during the study may be reviewed by other individuals for the purposes of the study.	
I agree to provide information to the researcher (s) on the understanding that my name will not use without my permission.	
I agree to participate in this study under the conditions set out in the information sheet.	

Name of the participant:_____

Sign/thumb impression: _____

Sign of the researcher: _____ Date: __ / __ / ____

সম্মতিপত্র

গবেষণার শিরোনাম: মানসিক অসুস্থতায় আক্রান্ত শিশু ও কিশোর-কিশোরীদের পিতামাতার মানিয়ে নেওয়ার সক্ষমতার মাত্রা পরিমাপ।

ছাত্রী গবেষক: ইলমিন আক্তার

অনুগ্রহ করে ডান পাশের ঘরে টিক দিন নিশ্চিত করার জন্য:

আমি নিশ্চিত করছি যে আমি উপরের গবেষণার তথ্যপত্রটি পড়েছি এবং বুঝেছি।	
আমি তথ্যটি বিবেচনার সুযোগ পেয়েছি, প্রশ্ন করার সুযোগ পেয়েছি এবং সন্তোষজনকভাবে তার উত্তর পেয়েছি।	
আমি বুঝতে পারছি যে এই গবেষণায় অংশগ্রহণ স্বেচ্ছামূলক এবং আমি যে কোনো সময় প্রত্যাহার করতে পারি, কোনো কারণ না দেখিয়েও, এবং এতে চিকিৎসা বা আইনগত অধিকার প্রভাবিত হবে না।	
আমি বুঝতে পারছি যে এই গবেষণার উদ্দেশ্যে প্রয়োজনীয় হলে, চিকিৎসা নোট এবং সংগৃহীত তথ্যের সংশ্লিষ্ট অংশ অন্য কেউ পর্যালোচনা করতে পারেন।	
আমি সম্মত হচ্ছি যে গবেষক/গবেষকগণকে তথ্য প্রদান করব এই শর্তে যে আমার নাম আমার অনুমতি ছাড়া ব্যবহার করা হবে না।	
আমি তথ্যপত্রে বর্ণিত শর্ত অনুযায়ী এই গবেষণায় অংশগ্রহণে সম্মত হচ্ছি।	

অংশগ্রহণকারীর নাম:

স্বাক্ষর/আঙুলের ছাপ:

গবেষকের স্বাক্ষর:

তারিখ: __/ __ / __

Appendix F: Withdrawal Form [English & Bangla Version]

WITHDEAWAL OF CONSENT FORM

Research Title: Level of Parental Coping among Parents of Children and Adolescents with Mental Illness.

Student investigator: Elmin Akter

I, _____ (the participant), wish to WITHDRAW my consent to the use of data arising from my participation. Data arising from my participation must NOT be used in this research project as described in the Information and Consent Form. I understand that data arising from my participation will be destroyed provided this request is received within four weeks of the completion of my participation in this project. I understand that this notification will be retained together with my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

Name of participant: _____

Signature of participant/ thumb print: _____

Date: __ / __ / ____

সম্মতি প্রত্যাহার পত্র

গবেষণার শিরোনাম: মানসিক অসুস্থতায় আক্রান্ত শিশু ও কিশোর-কিশোরীদের পিতামাতার মানিয়ে নেওয়ার সক্ষমতার মাত্রা পরিমাপ।

ছাত্রী গবেষক: ইলমিন আক্তার

আমি,_____ (অংশগ্রহণকারী), আমার অংশগ্রহণের মাধ্যমে প্রাপ্ত ডেটা ব্যবহারের অনুমতি প্রত্যাহার করতে ইচ্ছুক। তথ্য ও সম্মতিপত্রে বর্ণিত গবেষণা প্রকল্পে আমার অংশগ্রহণ থেকে প্রাপ্ত ডেটা ব্যবহার করা যাবে না। আমি বুঝি যে, আমার অংশগ্রহণ শেষ হওয়ার চার সপ্তাহের মধ্যে যদি এই অনুরোধ প্রদান করা হয়, তবে আমার অংশগ্রহণ থেকে প্রাপ্ত সব ডেটা ধ্বংস করে ফেলা হবে। আমি বুঝি যে, এই বিজ্ঞপ্তিটি আমার সম্মতিপত্রের সাথে সংরক্ষিত থাকবে, যেন এই গবেষণা প্রকল্পে আমি যে ডেটা দিয়েছি তা ব্যবহারে আমার সম্মতি প্রত্যাহারের প্রমাণ হিসেবে কাজ করে।

অংশগ্রহণকারীর নাম: _____

অংশগ্রহণকারীর স্বাক্ষর/ আঙুলের ছাপ: _____

তারিখ: __ / __ / __

Appendix G: Interview Questionnaires [English Version]

Sociodemographic Information Form

Please provide the following information. This information will be used for research purposes only and will remain confidential.

Section A: Parent/Caregiver Information ID/Serial No:

1. Name:

   Date:
2. Contact Number:
3. Adress:
4. Age: _____ years
5. Gender:
   - [1] Male
   - [2] Female
   - [3] Other (please specify): _____
6. Marital Status:
   - [1] Single Father/ Mother
   - [2] Married
   - [3] Separated/Divorced
   - [4] Widowed
7. Relationship to the Child:
   - [1] Mother
   - [2] Father

8. Educational Qualification:

    - [1] No formal education
    - [2] Primary
    - [3] Secondary
    - [4] Higher Secondary
    - [5] Graduate
    - [6] Postgraduate or above

9. Occupation:

    - [1] Housewife
    - [2] Service holder
    - [3] Business
    - [4] Farmer
    - [5] Others (_____)

10. Monthly Income: _____ Tk

11. Religion:

    - [1] Islam
    - [2] Hindusim
    - [3] Buddhism
    - [4] Christianity
    - [5] Others (_____)

12. Ethnicity (if relevant): _____

Section B: Family Information

1. Type of Family:
    - [1] Nuclear
    - [2] Joint
    - [3] Single-parent family

2. Place of Residence:
    - [1] Urban
    - [2] Semi-Urban
    - [3] Rural
3. Number of family members: _____
4. Number of children: _____
5. Any other member with chronic illness/disability? ☐ Yes ☐ No

    If yes, specify illness/disability: _____

Section C: Child's Health and Disability Information

1. Child's Name:
2. Child's Age: _____ years
3. Child's Gender:
    - [1] Male
    - [2] Female
    - [3] Other (please specify): _____
4. Child's Diagnosis:
    - [1] Autism-Spectrum-Disorder
    - [2] Attention-Deficit-Hyperactivity-Disorder
    - [3] Intellectual Disability
    - [4] Anxiety Disorders
    - [5] Depressive Disorders
    - [6] Conduct Disorder
5. Duration of Illness/Disability: _____ years/months

6. Current Treatments/Interventions: (Multiple response)
    - [1] Medications
    - [2] Physiotherapy
    - [3] Occupational therapy
    - [4] Speech therapy
    - [5] Counseling
    - [6] Educational support
    - [7] Other: _____
7. Current Treatment Setting: (Multiple response)
    - [1] Government Hospital
    - [2] Private Hospital
    - [3] NGO Clinic
    - [4] Home-based Care
    - [5] Other (please specify): _____
8. Current Schooling Status:
    - [1] Not enrolled
    - [2] Regular school
    - [3] Special school
    - [4] Home-based education
    - [5] Madrasa
9. Received Government Disability Card or Support Services? ☐ Yes ☐ No
10. Hospitalization in Last Year for This Condition? ☐ Yes ☐ No

    If yes, number of times: _____

11. How far is the nearest health facility from your home: _____km

CHIP

COPING HEALTH INVENTORY FOR PARENTS

English Version

Family Stress, Coping and Health Project
School of Human Ecology
1300 Linden Drift
University of Wisconsin-Madison

Madison. WI 63706

CHIP

COPING HEALTH INVENTORY FOR PARTENTS©

Hamilton I. McCubbin Marilyn A. McCubbin Robert S. Nevin Elizabeth Cauble

Purpose

CHIP – The Coping Health Inventory of Parents was developed to record what parents find helpful or not helpful to them in management of family life when one or more of its members is ill for a brief period *or* has a medical condition which calls for continued medical care. Coping is defined as personal or collective (with other individuals, programs) efforts to manage the hardships associated with health problems in the family.

Directions

- To complete this inventory you are asked to read the list of "Coping behaviors" below, one at a time.
- For each coping behavior you used, please record how helpful it was ○ How helpful was this coping behavior to you and/or your family: Circle one number
  - 3 = *Extremely* helpful
  - 2 = *Moderately* helpful
  - 1 = *Minimally* helpful
  - 0 = *Not* helpful
- For each coping behavior you did not use please record your "Reason." ○

  Please record this by checking on of the reasons: Chose not *or* Possible Not to use it

☐ ☐

Please begin: Please read and record your decision for each and every Coping Behavior listed below.

Coping Behaviors	Extremely Helpful	Moderately Helpful	Minimally Helpful	Not Helpful	I do not cope this way because: Choose Not to	Not Possible
1. Talking over personal feelings and concerns with spouse	3	2	1	0	☐	☐
2. Engaging in relationships and friendships	3	2	1	0	☐	☐
3. Trusting my spouse (or former spouse) to help support me and my child(ren)	3	2	1	0	☐	☐
4. Sleeping	3	2	1	0	☐	☐
5. Talking with the medical staff (nurses, social worker, etc.) when we visit the medical center	3	2	1	0	☐	☐
6. Believing that my child(ren) will get better	3	2	1	0	☐	☐
7. Working, outside employment	3	2	1	0	☐	☐
8. Showing that I am strong	3	2	1	0	☐	☐
9. Purchasing gifts for myself and/or other family members	3	2	1	0	☐	☐
10. Talking with other individuals/parents in my same situation	3	2	1	0	☐	☐
11. Taking good care of all the medical equipment at home	3	2	1	0	☐	☐
12. Eating	3	2	1	0	☐	☐
13. Getting other members of the family to help with chores and tasks at home	3	2	1	0	☐	☐
14. Getting away by myself	3	2	1	0	☐	☐
15. Talking with doctor about my concerns about my child(ren) with the medical condition	3	2	1	0	☐	☐
16. Believing that the medical center/hospital has my family's best interest in mind	3	2	1	0	☐	☐
17. Building close relationships with people	3	2	1	0	☐	☐
18. Believing in God	3	2	1	0	☐	☐
19. Develop myself as a person	3	2	1	0	☐	☐

Coping Behavior	Extremely Helpful	Moderately Helpful	Minimally Helpful	Not Helpful	I do not cope this way because: Choose Not to	I do not cope this way because: Not Possible
20. Talking with other parents in the same type of situation and learning about their experiences	3	2	1	0	☐	☐
21. Doing things together as a family (involving all members of the family)	3	2	1	0	☐	☐
22. Investing time and energy in my job	3	2	1	0	☐	☐
23. Believing that my child is getting the best medical care possible	3	2	1	0	☐	☐
24. Entertaining friends in our home	3	2	1	0	☐	☐
25. Reading about how other persons in my situation handled things	3	2	1	0	☐	☐
26. Doing things with family relatives	3	2	1	0	☐	☐
27. Becoming more self reliant and independent	3	2	1	0	☐	☐
28. Telling myself that I have many things I should be thankful for	3	2	1	0	☐	☐
29. Concentrating on hobbies (art, music, jogging, etc.)	3	2	1	0	☐	☐
30. Explaining family situation to friends and neighbors so they will understand us	3	2	1	0	☐	☐
31. Encouraging child(ren) with medical condition to be more independent	3	2	1	0	☐	☐
32. Keeping myself in shape and well groomed	3	2	1	0	☐	☐
33. Involvement in social activities (parties, etc.) with friends	3	2	1	0	☐	☐
34. Going out with my spouse on a regular basis	3	2	1	0	☐	☐
35. Being sure prescribed medical treatments for child(ren) are carried out at home on a daily basis	3	2	1	0	☐	☐
36. Building a closer relationship with my spouse	3	2	1	0	☐	☐
37. Allowing myself to get angry	3	2	1	0	☐	☐

Coping Behavior	Extremely Helpful	Moderately Helpful	Minimally Helpful	Not Helpful	I do not cope this way because: Choose Not to	I do not cope this way because: Not Possible
38. Investing myself in my child(ren)	3	2	1	0	☐	☐
39. Talking to someone (not professional counselor/doctor) about how I feel	3	2	1	0	☐	☐
40. Reading more about the medical problem which concerns me	3	2	1	0	☐	☐
41. Trying to maintain family stability	3	2	1	0	☐	☐
42. Being able to get away from the home care tasks and responsibilities for some relief	3	2	1	0	☐	☐
43. Having my child with the medical condition seen at the clinic/hospital on a regular basis	3	2	1	0	☐	☐
44. Believing that things will always work out	3	2	1	0	☐	☐
45. Doing things with my children	3	2	1	0	☐	☐

Appendix H: Interview Questionnaires [Bangla Version]

সামাজিক-জনতাত্ত্বিক প্রশ্নাবলী

অনুগ্রহ করে নিচের তথ্যগুলো প্রদান করুন। এই তথ্য শুধুমাত্র গবেষণার উদ্দেশ্যে ব্যবহার করা হবে এবং সম্পূর্ণ গোপনীয় থাকবে।

অনুচ্ছেদ ক: অভিভাবক/সেবা প্রদানকারীর তথ্য

আইডি/সিরিয়াল নম্বর:

১. নাম: _____ তারিখ:

২. যোগাযোগের নম্বর: _____

৩. ঠিকানা: _____

৪. বয়স: _____ বছর

৫. লিঙ্গ:

- পরুষ
- মহিলা

৬. বৈবাহিক অবস্থা:

- একক বাবা/ মা
- বিবাহিত
- আলাদা/তালাকপ্রাপ্ত
- বিধবা/বিপত্নীক

৭. সন্তানের সাথে সম্পর্ক:

- মা
- বাবা

৮. শিক্ষাগত যোগ্যতা:

- কোন আনুষ্ঠানিক শিক্ষা নেই
- প্রাথমিক
- মাধ্যমিক
- উচ্চ মাধ্যমিক
- স্নাতক
- স্নাতকোত্তর বা তার বেশি

৯. পেশা:
- গৃহিণী
- চাকরিজীবী
- ব্যবসায়ী
- কৃষক
- অন্যান্য (উল্লেখ করুন): _____

১০. মাসিক আয়:_____ টাকা
১১. ধর্ম:
- ইসলাম ধর্ম
- হিন্দুধর্ম
- বৌদ্ধধর্ম
- খ্রিস্টধর্ম
- অন্যান্য (উল্লেখ করুন): _____

১২. জাতিগোষ্ঠী (যদি প্রযোজ্য): _____

অনুচ্ছেদ খ: পারিবারিক তথ্য

১. পরিবার প্রকার:
- একক পরিবার
- যৌথ পরিবার
- একক অভিভাবক পরিবার

২. বসবাসের স্থান:
- শহর
- শহরতলী
- গ্রাম

৩. পরিবারের মোট সদস্য সংখ্যা: _____

৪. সন্তানের সংখ্যা: _____

৫. পরিবারের অন্য কোনো সদস্য কি দীর্ঘমেয়াদী অসুস্থতা/প্রতিবন্ধিতায় আক্রান্ত?

□হ্যাঁ □ না।

যদি হ্যাঁ হয়, অসুস্থতা/প্রতিবন্ধিতার ধরণ উল্লেখ করুন:_____

অনুচ্ছেদ গ: সন্তানের স্বাস্থ্য ও প্রতিবন্ধিতা সংক্রান্ত তথ্য

১. সন্তানের নাম: _____

২. সন্তানের বয়স: _____ বছর

৩. সন্তানের লিঙ্গ:

- ছেলে
- মেয়ে
- অন্যান্য (উল্লেখ করুন): _____

৪. সন্তানের নির্ণয়কৃত রোগ :

- অটিজম স্পেকট্রাম ডিসঅর্ডার
- অ্যাটেনশন ডেফিসিট হাইপারঅ্যাকটিভিটি ডিসঅর্ডার
- ইন্টেলেকচুয়াল ডিসএবিলিটি
- অ্যাংজাইটি ডিসঅর্ডার
- ডিপ্রেসিভ ডিসঅর্ডার
- কনডাক্ট ডিসঅর্ডার

৫. অসুস্থতা/প্রতিবন্ধিতার সময়কাল: _____ বছর/মাস

৬. বর্তমানে চলমান চিকিৎসা/হস্তক্ষেপ: (একাধিক উত্তর)

- ওষুধ
- ফিজিওথেরাপি
- অকুপেশনাল থেরাপি
- স্পিচ থেরাপি
- কাউন্সেলিং
- শিক্ষাগত সহায়তা
- অন্যান্য: _____

৭. বর্তমান চিকিৎসা ব্যবস্থা: (একাধিক উত্তর)

- সরকারি হাসপাতাল
- বেসরকারি হাসপাতাল
- এনজিও ক্লিনিক
- বাড়িভিত্তিক সেবা
- অন্যান্য (উল্লেখ করুন): _____

৮. বর্তমান শিক্ষার অবস্থা:

- ভর্তি নয়
- সাধারণ বিদ্যালয়
- বিশেষ বিদ্যালয়
- বাড়িভিত্তিক শিক্ষা
- মাদ্রাসা

৯. সরকার প্রদত্ত প্রতিবন্ধিতা কার্ড বা সহায়তা পেয়েছেন কি? □ হ্যাঁ □ না

১০. গত ১ বছরে কি এই অবস্থার জন্য হাসপাতালে ভর্তি হতে হয়েছে? □ হ্যাঁ □ না
যদি হ্যাঁ হয়, ভর্তি হওয়ার সংখ্যা: _____

১১. আপনার বাসা থেকে নিকটতম স্বাস্থ্যসেবা কেন্দ্র কত দূরে: _____ কিমি

কোপিং হেলথ ইনভেন্টরি ফর প্যারেন্টস (CHIP)

নির্দেশনা:
আপনাকে নিচে কিছু "কোপিং আচরণ" দেওয়া হয়েছে। প্রতিটি পড়ে বলুন, এই আচরণটি আপনি ব্যবহার করেছেন কি না এবং এটি আপনার ও আপনার পরিবারের জন্য কতটা সহায়ক ছিল। যদি ব্যবহার না করে থাকেন, অনুগ্রহ করে কারণ চিহ্নিত করুন।

সহায়কতার মাত্রা (বৃত্ত দিন):
৩ = অত্যন্ত সহায়ক; ২ = মাঝারি সহায়ক; ১ = অল্প সহায়ক; ০ = মোটেও সহায়ক না

যদি ব্যবহার না করে থাকেন, তাহলে নিচের দুটি বিকল্পের একটিতে চিহ্ন দিন:
□ ব্যবহার করিনি, ইচ্ছাকৃতভাবে করিনি; □ ব্যবহার সম্ভব ছিল না

কোপিং আচরণ	অত্যন্ত সহায়ক	মাঝারি সহায়ক	অল্প সহায়ক	মোটেও সহায়ক না	যদি ব্যবহার না করে থাকেন, নিচের যেকোনো একটি কারণ চিহ্নিত করুন:	
					ব্যবহার করিনি	সম্ভব নয়
১।জীবনসঙ্গীর সাথে ব্যক্তিগত	৩	২	১	০		

অনুভূতি ও উদ্বেগ নিয়ে কথা বলা।						
২।সম্পর্ক এবং বন্ধুত্বে জড়িত হওয়া।	৩	২	১	০		
৩।নিজের ও সন্তানদের দায়িত্ব পালনে জীবনসঙ্গীর (অথবা প্রাক্তন জীবনসঙ্গীর) ওপর আস্থা রাখা।	৩	২	১	০		
৪। ঘুমানো।	৩	২	১	০		
৫।চিকিৎসা কেন্দ্র গেলে চিকিৎসা কর্মীদের (নার্স, সমাজকর্মী, ইত্যাদি) সাথে কথা বলা।	৩	২	১	০		
৬। আমার সন্তান (সন্তানেরা) সুস্থ হয়ে উঠবে এই বিশ্বাস রাখা।	৩	২	১	০		
৭। চাকরি করছেন অথবা বাইরের কর্মসংস্থানে যুক্ত আছেন।	৩	২	১	০		
৮। নিজেকে শক্ত/দৃঢ় হিসেবে উপস্থাপন করা।	৩	২	১	০		
৯। নিজের/পরিবারের অন্যান্য সদস্যদের জন্য উপহার কেনা।	৩	২	১	০		

১০। আমার একই পরিস্থিতিতে থাকা অন্যান্য ব্যক্তি/ অভিভাবকের সাথে কথা বলা।	৩	২	১	০		
১১। বাড়িতে থাকা সমস্ত চিকিৎসা সরঞ্জামের ভালোভাবে যত্ন নেওয়া।	৩	২	১	০		
১২। খাওয়া।	৩	২	১	০		
১৩। পরিবারের অন্য সদস্যদের ঘরের কাজে সহায়তা করতে উৎসাহিত করা।	৩	২	১	০		
১৪। নিজেকে কিছু সময়ের জন্য আলাদা করা।	৩	২	১	০		
১৫। আমার সন্তানের (সন্তানদের) শারীরিক অবস্থা সম্পর্কে আমার উদ্বেগ নিয়ে ডাক্তারের সাথে কথা বলা।	৩	২	১	০		
১৬।বিশ্বাস করা যে চিকিৎসাকেন্দ্র / হাসপাতাল আমার পরিবারের সর্বোত্তম স্বার্থের কথা ভাবছে।	৩	২	১	০		
১৭।মানুষের সাথে ভালো সম্পর্ক গড়ে তোলা।	৩	২	১	০		

১৮। ঈশ্বরে বিশ্বাস রাখা।	৩	২	১	০		
১৯। নিজেকে একজন মানুষ হিসেবে গড়ে তোলা।	৩	২	১	০		
২০। একই ধরণের পরিস্থিতিতে থাকা অন্যান্য অভিভাবকদের সাথে কথা বলা এবং তাদের অভিজ্ঞতা সম্পর্কে জানা।	৩	২	১	০		
২১। পরিবারের সব সদস্যকে সঙ্গে নিয়ে একসাথে কিছু করা।	৩	২	১	০		
২২।নিজের পেশাগত কাজে সময় ও শক্তি বিনিয়োগ করা।	৩	২	১	০		
২৩। আমার সন্তান সম্ভাব্য সর্বোত্তম চিকিৎসা সেবা পাচ্ছে এই বিশ্বাস রাখা।	৩	২	১	০		
২৪। আমাদের বাড়িতে বন্ধুদের আপ্যায়ন করা।	৩	২	১	০		
২৫। আমার মতো পরিস্থিতিতে থাকা অন্য অভিভাবকেরা কীভাবে সমস্যাগুলো মোকাবিলা করেছে,	৩	২	১	০		

তা জানা বা পড়া।						
২৬। পরিবারের আত্মীয়স্বজনের সাথে একসাথে কিছু করা।	৩	২	১	০		
২৭। আরও স্বাবলম্বী এবং আত্মনির্ভরশীল হওয়া।	৩	২	১	০		
২৮। নিজেকে বলা যে আমার কাছে অনেক কিছু আছে যার জন্য আমার কৃতজ্ঞ থাকা উচিত।	৩	২	১	০		
২৯। শখের উপর মনোনিবেশ (যেমন: সঙ্গীত, আঁকা, দৌড়) করা।	৩	২	১	০		
৩০।বন্ধুবান্ধব এবং প্রতিবেশীদের কাছে পারিবারিক পরিস্থিতি ব্যাখ্যা করা যাতে তারা আমাদের বুঝতে পারে।	৩	২	১	০		
৩১। অসুস্থ সন্তানকে আরও স্বনির্ভর হতে উৎসাহিত করা।	৩	২	১	০		
৩২। নিজেকে সুস্থ এবং সুসজ্জিত রাখা।	৩	২	১	০		
৩৩। বন্ধুদের সাথে সামাজিক অনুষ্ঠানে (পার্টি,	৩	২	১	০		

ইত্যাদি) অংশ নেওয়া।						
৩৪। জীবনসঙ্গীর সাথে নিয়মিত বাইরে যাওয়া।	৩	২	১	০		
৩৫। সন্তানদের জন্য নির্ধারিত চিকিৎসা কার্যক্রম প্রতিদিন বাড়িতে অনুসরণ করা হচ্ছে কিনা তা নিশ্চিত করা।	৩	২	১	০		
৩৬। জীবনসঙ্গীর সাথে আরও ঘনিষ্ঠ সম্পর্ক গড়ে তোলা।	৩	২	১	০		
৩৭। নিজেকে রাগ প্রকাশের সুযোগ দেওয়া।	৩	২	১	০		
৩৮। সন্তানদের প্রতি নিজেকে সম্পূর্ণভাবে নিবেদন করা।	৩	২	১	০		
৩৯। আমার ভাবনা ও অনুভূতি পেশাদার নয় এমন কারো সঙ্গে ভাগ করে নেওয়া (পেশাদার পরামর্শদাতা/ডাক্তার নয়)।	৩	২	১	০		
৪০। সন্তানের চিকিৎসা সংক্রান্ত সমস্যাটি সম্পর্কে আরও জানার চেষ্টা করা /পড়াশোনা	৩	২	১	০		

করা।						
৪১। পারিবারিক স্থিতিশীলতা বজায় রাখার চেষ্টা করা।	৩	২	১	০		
৪২। ঘরের কাজ ও দায়িত্ব থেকে সাময়িক বিরতি নিয়ে কিছুটা বিশ্রাম নেওয়া।	৩	২	১	০		
৪৩। সন্তানের শারীরিক অবস্থার জন্য নিয়মিত ক্লিনিক / হাসপাতালে যাওয়া।	৩	২	১	০		
৪৪। বিশ্বাস রাখা যে সবকিছু একদিন ঠিক হয়ে যাবে।	৩	২	১	০		
৪৫।সন্তানের সাথে মিলেমিশে কিছু করা/কার্যকর সময় কাটানো।	৩	২	১	০		

Appendix I: Supervisor Contact Schedule

Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis: Level of parental coping among parents of children and adolescents with mental illness: A cross-sectional study.

Name of student: Elmin Akter

Name and designation of thesis supervisor: Md. Saddam Hossain, Assistant Professor, BHPI.

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	26.5.25	BHPI waiting room	Title, Scale, Aim. Objectives	1 hours	Need to check feasibility of the title.	Elmin.	
2	27.5.25	BHPI waiting room	Proposal presentation guideline.	1 hours	Guideline was understandable and clear.	Elmin.	
3	31.05.25	BHPI waiting room	Proposal presentation review & feedback	1 hours	Effective feedback	Elmin.	

4	04.06.25	BHPI waiting room	Discussion about sample size, data collection	30 minutes	Got a clear concept	Elmin.	
5	07.06.25	Library	Discussion about Socio-demographic Qus.	2hours	Effective discussion.	Elmin.	
6	09.06.25	Library	Feedback on socio-demographic Questionnaire	1hours	Effective feedback	Elmin.	
7	11.06.25	BHPI waiting room	Guideline on literature review	2 hours	Effective & helpful discussion	Elmin.	
8	14.06.25	BHPI waiting room	Feedback on Questionnaire bangla translation	30 minutes	Helpful feedback.	Elmin.	
9	21.06.25	BHPI waiting room	Feedback on literature review.	2 hours	Effective discussion	Elmin.	
10	06.08.25	BHPI waiting room	Discussion on data collection status.	2hours	Got a clear concept.	Elmin.	
11	19.08.25	BHPI waiting room	Guideline and feedback on data collection.	2hours	Got a clear concept	Elmin.	
12	30.08.25	classroom BHPI	Discussion on data entry.	3hours	Got a clear concept.	Elmin.	
13	01.09.25	classroom BHPI	Data variable set	3hours	Got a clear concept	Elmin.	
14	10.11.25	classroom BHPI	Data analysis guideline	3hours	Got a clear concept	Elmin.	

15	11.11.25	BHPI classroom	Descriptive analysis guideline	4 hours	Effective & clear guideline	Elmin	
16	12.11.25	BHPI classroom	Feedback on descriptive analysis, result writing	4 hours	Effective discussion	Elmin	
17	13.11.25	BHPI class-room	Discussion on inferential analysis	4 hours	Effective discussion	Elmin	
18	15.11.25	BHPI classroom	Overall feedback	3 hours	Effective feedback	Elmin	
19	23.12.25	BHPI waiting room	Feedback on 1st draft	3 hours	Got a clear concept	Elmin	
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Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face to face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.