# Status of Childhood Trauma among the Adolescents with Mental Illness : A Cross-Sectional Study

By

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# DEDICATION

I want to dedicate my work to Almighty Allah who keeps me well and on the right track and helps me to keep patience during the work period. I dedicated my thesis to my parents, my family members and all the teachers of BHPI for their endless love, support and encouragement throughout my pursuit of education. I hope this achievement will fulfill the dream they envisioned for me.

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| APA | American Psychiatric Association |
| BHPI | Bangladesh Health Professions Institute |
| BMD | Bipolar Mood Disorder |
| BDT | Bangladeshi Taka |
| CRP | Centre for the Rehabilitation of the Paralysed |
| CTQ | Childhood Trauma Questionnaire |
| CTQ-SF | Childhood Trauma Questionnaire – Short Form |
| ID | Intellectual Disability |
| IRB | Institutional Review Board |
| MDD | Major Depressive Disorder |
| NIMH | National Institute of Mental Health |
| OCD | Obsessive-Compulsive Disorder |
| OT | Occupational Therapy |
| PTSD | Post-Traumatic Stress Disorder |
| SD | Standard Deviation |
| SPSS | Statistical Package for the Social Sciences |
| WHO | World Health Organization |

# ABSTRACT

**Background:** Childhood trauma is a major global mental health concern that deeply affects a person's emotional, behavioral, and social development. Early exposure to abuse or neglect often leads to psychological difficulties in adolescence and adulthood. Adolescents with mental illness are especially vulnerable, as past trauma can worsen emotional instability and social dysfunction.

**Aim:** The aim of this study was to explore the status of childhood trauma among adolescents with mental illness, identify the levels and types of trauma across five domains, and examine their associations with socio-demographic factors.

**Methods:** This study followed a quantitative cross-sectional design. A total of 110 adolescents aged 12-18 years diagnosed with mental illness were selected through purposive sampling. Data were collected from four mental health institutions : the National Institute of Mental Health (NIMH)**,** CRP-Rabia Noor Mental Health Day Centre and Pabna Mental Hospital using a structured questionnaire based on the Childhood Trauma Questionnaire-Short Form (CTQ-SF). Face-to-face interviews were conducted, and data were analyzed using the Statistical Package for Social Science (SPSS) version 27.

**Results:** A total of 110 adolescents with mental illness participated in this study. Among them, most were aged between 17–18 years (60.9%), while 39.1% were from the 12-16 years age group. Male participants (59.1%) were slightly higher than females (40.9%). In terms of diagnosis, Bipolar Mood Disorder (27.3%) was the most common, followed by Schizophrenia (20.0%) and Substance Abuse Disorder (12.7%). When

looking at childhood trauma, most participants reported experiencing low levels of trauma overall. However, among the different types, emotional neglect appeared to be the most common issue. The mean scores also reflected this pattern, where emotional neglect had the highest mean score (Mean = 2.09, SD = 0.517), while sexual abuse had the lowest (Mean = 1.26, SD = 0.536). Some important relationships were also found. For example, gender and sexual abuse were significantly related ($P = 0.002$), with female participants reporting higher experiences. Similarly, family type was linked with physical neglect ($P = 0.033$). Emotional neglect showed significant associations with age, educational status, and parental marital status ($P < 0.05$).

**Conclusion:** The study concludes that emotional neglect and abuse are common among adolescents with mental illness in Bangladesh, highlighting the urgent need for trauma-informed mental health care. The results can help mental health professionals, occupational therapists and policymakers develop early intervention strategies, promote family counseling, and raise awareness about the long-term effects of childhood trauma to improve adolescent mental health outcomes.

**Keywords:** Adolescents, Mental Illness, Childhood Trauma, Emotional Neglect

# CHAPTER I: INTRODUCTION

## 1.1 Background

Childhood trauma is a serious public health concern that can deeply affect a person's emotional, behavioral, and social development. Experiences such as abuse or neglect during childhood often leave long-lasting marks that may lead to mental health problems later in life. According to the World Health Organization (2022), more than one billion children experience some form of violence or neglect every year, many of whom suffer from depression, anxiety, or other psychiatric conditions as they grow older.

The Childhood Trauma Questionnaire-Short Form (CTQ-SF) developed by Bernstein and Fink (1998) identifies five main areas of trauma - emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. Such experiences can disturb a child's sense of safety and connection with others, leading to emotional instability and poor coping skills in adolescence (Wang et al., 2025). Adolescents who go through these experiences often struggle with mood swings, impulsive behavior, and difficulties in relationships (Xiao et al., 2022).

Many studies have found that childhood trauma is closely linked to different forms of mental illness. Emotional and physical abuse are often connected with depression and anxiety, while neglect is linked with low self-esteem and social withdrawal (Maheshwari et al., 2024). Adolescents exposed to more than one type of trauma tend to show higher levels of psychiatric symptoms and behavioral difficulties (Afifi et al., 2020).

In Bangladesh, mental illness among adolescents is becoming a growing concern, but research on childhood trauma within this group remains very limited. Adolescents who experience neglect, family conflict, or violence are more likely to develop emotional and behavioral problems (Anjum et al., 2022). Despite this, the issue of trauma is still under-researched, and many young people remain undiagnosed or untreated.

International studies show that trauma not only affects emotional health but also impacts social life, education, and interpersonal relationships (Hellfeldt et al., 2020). Adolescents who have experienced neglect or emotional abuse often struggle to trust others and may face isolation or difficulty in forming healthy social bonds (Frost et al., 2024). Socio-demographic factors - such as family type, parental education, and income - also influence how trauma affects mental health. Those from single-parent or low-income families tend to experience more neglect or inconsistent caregiving (Marshall & Semovski, 2020). Gender differences are also evident, as girls often face higher risks of sexual and emotional abuse, while boys are more vulnerable to physical abuse (Maheshwari et al., 2024; Xiao et al., 2022).

## 1.2 Justification of the study

Childhood trauma is a serious issue that can deeply affect a person's mental health and overall well-being. When children experience abuse or neglect, it often leads to emotional problems, behavioral difficulties, and trouble building healthy relationships later in life. For adolescents with mental illness, the effects of childhood trauma can be even more severe, as it may increase their emotional distress and make recovery harder.

In Bangladesh, very little research has been done to explore childhood trauma among adolescents with mental illness. Many families and communities are not fully aware of how negative experiences in childhood can shape a person's mental health. As a result, many adolescents suffer silently without getting the help they need. This study is important because it will help identify the types and levels of childhood trauma experienced by adolescents and how these are related to their family background, gender and living situation**.**

The findings from this study will be useful for mental health professionals and occupational therapists, as it will help them understand the emotional and behavioral problems faced by these adolescents. This knowledge can support the development of trauma-informed treatment plans that focus on emotional support, social connection, and better coping skills.

This research will also help to raise awareness among families, teachers, and policymakers about the importance of recognizing and addressing childhood trauma early. By doing so, it can help reduce stigma, promote mental health awareness, and improve the quality of life for adolescents with mental illness in Bangladesh.

## 1.3 Operational Definition

### 1.3.1 Childhood Trauma

Childhood trauma refers to any distressing or harmful experiences that occur during childhood, such as emotional, physical or sexual abuse and emotional or physical neglect. These experiences can have a lasting impact on a person's emotions, behavior and relationships. In this study, childhood trauma was measured using the Childhood Trauma Questionnaire-Short Form (CTQ-SF), which identifies five main areas - emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect (Bernstein & Fink, 1998; Xiao et al., 2022).

### 1.3.2 Adolescent with Mental Illness

An adolescent is a young person between the ages of 12 and 18 years, a period marked by physical, emotional, and social development. During this stage, individuals are more vulnerable to psychological stress and the effects of early trauma. In this study, adolescents with diagnosed mental illnesses were selected as participants from different mental health institutions in Bangladesh (Anjum et al., 2022; Frost et al., 2024).

Mental illness refers to conditions that affect a person's emotions, thoughts, or behaviors and often cause distress or difficulty in daily functioning. Examples include depression, bipolar disorder, schizophrenia and anxiety disorders. In this study, participants were adolescents diagnosed with a recognized psychiatric disorder by mental health professionals (Maheshwari et al., 2024; Wang et al., 2025).

### 1.3.3 Emotional Regulation

Emotional regulation refers to a person's ability to manage and express emotions appropriately, especially during stressful situations. Adolescents who experience childhood trauma often face challenges in controlling their emotions, leading to anxiety, irritability or mood swings (Wang et al., 2025; Xiao et al., 2022).

### 1.3.4 Behavioral Functioning

Behavioral functioning means how individuals act and respond to their environment or daily situations. It includes habits, coping skills and decision-making behaviors. Childhood trauma can lead to maladaptive behaviors such as aggression, withdrawal, or risk-taking among adolescents (Afifi et al., 2020; Marshall & Semovski, 2020).

### 1.3.5 Social Relationship

Social relationship refers to an individual's ability to form and maintain positive connections with others, including family, friends and peers. Childhood trauma can weaken trust and communication skills, resulting in isolation or social withdrawal (Hellfeldt et al., 2020; Frost et al., 2024).

## 1.4 Aim of the study

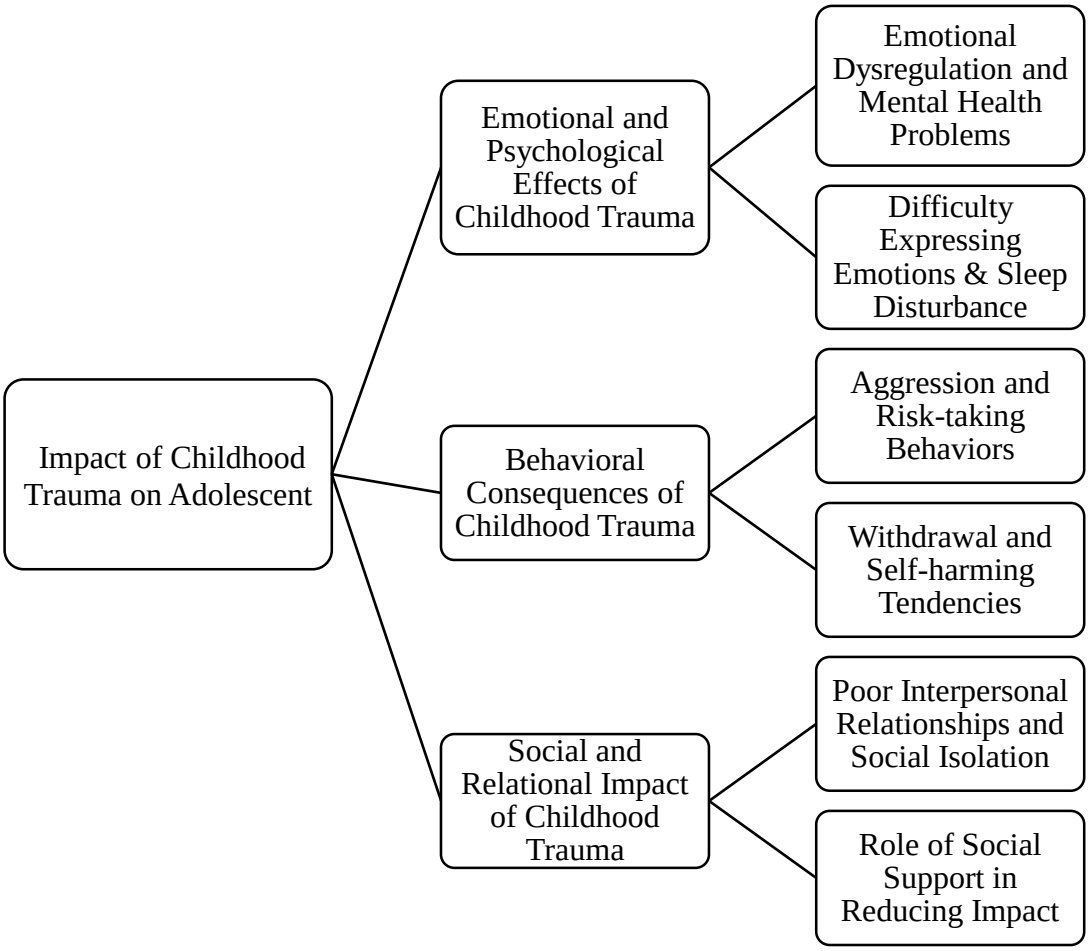
To explore the influence of childhood trauma on adolescent's emotional regulation, behavior and social relationships.

# CHAPTER II: LITERATURE REVIEW

This chapter presents a review of the literature on the different level of abuse among adolescents with mental illness. The review focuses on articles published over the past 5-6 years in databases such as PubMed, Google Scholar, SCI Hub etc. It provides an overview of the impact of childhood trauma on adolescents, the association between adolescent's emotional regulation, behavior & social relationships & different level of childhood trauma. The chapter concludes by highlighting the existing gaps in the literature, which form the basis for the present study.

**Figure 2.1**

*Overview of the Literature Finding*



## 2.1 Emotional and Psychological Effects of Childhood Trauma

Childhood trauma, specially emotional abuse and emotional neglect, strongly affects adolescents' emotional regulation and mental well-being. Studies show that such experiences are linked with depression, anxiety and emotional instability due to disrupted attachment and coping mechanisms (Xiao et al., 2022). Adolescents who face emotional neglect often struggle to identify or express emotions, leading to alexithymia and chronic stress (Wang et al., 2025).

### 2.1.1 Emotional Dysregulation and Mental Health Problems

Emotional abuse and emotional neglect significantly contribute to poor emotional regulation among adolescents. Individuals who have experienced these trauma types show increased rates of depression, anxiety, and stress-related disorders due to difficulties identifying and managing emotions (Xiao et al., 2022). Early emotional deprivation disrupts the adolescent's ability to develop emotional stability, often resulting in heightened sensitivity to rejection and emotional reactivity (Wang et al., 2025)

### 2.1.2 Difficulty Expressing Emotions & Sleep Disturbance

Difficulty expressing emotions and sleep disturbance as mediators linking emotional trauma to mental health issues. Adolescents facing emotional neglect often experience insomnia and emotional detachment, which worsen depressive and anxiety symptoms (Marshall et al., 2020). The dysregulation of the axis and chronic stress responses observed in these adolescents explain the persistence of emotional instability (Maheshwari et al., 2024)

## 2.2 Behavioral Consequences of Childhood Trauma

Exposure to physical abuse and sexual abuse is often reflected in adolescents' behavior. Studies link these trauma domains with aggression, impulsivity, and substance abuse as coping strategies for unresolved emotional pain (Afifi et al., 2020). Internalizing behaviors such as self-harm and withdrawal are also common, particularly among female adolescents (Xiao et al., 2022). Adolescents with high trauma scores across multiple domains show greater psychiatric comorbidity, suicidal tendencies, and risk behaviors (Maheshwari et al., 2024).

### 2.2.1 Aggression and Risk-taking Behaviors

Physical abuse and sexual abuse are highly correlated with externalizing behaviors such as aggression, substance use and impulsivity (Afifi et al., 2020). Adolescents exposed to these trauma forms often engage in risk-taking as a maladaptive coping response to unresolved emotional pain. These behaviors serve as outlets for internal distress and are more prevalent among youth (Anjum et al., 2022).

### 2.2.2 Withdrawal and Self-harming Tendencies

Internalizing symptoms such as self-harm, social withdrawal and suicidal ideation are also prominent among adolescents with histories of physical or sexual trauma. These behaviors reflect inward-directed distress and feelings of shame and helplessness (Xiao et al., 2022). Adolescents in psychiatric care with multiple trauma domains report particularly high rates of self-injury and suicidal thoughts (Maheshwari et al., 2024)

## 2.3 Social and Relational Impact of Childhood Trauma

Emotional neglect and physical neglect deeply affects adolescents' relationships and social skills. Traumatized adolescents often struggle with trust, communication, and forming stable attachments (Hellfeldt et al., 2020). Peer victimization and family conflict further isolate adolescents, leading to poor social adjustment and low self-

esteem (Afifi et al., 2020).

### 2.3.1 Poor Interpersonal Relationships and Social Isolation

Emotional and physical neglect lead to difficulties in forming secure attachments and maintaining healthy peer or family relationships. Adolescents exposed to neglect often exhibit mistrust, social withdrawal, and a lack of empathy (Hellfeldt et al., 2020). Peer victimization also mediates this association, where victims of early trauma are more likely to experience bullying and social rejection (Afifi et al., 2020)

### 2.3.2 Role of Social Support in Reducing Impact

Social support from family, teachers, and peers plays a crucial buffering role against trauma's social and emotional consequences. Adolescents with higher perceived support demonstrate greater resilience, improved self-concept, and fewer depressive symptoms (Maheshwari et al., 2024). Supportive relationships mitigate the negative effects of neglect and abuse by providing emotional stability and belonging (Anjum et al., 2022)

## 2.4 Key Gaps of the Studies

- Around 10 related studies from 2020-2025 were reviewed, but very few focused specifically on adolescents with mental illness. Most examined general or adult samples.
- Although the Childhood Trauma Questionnaire-Short Form scale was commonly used, few studies explored the link between socio-demographic factors (e.g., gender, education, family type) and trauma domains.
- Most research followed a cross-sectional design; therefore, evidence of causal or intervention effectiveness is limited.
- The majority of studies included college youth or clinical patients, but no studies involved psychiatric adolescents in Bangladesh or South Asia.

- Most research was conducted in Western and upper-middle-income countries; only limited studies represented the South Asian context.
- Few studies analyzed the combined effects of all five CTQ domains (Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, Physical Neglect), most focused on single trauma types.

# CHAPTER III: METHODS & METERIALS

## 3.1 Study Question, Aim, Objective

### 3.1.1 Study Question

What are the levels of childhood trauma (emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect) among adolescents with mental illness?

### 3.1.2 Aim

To explore the influence of childhood trauma on adolescent's emotional regulation, behavior and social relationships.

### 3.1.2 Objectives

- To identify the level of abuse across the five trauma domains among adolescents with mental illness.
- To find out the socio-demographic profile of the adolescent participants with mental illness.
- To assess the association between socio-demographic characteristics & different domains and levels of childhood trauma among adolescents with mental illness.

## 3.2 Study Design

### 3.2.1 Study Method

The researcher used a quantitative research method to assess the status of childhood trauma among adolescents with mental illness. Quantitative research helped collect and analyzed numerical data to identify patterns, relationships and differences between variables. This approach allowed the researcher to measure trauma experiences accurately and analyze the data statistically to reach objective conclusions.

### 3.2.2 Study Approach

This study followed a cross-sectional research design. A cross-sectional design was considered most suitable because it allows the researcher to collect data at a single point in time from a specific group of participants. This design helps to describe and understand the current situation of childhood trauma among adolescents with mental illness without manipulating any variables. The descriptive nature of the study provides a clear concept of the level of trauma across the five domains of the Childhood Trauma Questionnaire (CTQ) - emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect.(Maheshwari et al., 2024; Frost et al., 2024; Wang et al., 2025).

## 3.3 Study Setting and Period

### 3.3.1 Study Setting

Data for this study collected from the National Institute of Mental Health (NIMH), CRP Rabia Noor Mental Health Day Centre & Pabna Mental Hospital.

### 3.3.2 Study Period

The study was conducted from June 15 to December 15, 2025. Data was collected from 2 August to 15 September, 2025.

## 3.4 Study Participants

### 3.4.1 Study Population

The population of this study were Adolescents with mental illness.

### 3.4.2 Sampling Techniques

The researcher used purposive sampling techniques to conduct the study by following the inclusion and exclusion criteria. This method was chosen because it allows the researcher to intentionally select individuals who meet specific characteristics relevant to the study’s purpose. In this case, participants were adolescents diagnosed with

mental illness (Campbell et al., 2020).

### 3.4.3 Inclusion Criteria

- Adolescents with mental illness aged between 12 to 18 years.
- Adolescents who diagnosed with mental health disorders (such as Behavioral disability, BMD, PTSD,ID, OCD, MDD, Schizophrenia, Substance abuse, Personality Disorder & Neurodevelopmental disorder)

### 3.4.4 Exclusion Criteria

- Participants who have speech difficulties.
- Adolescents who do not have any insight or understanding about their mental health condition were not be included.

### 3.4.5 Sample Size

Sample Size, n

$= \{Z^2 \times p \times (1 - p)\} / d^2$

$= (1.96)^2 \times 0.15 \times (1 - 0.15) / (0.05)^2$

$= 3.8416 \times 0.15 \times 0.85 / 0.0025$

$= 0.489282 / 0.0025$

$= 195.71 \sim 196$ Participants

Here,

n = required sample size

Z = Z-score (1.96 for 95% confidence level)

p = estimated prevalence (15% or 0.15)

d = margin of error (0.05 or 5%)

(Bernstein, D. P., & Fink, L.,1998).

As a student researcher, If was not possible to get enough time for collecting data. The student researcher got one month for collecting data and during this short period student researchers could not be able to collect data from 196 participants. That’s why student researcher’s could collect 110 data from the participants of this study.

## 3.5 Ethical Consideration

### 3.5.1 Ethical Clearance

The ethical clearance took from the Institutional Ethical Review Board (IRB) of Bangladesh Health Professions Institute (BHPI) through the department of Occupational Therapy, BHPI ("World Medical Association Declaration of Helsinki," 2013). The IRB form number is CRP-BHPI/IRB/07/2025/1124.

### 3.5.2 Informed Consent

A written information sheet was provided to all potential participants and the student researcher explained the purpose and aims of the study in clear and simple language. After having the opportunity to ask questions and indicating that they were willing to take part, participants were given a consent form to read and sign. Data were then collected from those who provided consent. All participants were informed that the information they shared would be used only for research purposes and that their personal details (such as their name and address) would remain strictly confidential.

### 3.5.3 Unequal Relationship

The student researcher did not have any unequal or power relationship with the participants because data collected from the unknown persons selected the participants according to inclusion and exclusion criteria.

### 3.5.4 Risk and Beneficence

- Student researcher ensured that the participants did not have any risk for participation.
- The participants did not get any payment for giving their data.
- Even without payment, their help made the research better and more useful.

### 3.5.5 Power Relationship

Researcher ensured that power relationship was executed to prevent any influence on the participants.

### 3.5.6 Confidentiality

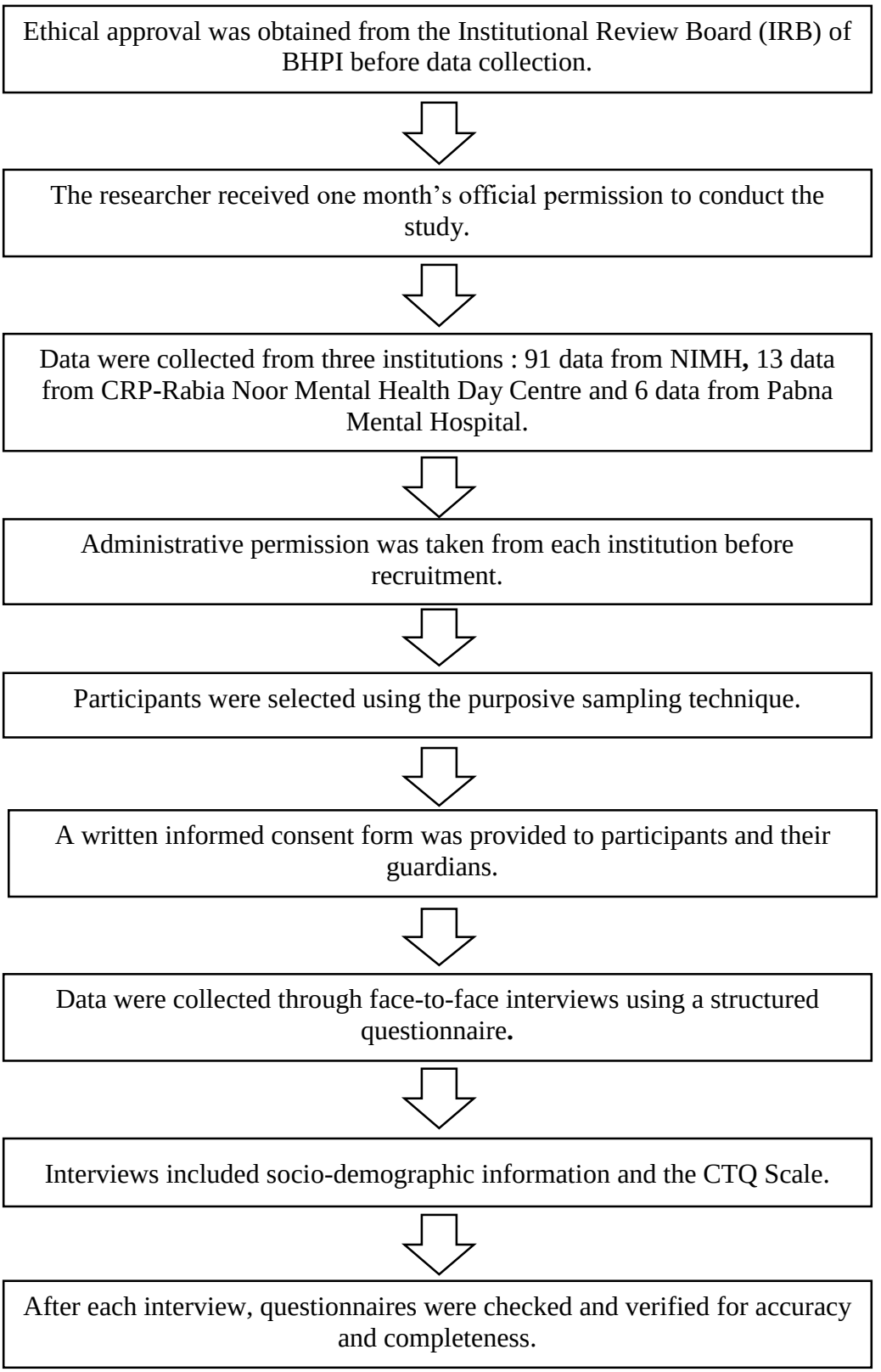
The information of each participant was kept completely private. Their names and identities were not shared with anyone except the research supervisor, as clearly mentioned in the information sheet (see Appendix C). Only the researchers and supervisors, who agreed to maintain confidentiality, were allowed to access the information.

## 3.6 Data Collection Process

### 3.6.1 Participant Recruitment Process

**Figure 3.6.1**

*Overview of the participant recruitment process*



### 3.6.2 Data Collection Method

The student researcher used a face-to-face survey method to collect data for this study. In this process, the researcher asked the survey questions directly and provided clarification whenever needed. This approach helped participants feel comfortable and encouraged them to share accurate information.

### 3.6.3 Data Collection Instrument

The Childhood Trauma Questionnaire (CTQ), developed by Bernstein and Fink (1998), was used to assess the experiences of childhood abuse and neglect among adolescents with mental illness. It is a standardized and widely used self-report tool that identifies past traumatic experiences across five domains: Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect and Physical Neglect.

The CTQ consists of 28 items, each rated on a five-point Likert scale ranging from 1 (Never True) to 5 (Very Often True). Higher scores indicate greater severity of trauma. The scale also includes three Minimization/Denial items to detect possible underreporting. Based on the scoring guidelines by Bernstein and Fink, trauma levels are categorized as none, low, moderate, and severe for each domain.

The CTQ has shown strong reliability and validity in both adolescent and psychiatric populations (Xiao et al., 2022; Maheshwari et al., 2024). The questionnaire is attached in the Appendix.

### 3.6.4 Field Test

The purpose of the field test was to check the clarity and effectiveness of the questionnaire and interview process before the main data collection. The researcher conducted the field test with two adolescents with mental illness who met the inclusion and exclusion criteria. The Childhood Trauma Questionnaire (CTQ) and the socio-demographic questionnaire were used during this process.

Based on the field test, a few minor modifications were made to improve the wording and flow of the questions. The field test confirmed that the tools were easy to understand and suitable for use in the main study.

### 3.7 Data Management and Analysis

The document was presented in the Microsoft office word and the Microsoft office excel will use to make bar charts and tables. The data collected from the participants initially be stored in an excel database. All statistical analyses were conducted using IBM SPSS version 27. SPSS is used by various kinds of researchers for complex statistical data analysis. The SPSS software package was created for the management and statistical analysis of social science data.

### 3.8 Quality Control and Quality Assurance

To ensure the quality and accuracy of the data, all steps of data management were properly followed. A total of 110 adolescents with mental illness participated in this study. The researcher collected and entered all data carefully and without any bias. All data were entered into SPSS software for analysis, and the researcher checked for any missing or incorrect values before starting the analysis. A backup copy of the dataset was also stored in Google Drive, which is protected by Google's security system to keep the data safe. The researcher worked under the supervision of the research supervisor to make sure all data were accurate and used properly. No changes, manipulation, or unauthorized access occurred during the research. All information from participants was kept private and confidential throughout the study.

# CHAPTER IV: RESULTS

This chapter presents the findings of the study. The research was conducted among adolescents with mental illness who were admitted to the National Institute of Mental Health (NIMH), CRP-Rabia Noor Mental Health Day Centre & Pabna Mental Hospital. According to the inclusion criteria, data were collected from 110 participants using a structured questionnaire. The chapter includes results presented through tables and figures, focusing on the socio-demographic characteristics of the participants and the levels of childhood trauma across the five domains of the Childhood Trauma Questionnaire (CTQ). The analysis also explores the relationship between socio-demographic variables and different trauma domains to better understand the overall status of childhood trauma among adolescents with mental illness.

## 4.1 Socio-demographic Characteristics

**Table 4.1**

*Socio-demographic characteristics of the participants*

| Variable | Catagory | Frequency, n = 110 | Percentage (%) |
|---|---|---|---|
| Age | 12-16 years | 43 | 39.1 |
| | 17-18 years | 67 | 60.9 |
| Gender | Male | 65 | 59.1 |
| | Female | 45 | 40.9 |
| Educational Status | Currently Studying | 75 | 68.2 |
| | Dropped Out | 30 | 27.3 |
| | Never Attended School | 5 | 4.5 |
| If Educational Status Currently Studying | Primary | 26 | 23.6 |
| | Secondary | 58 | 52.7 |
| | Higher Secondary | 17 | 15.5 |

| | | | |
|---|---|---|---|
| | Illiterate | 6 | 5.5 |
| | Madrasha | 3 | 2.7 |
| Current Living Arrangement | With both parents | 82 | 74.5 |
| | With single parent | 19 | 17.3 |
| | With relatives | 9 | 8.2 |
| Father Educational Qualification | Primary | 18 | 16.4 |
| | Secondary | 27 | 24.5 |
| | Higher Secondary | 13 | 11.8 |
| | Bachelor | 40 | 36.4 |
| | Masters | 9 | 8.2 |
| | Illiterate | 3 | 2.7 |
| Mother Educational Qualification | Primary | 33 | 30.0 |
| | Secondary | 23 | 20.9 |
| | Higher Secondary | 26 | 23.6 |
| | Bachelor | 22 | 20.0 |
| | Masters | 1 | 0.9 |
| | Illiterate | 5 | 4.5 |
| Father Occupation | Job Holder | 57 | 51.8 |
| | Business | 22 | 20.0 |
| | Farmer | 5 | 4.5 |
| | Death | 7 | 6.4 |
| | Driving | 2 | 1.8 |
| | Work in Abroad | 16 | 14.5 |
| | Not at present | 1 | 0.9 |
| Mother Occupation | House Wife | 77 | 70.0 |
| | Job Holder | 29 | 26.4 |
| | Death | 1 | 0.9 |
| | Tailor | 2 | 1.8 |
| | Work in Abroad | 1 | 0.9 |
| Sibling Numbers | 1-2 | 61 | 55.5 |
| | 3-8 | 49 | 44.5 |
| Monthly Family Income (BDT) | < 5,000 | 1 | 0.9 |
| | 5,000 – 10,000 | 12 | 10.9 |
| | 10,001 – 20,000 | 52 | 47.3 |
| | > 20,000 | 45 | 40.9 |
| Parental Marital Status | Married and living together | 91 | 82.7 |

| | | | |
|---|---|---|---|
| | Separated | 11 | 10.0 |
| | One/both deceased | 8 | 7.3 |
| Primary Caregiver | Mother | 36 | 32.7 |
| | Father | 69 | 62.7 |
| | Both parents | 1 | 0.9 |
| | Relative | 4 | 3.6 |
| Family Type | Joint/Extended family | 20 | 18.2 |
| | Single-parent family | 90 | 81.8 |

Table 4.1 presents the socio-demographic characteristics of the participants included in this study. A total of 110 adolescents with mental illness aged between 12 and 18 years participated in the study. Among them, 39.1% (n=43) were aged between 12–16 years, while the majority, 60.9% (n=67), belonged to the 17–18 years age group. Regarding gender distribution, 59.1% (n=65) were male and 40.9% (n=45) were female, indicating a higher proportion of male participants.

In terms of educational status, most participants, 68.2% (n=75), were currently studying, whereas 27.3% (n=30) had dropped out and 4.5% (n=5) had never attended school. Among those currently studying, the majority, 52.7% (n=58), were in secondary level, followed by 23.6% (n=26) in primary level and 15.5% (n=17) in higher secondary education. A smaller portion were illiterate (5.5%) and Madrasha students (2.7%). Considering living arrangements, most participants, 74.5% (n=82), lived with both parents, while 17.3% (n=19) lived with a single parent and 8.2% (n=9) stayed with relatives. Regarding parental education, 36.4% of fathers had a bachelor's degree, followed by 24.5% with secondary education and 16.4% with primary education. Among mothers, the majority, 30.0%, completed primary education, followed by 23.6% with higher secondary and 20.9% with secondary education.

In terms of occupation, 51.8% of fathers were job holders, 20.0% were businessmen and 14.5% were working abroad. Among mothers, the majority, 70.0%, were housewives, while 26.4% were engaged in jobs. Regarding sibling numbers, 55.5% (n=61) had 1-2 siblings and 44.5% (n=49) had 3-8 siblings.

Family income data showed that nearly half of the participants, 47.3% (n=52), had a monthly family income between 10,001–20,000 BDT, while 40.9% (n=45) had income above 20,000 BDT. Only a small proportion, 0.9%, had income less than 5,000 BDT. Regarding parental marital status, the majority, 82.7% (n=91), were married and living together, while 10.0% (n=11) were separated and 7.3% (n=8) had one or both parents deceased.

In terms of primary caregiver, most participants, 62.7% (n=69), reported their father as the main caregiver, followed by 32.7% (n=36) who reported their mother. Regarding family type, the majority, 81.8% (n=90), belonged to single-parent families, while 18.2% (n=20) were from joint or extended families.

**Table 4.2**

*Clinical Characteristics of the Participants*

| **Variable** | **Catagory** | **Frequency, n = 110** | **Percentage (%)** |
|---|---|---|---|
| Family History of Mental Illness | Yes | 10 | 9.1 |
| | No | 98 | 89.1 |
| | Not Sure | 2 | 1.8 |
| Types of Mental Illness | Bipolar Mood Disorder | 30 | 27.3 |
| | Schizophrenia | 22 | 20.0 |
| | Behavioral Disability | 11 | 10.0 |
| | Substance Abuse | 14 | 12.7 |
| | Intellectual Disability | 6 | 5.5 |
| | Personality Disorder | 5 | 4.5 |

| | | | |
|---|---|---|---|
| | Post Traumatic Stress Disorder | 6 | 5.5 |
| | Major Depressive Disorder | 11 | 10.0 |
| | Obsessive Compulsive Disorder | 5 | 4.5 |
| Duration of Mental Illness | Less than 1 Year | 14 | 12.7 |
| | 1year-less than 3 Years | 47 | 42.7 |
| | 3-5 Years | 43 | 39.1 |
| | More than 5 Years | 6 | 5.5 |
| Any Physical Complications | Yes | 8 | 7.3 |
| | No | 102 | 92.7 |
| If Physical Complication yes | Heart Disease | 4 | 3.6 |
| | Over Weight | 2 | 1.8 |
| | Heart Disease & High Blood Pressure | 2 | 1.8 |
| History of Taking Psychiatric Treatment | Yes | 34 | 30.9 |
| | No | 76 | 69.1 |
| Mention what type of treatment you receive | Counseling | 14 | 12.7 |
| | Therapy & Counseling | 20 | 18.2 |

Table 4.2 presents the clinical characteristics of the participants with mental illness. Regarding family history of mental illness, the majority of participants, 89.1% (n=98), reported no such history, while 9.1% (n=10) had a positive family history and 1.8% (n=2) were not sure.

In terms of types of mental illness, Bipolar Mood Disorder (BMD) was the most common diagnosis, reported by 27.3% (n=30) of participants, followed by Schizophrenia at 20.0% (n=22) and Substance Abuse Disorder at 12.7% (n=14). Additionally, 10.0% (n=11) of participants were diagnosed with Behavioral Disability and another 10.0% (n=11) with Major Depressive Disorder (MDD). Smaller proportions included Intellectual Disability 5.5% (n=6), Post-Traumatic Stress Disorder (PTSD) 5.5% (n=6), Personality Disorder 4.5% (n=5), and Obsessive-Compulsive

Disorder (OCD) 4.5% (n=5).

Regarding the duration of mental illness, 42.7% (n=47) of participants reported experiencing symptoms for 1 year to less than 3 years, while 39.1% (n=43) had a duration of 3–5 years. A smaller proportion, 12.7% (n=14), had illness for less than 1 year, and only 5.5% (n=6) reported a duration of more than 5 years.

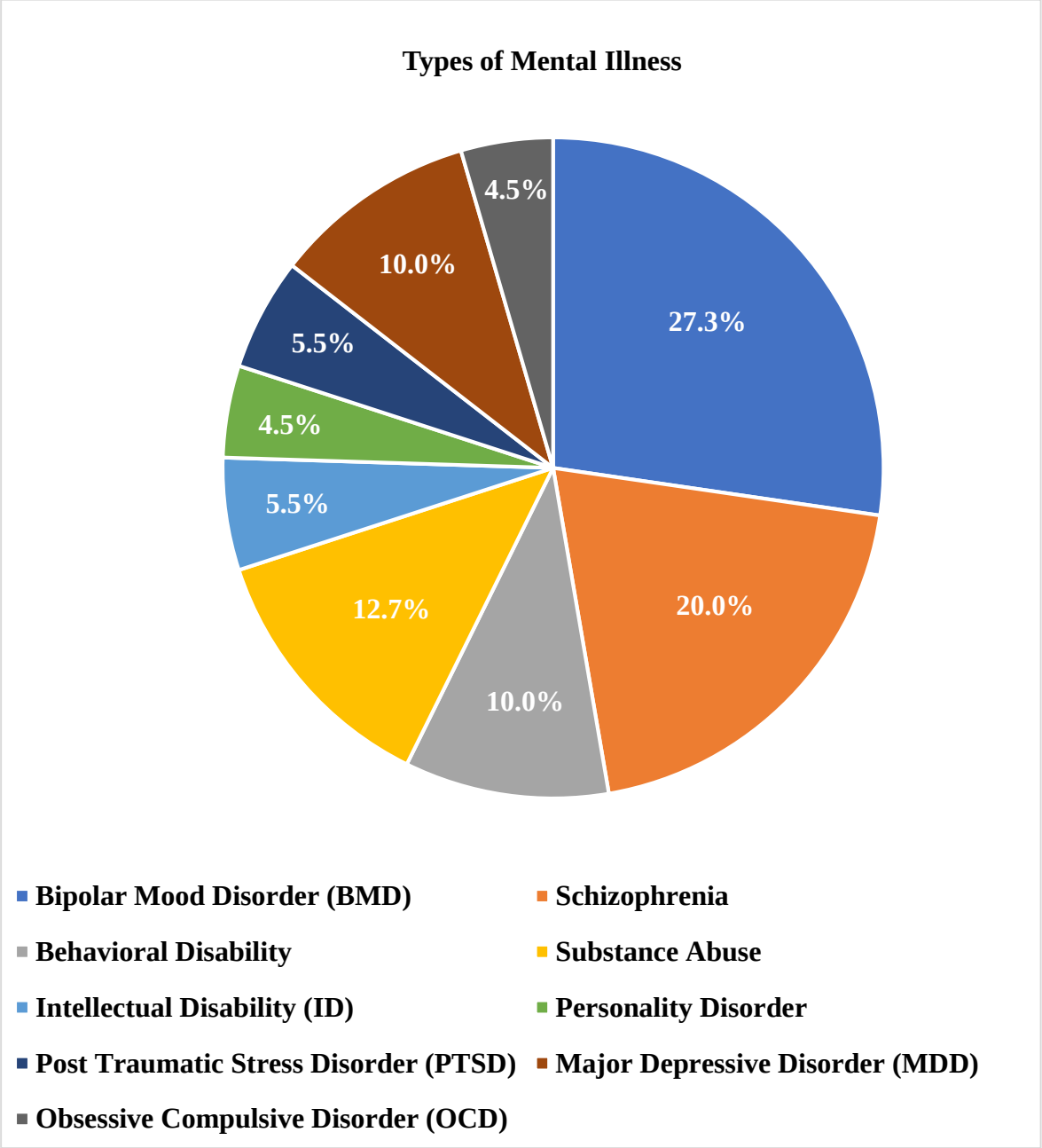
In terms of physical complications, the majority of participants, 92.7% (n=102), reported no physical health problems, while only 7.3% (n=8) had complications. Among those with physical complications, 3.6% (n=4) had heart disease, 1.8% (n=2) were overweight, and another 1.8% (n=2) had both heart disease and high blood pressure.

Regarding history of psychiatric treatment, 30.9% (n=34) of participants had received previous treatment, while the majority, 69.1% (n=76), had no such history. Among those who received treatment, 12.7% (n=14) underwent counseling, while 18.2% (n=20) received both therapy and counseling.

## 4.2 Types of Mental Illness

**Figure 4.1**

*Overview of  Types of Mental Illness among the Participants*



### 4.3 Frequency of Participants

**Table 4.3**

*Frequency of participants regarding their level of abuse in CTQ*

| Statements | Never True % (n) | Rarely True % (n) | Sometimes True % (n) | Often True % (n) | Very Often True % (n) |
|---|---|---|---|---|---|
| **Physical Abuse** | | | | | |
| I got hit so hard that I had to see a doctor | 17.3 (19) | 44.5 (49) | 30.0 (33) | 8.2 (9) | 0.0 (0) |
| I have been hit so that it left bruises and marks | 35.5 (39) | 52.7 (58) | 10.9 (12) | 0.9 (1) | 0.0 (0) |
| I was punished with a belt, board, cord or another hard object | 35.5 (39) | 60.0 (66) | 2.7 (3) | 1.8 (2) | 0.0 (0) |
| I was physically abused | 12.7 (14) | 39.1 (43) | 33.6 (37) | 14.5 (16) | 0.0 (0) |
| I got hit badly and it was noticed by a teacher, neighbor and/or doctor | 11.8 (13) | 36.4 (40) | 31.8 (35) | 20.0 (22) | 0.0 (0) |
| **Emotional Abuse** | | | | | |
| I have been called stupid,lazy and/or ugly | 7.3 (8) | 30.0 (33) | 36.4 (40) | 25.5 (28) | 0.9 (1) |
| I felt/thought that my parents wished I had never been born | 5.5 (6) | 50.0 (55) | 32.7 (36) | 10.0 (11) | 1.8 (2) |
| My family said hurtful or insulting things to me | 1.8 (2) | 20.0 (22) | 50.9 (56) | 26.4 (29) | 0.9 (1) |

| | | | | | |
|---|---|---|---|---|---|
| Someone in my family hated me | 5.5 (6) | 29.1 (32) | 56.4 (62) | 8.2 (9) | 0.9 (1) |
| I have the best family in the world | | | 97.3 (107) | | 2.7 (3) |
| **Sexual Abuse** | | | | | |
| Someone tried to touch me in a sexual way or tried to make me touch them | 74.5 (82) | 6.4 (7) | 14.5 (16) | 4.5 (5) | 0.0 (0) |
| Someone threatened to hurt me unless I did something sexual with them | 77.3 (85) | 11.8 (13) | 9.1 (10) | 1.8 (2) | 0.0 (0) |
| Someone made me try to do sexual things/watch sexual things | 74.5 (82) | 7.3 (8) | 11.8 (13) | 5.5 (6) | 0.9 (1) |
| Someone molested me | 81.8 (90) | 12.7 (14) | 4.5 (5) | 0.9 (1) | 0.0 (0) |
| I was sexually abused | 87.3 (96) | 4.5 (5) | 5.5 (6) | 2.7 (3) | 0.0 (0) |
| **Physical Neglect** | | | | | |
| I did not have enough to eat | 37.3 (41) | 43.6 (48) | 13.6 (15) | 5.5 (6) | 0.0 (0) |
| I had someone to take care of me & protect me | 0.0 (0) | 20.0 (22) | 20.0 (22) | 48.2 (53) | 11.8 (13) |
| My parents were too drunk/high to take care of me | 3.6 (4) | 23.6 (26) | 42.7 (47) | 29.1 (32) | 0.9 (1) |

| | | | | | |
|---|---|---|---|---|---|
| I had to wear dirty clothes | 54.5 (60) | 32.7 (36) | 9.1 (10) | 2.7 (3) | 0.9 (1) |
| Someone took me to see the doctor when I needed to/if I needed to | 0.0 (0) | 2.7 (3) | 36.4 (40) | 57.3 (63) | 3.6 (4) |
| **Emotional Neglect** | | | | | |
| Someone helped me feel important | 0.0 (0) | 4.5 (5) | 25.5 (28) | 61.8 (68) | 8.2 (9) |
| I felt loved | 1.8 (2) | 13.6 (15) | 38.2 (42) | 38.2 (42) | 8.2 (9) |
| My family looked out for each other | 0.9 (1) | 7.3 (8) | 39.1 (43) | 48.2 (53) | 4.5 (5) |
| My family felt close to each other | 0.0 (0) | 7.3 (8) | 21.8 (24) | 63.6 (70) | 7.3 (8) |
| My family gave me strength and support | 1.8 (2) | 13.6 (15) | 33.6 (37) | 46.4 (51) | 4.5 (5) |

Table 4.3 presents the frequency distribution of participants' responses to the Childhood Trauma Questionnaire (CTQ) items across five domains, namely physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. Each item was rated on a five-point Likert scale ranging from "never true" to "very often true."

In the physical abuse domain, responses varied across the five items. For the statement "I got hit so hard that I had to see a doctor," 44.5% (n=49) reported "rarely true," followed by 30.0% (n=33) "sometimes true" and 17.3% (n=19) "never true." Regarding "I have been hit so that it left bruises and marks," the majority, 52.7%

(n=58), reported “rarely true,” while 35.5% (n=39) indicated “never true.” For “I was punished with a belt, board, cord or another hard object,” 60.0% (n=66) responded “rarely true,” and 35.5% (n=39) “never true.” In the case of “I was physically abused,” 39.1% (n=43) reported “rarely true” and 33.6% (n=37) “sometimes true.” Similarly, for “I got hit badly and it was noticed by others,” 36.4% (n=40) responded “rarely true,” followed by 31.8% (n=35) “sometimes true,” and 20.0% (n=22) “often true.”

In the emotional abuse domain, for the statement “I have been called stupid, lazy and/or ugly,” 36.4% (n=40) reported “sometimes true,” and 25.5% (n=28) “often true.” For “I felt that my parents wished I had never been born,” 50.0% (n=55) indicated “rarely true,” while 32.7% (n=36) reported “sometimes true.” Regarding “My family said hurtful or insulting things to me,” the majority, 50.9% (n=56), responded “sometimes true,” followed by 26.4% (n=29) “often true.” For “Someone in my family hated me,” 56.4% (n=62) reported “sometimes true.” In contrast, for the positive statement “I have the best family in the world,” a very high proportion, 97.3% (n=107), reported “never true,” indicating poor perceived family support.

In the sexual abuse domain, most participants reported low exposure. For “Someone tried to touch me in a sexual way,” 74.5% (n=82) reported “never true.” Similarly, for “Someone threatened me to do sexual things,” 77.3% (n=85) responded “never true.” For “Someone made me do or watch sexual things,” 74.5% (n=82) reported “never true.” Regarding “Someone molested me,” 81.8% (n=90) indicated “never true.” Likewise, for “I was sexually abused,” the majority, 87.3% (n=96), reported “never true,” indicating minimal reported sexual abuse among participants.

In the physical neglect domain, for “I did not have enough to eat,” 43.6% (n=48) reported “rarely true,” and 37.3% (n=41) “never true.” For “I had someone to take care of me and protect me,” 48.2% (n=53) reported “often true” and 20.0% (n=22)

"sometimes true." Regarding "My parents were too drunk/high to take care of me," 42.7% (n=47) indicated "sometimes true," followed by 29.1% (n=32) "often true." For "I had to wear dirty clothes," 54.5% (n=60) reported "never true." Lastly, for "Someone took me to see a doctor when needed," the majority, 57.3% (n=63), responded "often true."

In the emotional neglect domain, responses showed mixed patterns. For "Someone helped me feel important," 61.8% (n=68) reported "often true," and 25.5% (n=28) "sometimes true." For "I felt loved," equal proportions, 38.2% (n=42), reported "sometimes true" and "often true." Regarding "My family looked out for each other," 48.2% (n=53) indicated "often true." For "My family felt close to each other," the majority, 63.6% (n=70), responded "often true." Lastly, for "My family gave me strength and support," 46.4% (n=51) reported "often true," followed by 33.6% (n=37) "sometimes true."

### 4.4 The Level of Abuse among the Participants

**Table 4.4**

*The Level of Abuse status among the Participants with Mental Illness*

| Sub-Scale | Level of Abuse | | | | Mean | SD |
|---|---|---|---|---|---|---|
| | None | Low | Moderate | Severe | | |
| | % (n) | % (n) | % (n) | % (n) | | |
| Physical Abuse | 31.8 (35) | 61.8 (68) | 6.4 (7) | 0.0 (0) | 1.75 | .566 |
| Emotional Abuse | 26.4 (29) | 67.3 (74) | 6.4 (7) | 0.0 (0) | 1.80 | .538 |
| Sexual Abuse | 78.2 (86) | 17.3 (19) | 4.5 (5) | 0.0 (0) | 1.26 | .536 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Physical Neglect | 16.4 (18) | 76.4 (84) | 6.4 (7) | 0.9 (1) | 1.92 | .509 |
| Emotional Neglect | 9.1 (10) | 72.7 (80) | 18.2 (20) | 0.0 (0) | 2.09 | .517 |

Table 4.4 presents the level of abuse status among the participants across the five sub-scales of the Childhood Trauma Questionnaire (CTQ), including physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. The findings indicate that the majority of participants experienced low levels of abuse across most domains, although some variations were observed.

In the physical abuse domain, the majority of participants, 61.8% (n=68), reported low levels of abuse, while 31.8% (n=35) experienced no abuse. A small proportion, 6.4% (n=7), reported moderate levels, and none of the participants reported severe physical abuse. The mean score for physical abuse was 1.75 (SD = 0.566), indicating generally low exposure.

Regarding emotional abuse, 67.3% (n=74) of participants experienced low levels, while 26.4% (n=29) reported no emotional abuse. Only 6.4% (n=7) experienced moderate levels, and no cases of severe emotional abuse were reported. The mean score was 1.80 (SD = 0.538), suggesting that emotional abuse was present but mostly mild in severity.

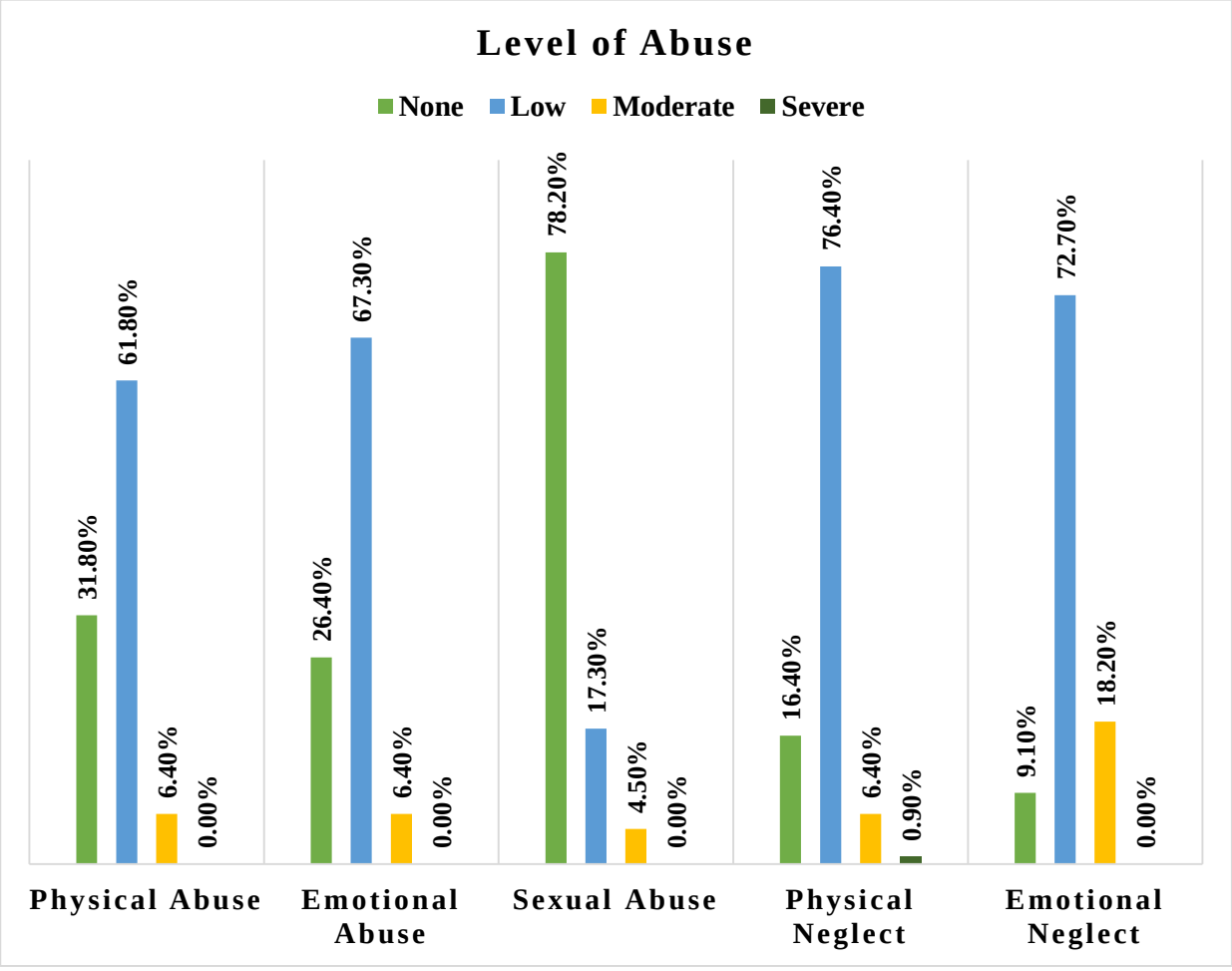
In the sexual abuse domain, the majority of participants, 78.2% (n=86), reported no experience of sexual abuse. Additionally, 17.3% (n=19) experienced low levels, and only 4.5% (n=5) reported moderate levels. No participants reported severe sexual abuse. The mean score was 1.26 (SD = 0.536), indicating the lowest level of exposure among all domains.

For physical neglect, most participants, 76.4% (n=84), experienced low levels, while 16.4% (n=18) reported no neglect. A small proportion, 6.4% (n=7), experienced moderate neglect, and only 0.9% (n=1) reported severe neglect. The mean score was 1.92 (SD = 0.509), reflecting relatively low but notable levels of neglect.

Emotional neglect appeared to be the most prominent domain among the participants. The majority, 72.7% (n=80), experienced low levels, while 18.2% (n=20) reported moderate levels. Only 9.1% (n=10) reported no emotional neglect, and none experienced severe levels. The mean score was 2.09 (SD = 0.517), which was the highest among all sub-scales, indicating comparatively greater emotional deprivation.

**Figure 4.2**

*Overview of the Level of Abuse among the Participants with Mental Illness*



**4.5 Association Between Sexual Abuse Level & Socio-demographic characteristics**

**Table 4.5**

*Association Between Sexual Abuse Level & Socio-demographic characteristics*

| Variables | | Sexual Abuse | | $\chi^2$ / Fisher's Exact Test | *P* value |
|---|---|---|---|---|---|
| | | **Yes % (n)** | **No % (n)** | | |
| Age | 12-16 years | 9.1 (10) | 30.0 (33) | 2.815 | **.048** |
| | 17-18 years | 12.7 (14) | 48.2 (53) | | |
| Gender | Male | 0.0 (0) | 65 (59.1) | 44.341 | **.002** |
| | Female | 21.8 (24) | 19.1 (21) | | |

Table 4.5 presents the association between sexual abuse level and selected socio-demographic characteristics of the participants, specifically age and gender. The analysis indicates that both variables show statistically significant relationships with sexual abuse.

There was a statistically significant association between age and experience of sexual abuse (Fisher's Exact Test = 2.815, P = 0.048). Among participants aged 12–16 years, 9.1% (n=10) reported experiencing sexual abuse, while 30.0% (n=33) reported no experience. In comparison, among those aged 17–18 years, a slightly higher proportion, 12.7% (n=14), reported experiencing sexual abuse, whereas 48.2% (n=53) reported no experience. This finding suggests that older adolescents were relatively more exposed to sexual abuse compared to the younger age group.

A highly significant association was observed between gender and sexual abuse ($\chi^2$ = 44.341, P = 0.002). None of the male participants (0.0%, n=0) reported experiencing sexual abuse, while 59.1% (n=65) reported no such experience. In contrast, a notable proportion of female participants, 21.8% (n=24), reported experiencing sexual abuse, while 19.1% (n=21) reported no experience. This indicates that female participants were significantly more likely to report sexual abuse compared to male participants.

Overall, the findings demonstrate that both age and gender are significantly associated with sexual abuse among adolescents with mental illness, with higher vulnerability observed among older adolescents and females.

### 4.6 Association Between Physical Neglect Level & Socio-demographic characteristics

**Table 4.6**

*Association Between Physical Neglect Level & Socio-demographic characteristics*

| Variables | | Physical Neglect | | $\chi^2$ / Fisher's Exact Test | *P* value |
|---|---|---|---|---|---|
| | | Yes % (n) | No % (n) | | |
| Family Type | Joint/Extended Family | 15.5 (17) | 2.7 (3) | 0.855 | **.033** |
| | Single-Parent Family | 68.2 (75) | 13.6 (15) | | |

Table 4.6 presents the association between physical neglect level and selected socio-demographic characteristics of the participants. The findings indicate that family type shows a statistically significant association with physical neglect.

There was a statistically significant association between family type and physical neglect ($\chi^2$ / Fisher's Exact Test, P = 0.033). Participants from single-parent families reported higher levels of physical neglect compared to those from joint or extended families. In contrast, adolescents living in joint or extended family settings experienced relatively lower levels of physical neglect. This suggests that the presence of multiple caregivers and family support in extended families may reduce the risk of physical neglect.

Overall, the results demonstrate that family type is significantly associated with physical neglect among adolescents with mental illness, with higher vulnerability observed among those living in single-parent family structures.

**4.7 Association Between Emotional Neglect Level & Socio-demographic characteristics**

**Table 4.7**

*Association Between Emotional Neglect Level & Socio-demographic characteristics*

| **Variables** | | **Emotional Neglect** | | **$\chi^2$ / Fisher's Exact Test** | ***P* value** |
|---|---|---|---|---|---|
| | | **Yes % (n)** | **No % (n)** | | |
| Age | 12-16 years | 33.6 (37) | 5.5 (6) | 14.362 | **.001** |
| | 17-18 years | 57.3 (63) | 3.6 (4) | | |
| Educational Status | Currently Studying | 60.0 (66) | 8.2 (9) | 8.921 | **.042** |
| | Dropped Out | 26.4 (29) | 0.9 (1) | | |
| | Never Attended School | 4.5 (5) | 0.0 (0) | | |

| | | | | | |
|---|---|---|---|---|---|
| Parental Marital Status | Married and Living Together | 73.6 (81) | 9.1 (10) | 15.223 | **.002** |
| | Separated | 10.0 (11) | 0.0 (0) | | |
| | One/Both Decreased | 7.3 (8) | 0.0 (0) | | |

Table 4.7 presents the association between emotional neglect level and selected socio-demographic characteristics of the participants. The analysis reveals that several socio-demographic variables show statistically significant relationships with emotional neglect.

A statistically significant association was found between age and emotional neglect ($P < 0.05$). Participants aged 17–18 years showed comparatively higher levels of emotional neglect than those aged 12–16 years. This suggests that older adolescents were more likely to experience emotional deprivation.

Educational status was also significantly associated with emotional neglect ($P < 0.05$). Participants who had dropped out of school or never attended school reported higher levels of emotional neglect compared to those who were currently studying. This indicates that lack of educational engagement may be linked with poorer emotional support within the family environment.

A significant relationship was observed between parental marital status and emotional neglect ($P < 0.05$). Adolescents from separated families or those with one or both parents deceased experienced higher levels of emotional neglect compared to those whose parents were married and living together. This highlights the importance of family stability in ensuring emotional support for adolescents.

Overall, the findings of Table 4.7 suggest that emotional neglect among adolescents with mental illness is significantly influenced by age, educational status,

and parental marital condition. These factors play a crucial role in shaping the emotional well-being of the participants.Furthermore, a significant association was observed between parental marital status and emotional neglect (Fisher's Exact Test = 15.223, P = .002). Among participants whose parents were married and living together, 73.6% (n = 81) experienced emotional neglect, while 9.1% (n = 10) did not. In contrast, all adolescents from separated families 10.0% (n = 11) and those with one or both parents deceased 7.3% (n = 8) reported experiencing emotional neglect. This finding highlights that family disruption is strongly linked with higher levels of emotional neglect among adolescents with mental illness.

Overall, the results demonstrate that emotional neglect is significantly influenced by age, educational status, and parental marital status. Older adolescents, those with disrupted educational backgrounds, and those from separated or bereaved families were particularly at risk of emotional neglect, emphasizing the need for targeted psychosocial and family-based interventions.

# CHAPTER V: DISCUSSION

The aim of this study was to explore the status of childhood trauma among adolescents with mental illn**ess** using the Childhood Trauma Questionnaire-Short Form (CTQ-SF). A total of 110 adolescents participated in the study. The findings showed that most participants experienced low levels of abuse across all trauma domains, but emotional neglect and emotional abuse were the most common types of trauma. This indicates that many adolescents with mental illness face emotional deprivation rather than severe physical or sexual abuse.

Similar studies support these results. Maheshwari et al. (2024) and Wang et al. (2025) found that emotional neglect was strongly linked to depression and poor emotional control among adolescents. Emotional trauma often remains unnoticed but can lead to lasting psychological problems.

In this study, female participants reported higher levels of sexual and emotional abuse, while males showed slightly higher physical abuse. This pattern supports previous findings that females are more vulnerable to emotional and sexual abuse, whereas males are more likely to face physical punishment **(**Xiao et al., 2022; Afifi et al., 2020**).**

A significant relationship was also found between family type and emotional neglect. Adolescents from single-parent families experienced higher neglect than those from joint or extended families, consistent with Marshall and Semovski (2020) and Frost et al. (2024)**.** Similarly, low family income was associated with higher levels of neglect, as financial stress often limits parents' ability to provide emotional care **(**Anjum et al., 2022**).**

The study also found that parental marital status had a significant effect on emotional neglect. Adolescents with separated or widowed parents experienced more emotional neglect than those with both parents living together. This finding matches Hellfeldt et al. (2020), who found that family disruption increases emotional and behavioral problems in youth.

Although no significant difference was found by age, older adolescents tended to report more emotional neglect, possibly due to greater awareness of their experiences **(**Wang et al., 2025**)**. Overall, the results show that emotional neglect and abuse are common among adolescents with mental illness in Bangladesh.

These findings align with international studies **(**Deavy, 2020; Frost et al., 2024; Xiao et al., 2022) and highlight the need for family-based and trauma-informed interventions. Providing emotional support, strengthening family relationships, and early detection of trauma can help reduce the long-term psychological effects and improve adolescents' well-being.

# CHAPTER VI: CONCLUSION

## 6.1 Strength and Limitation

### 6.1.1 Strength

- In this study, the researcher used the Childhood Trauma Questionnaire–Short Form (CTQ-SF), a well-developed and reliable tool to measure five types of childhood trauma: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect.
- The student researcher collected data through face-to-face interviews, which helped improve the accuracy and quality of responses and reduced possible bias.
- The study obtained ethical approval from the Institutional Review Board (IRB) of BHPI, ensuring that all data collection followed ethical rules and participant rights were protected.
- The study focused on adolescents with mental illness, which is an under-researched group in Bangladesh. This adds new and valuable knowledge to the country's mental health field.
- The results of this study are supported by several international studies, which makes the findings more reliable and comparable with global evidence.

### 6.1.2 Limitation

- The researcher could not include a large sample size due to time and resource limitations.
- The participants were selected from specific mental health institutions (NIMH, CRP-Rabia Noor Mental Health Centre, and Pabna Mental Hospital), so the results may not represent all adolescents in Bangladesh.

- The study used purposive sampling, which may limit generalization since participants were chosen based on set criteria instead of random selection.
- The data were based on self-reported responses, which may include recall bias, as participants were asked to share past childhood experiences.
- Most participants were from urban and middle-income families, so the findings might not fully reflect the experiences of adolescents from rural or very low-income backgrounds.
- There is still a lack of national studies on childhood trauma among adolescents with mental illness in Bangladesh, which made it difficult to compare results within the local context.

## 6.2 Practice Implication

### 6.2.1 Recommendation for Future Practice

This study provides valuable insights into the status of childhood trauma among adolescents with mental illness in Bangladesh. The findings highlight that emotional neglect and emotional abuse are the most common trauma experiences faced by adolescents, which often remain unnoticed but have deep effects on emotional and social well-being.

The results of this study can be very useful for mental health professionals**,** occupational therapists and counselors. They can use this information to design trauma-informed intervention programs that focus on improving emotional control, developing healthy coping strategies, and rebuilding self-esteem in adolescents. Therapists can also provide guidance to parents and caregivers to create a more caring and supportive home environment that helps reduce emotional neglect.

Furthermore, this study emphasizes the need for awareness programs in schools, hospitals, and communities to help identify trauma early and provide timely

psychological support. Policymakers and mental health organizations can use the study findings to develop inclusive and youth-friendly mental health policies, focusing on prevention, early intervention, and family counseling. By doing so, professionals can help adolescents heal from their past trauma and improve their emotional health and quality of life.

### 6.2.2 Recommendation for Future Research

A few recommendations are made for future research:

- Similar studies should be conducted with a larger sample size from different areas of Bangladesh to make the results more generalizable.
- Longitudinal studies are needed to understand how childhood trauma affects adolescents' mental health over time and how recovery progresses with age.
- Mixed-method studies should be carried out to combine both statistical data and personal experiences, which would provide a deeper understanding of trauma and its emotional effects.
- Future research could explore the relationship between childhood trauma and resilience, to identify the protective factors that help adolescents recover from past trauma.
- Further studies should include participants from different institutions and community settings, to better understand the social and family factors influencing trauma among adolescents with mental illness.

## 6.3 Conclusion

This study explored the status of childhood trauma among adolescents with mental illness in Bangladesh using the Childhood Trauma Questionnaire-Short Form (CTQ-SF). The findings showed that most participants experienced low levels of abuse, but emotional neglect and emotional abuse were the most common trauma types. These experiences often remain unnoticed but can deeply affect an adolescent's emotions, behavior, and social life. The study also found significant links between family background and trauma. Adolescents from single-parent or low-income families experienced higher levels of neglect, while those from stable and supportive families reported fewer trauma experiences. These findings suggest that family environment and parental care play an important role in shaping a child's emotional well-being. This research highlights the need for trauma-informed mental health care in Bangladesh. Mental health professionals, especially occupational therapists, can use these findings to design early interventions, promote emotional support, and involve families in treatment. Awareness programs at schools and communities are also essential to identify and support adolescents facing trauma. Although the study had some limitations, such as a small sample size and purposive sampling, it provides a valuable starting point for future research. Larger and more diverse studies are needed to explore protective factors like resilience and social support that help adolescents recover from trauma.

# CHAPTER VII: LIST OF REFERENCE

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# APPENDICES

## Appendix A: IRB Approval

### Ethical Approval Letter from IRB

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

Ref: CRP-BHPI/IRB/07/2025/1124 Date: 21.07.2025

To
Md. Nurul Amin
4th Year B.Sc. in Occupational Therapy
Session: 2020-2021 Student ID: **122200417**

**Subject: Approval of the thesis proposal The Status of Childhood Trauma among Adolescents with Mental Health Illness by ethics committee.**

Dear Md. Nurul Amin,
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 Kaniz Fatema, Lecturer, 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 | Childhood Trauma Questionnaire (CTQ) (English & Bangla) |
| 3 | Information sheet & consent form. |

The purpose of the study is to explore the influence of childhood trauma on adolescent's emotional regulation, behavior & social relationships. The study involves use of a Childhood Trauma Questionnaire to explore the influence of childhood trauma on adolescent's emotional regulation, behavior & social relationships that may take 15 to 20 minutes to answer the Interview Guide 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, Dept. of Rehabilitation Science
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪১৪০৪, 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

Date: 24/06/25
The Chairman
Institutional Review Board (IRB)
Bangladesh Health Professions Institute (BHPI)
CRP-Savar, Dhaka-1343, Bangladesh

Subject: **Application for review and ethical approval.**

Sir,

With due respect I would like to draw your kind attention that I am a student of 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. I would like to conduct a thesis titled, **"The Status of Childhood Trauma among the Adolescents with Mental Health illness : A Quantitative Study"** with myself, as the principal investigator and **Kaniz Fatema**, Lecturer, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as my thesis supervisor. The purpose of the study is to "explore the influence of childhood trauma on adolescent's emotional regulation, behavior & social relationships."
Childhood Trauma Questionnaire (CTQ) will be used in the study that will take about 15 to 20 minutes. Other related information will be collected from the Socio-demographic questions. Data collectors will receive informed consents from all participants. Any data collected will be kept confidential.

Therefore, I look forward to having your approval for the thesis proposal and to start data collection. I also assure you that I will maintain all the requirements for study.

Sincerely yours,
Nurul Amin
**Md. Nurul Amin**
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21, Student ID: **122200417**
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the thesis supervisor/concerned authority:

**Kaniz Fatema**
Lecturer, Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI),
CRP, Savar, Dhaka-1343

## Appendix B: Approval/Permission Letter

### Permission Letter 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 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 **"The Status of Childhood Trauma among the Adolescents with Mental Illness: A Cross-Sectional Study"** with myself & Kaniz Fatema as my thesis supervisor. The purpose of my study is to identify the level of abuse and find out the socio-demographic profile of the adolescent participants and assess the relationship between socio-demographic characteristics & different domains and levels of childhood trauma among adolescents with mental illness. In order to fulfill the objectives of this study, I would like to collect data from individuals who are currently receiving services 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,
Nurul Amin
Md. Nurul Amin
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200417
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Approved and permitted for data collection from CRP- Rabia Noor Mental Health Day Centre.
Rabiul (2209)
02.08.2025

Md. Rabiul Hasan
Project Manager
Mental Health Project-CRP

**Recommendation from the Head of the Department:**

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/ ২৫৮৪ তারিখঃ ২৫/৮/২৫

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 "The Status of Childhood Trauma among the Adolescents with Mental Illness: A Quantitative Study" 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

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালকের কার্যালয়
মানসিক হাসপাতাল, পাবনা।
e-mail:pmh@hospi.dghs.gov.bd

স্মারক নং-মাহাপা/কমিটি/২০২৫/

তারিখ:

## অফিস আদেশ

অত্র কার্যালয়ের বহি: পত্র নিবন্ধন নং-২০৩৪ তারিখ: ২৫/০৮/২০২৫ খ্রি. মোতাবেক বাংলাদেশ হেল্‌থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) ঢাকা এর মো: নুরুল আলম (স্টুডেন্ট আইডি-১২২২০০৪১৭, ৪র্থ বর্ষ, বি.এসসি ইন অকুপেশনাল থেরাপিষ্ট) কর্তৃক মানসিক হাসপাতাল, পাবনায় "The Status of Childhood Trauma Among the Asolescents with Mental Illness" শিরোনামে ডাটা কালেকশনের জন্য আবেদন করায় এবং অত্র কার্যালয়ের Ethical Committee এর সুপারিশ ক্রমে উক্ত বিষয়ে গবেষনা করার অনুমতি প্রদান করা হলো।

স্বা:
(ডা: শাফ্‌কাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।

স্মারক নং-মাহাপা/কমিটি/২০২৫/১২২০/৮(১৫)

তারিখ: ১৫/৯/২০২৫

অনুলিপি সদয় অবগতি/অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য:

১। সিনিয়র সচিব, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
২। মহা-পরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা। দৃষ্টি আকর্ষণঃ সহকারী পরিচালক (সমন্বয়)।
৩। মহাপরিচালক, স্বাস্থ্য শিক্ষা অধিদপ্তর, মহাখালী, ঢাকা।
৪। ডা: এহিয়া কামাল, চিকিৎসা তত্ত্বাবধায়ক,মানসিক হাসপাতাল, পাবনা।
৫। ডা: আহসান আজিজ সরকার, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৬। ডা: মো: রাজিবুর রহমান, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৭। ডা: এ কে এম শফিউল আযম আবাসিক সাইকিয়াট্রিষ্ট (ভারপ্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
৮। ডা: মো: রুহিদ হোসেন, জুনিয়র কনসালটেন্ট, জেনারেল হাসপাতাল, পাবনা।
৯। বোরহান উদ্দিন হায়দার, সাইকিয়াট্রিক সোসাল ওয়ার্কার (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১০। মো: মজাহার আলী, সাইকিয়াট্রিক সোসাল ওয়ার্কার, মানসিক হাসপাতাল, পাবনা।
১১। মো: জাকির হোসেন, সমাজসেবা কর্মকর্তা (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১২। মো: আলমগীর হোসেন, সমন্বয়কারী, বাংলাদেশ লিগ্যাল এইড এন্ড সার্ভিসেস ট্রাস্ট (BLAST), পাবনা ইউনিট।
১৩। Prof.SK Moniruzzaman, Professor & Head, Department of OccupationalTherapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka.
১৪। Md. Nurul Amin, 4th Year, B.Sc. in Occupational Therapy, Student ID-122200417, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka.
১৫। প্রধান সহকারী/পিএ/পরিসংখ্যান বিভাগ, মানসিক হাসপাতাল, পাবনা।
১৬। অফিস নথি।

(ডা: শাফ্‌কাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।
ফোন: ০২৫৮৮৮০-৫২১২
১৫/০৯/২০২৫

## Appendix C : Information Sheet (English Version)

**BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)**

**Department of Occupational Therapy**

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

**Participants Information sheet**

**Research Title:** ‘‘Status of Childhood Trauma among the Adolescents with Mental Illness : A Cross-Sectional Study”

**Researcher:** Md. Nurul Amin, 4th year, Student of Bachelor of Science in Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP- Savar, Dhaka-1343.

**Supervisor:** Kaniz Fatema, Lecturer, Department of Occupational Therapy, BHPI, CRP, Savar, Dhaka.

**Place of Research:** The study will be conducted in the National Institute of Mental Health (NIMH) which is located at Sher-E-Bangla Nagar, Dhaka, CRP - Rabia Noor Mental Health Day Centre which is located at Nabinagar, Savar, Dhaka and Pabna Mental Hospital which is located at Hemayetpur, Pabna Sadar, Pabna.

**Introduction:**

I am Md. Nurul Amin, a 4th year student of the B.Sc. in Occupational Therapy program (Session: 2020-2021) at Bangladesh Health Professions Institute under the Faculty of Medicine, University of Dhaka. To complete B.Sc. in Occupational Therapy from BHPI, conducting a research project is mandatory. This research project will be done under the supervision of Kaniz Fatema, Lecturer, Department of Occupational Therapy, BHPI. The purpose of the research project is the collection of data and how it will be related to the research and this will be presented to you in detail through this participant paper. if you are willing to participate in this research, in that case, a clear idea about the research topic will be easier for decision-making. Of course, you do not have to

make sure you participate now. Before taking any decision, you can discuss it with your relatives, or guardians about this. On the other hand, after reading the information sheet if you feel a problem understanding the content or if you need to know more about something, you can freely ask.

**Research Background and Objectives:**

You are invited to be a part of this research because, in Bangladesh, there is no research that measures the level of abuse and find out the socio-demographic profile of the adolescent participants with mental illness. This study aims to identify the level of abuse and find out the socio-demographic profile of the adolescent participants and assess the relationship between socio-demographic characteristics & different domains and levels of childhood trauma among adolescents with mental illness.. Your information will be helpful to reveal the level of abuse faced by adolescents with mental illness through your voluntary participation in this study.

**Let's Know about the topic related to participation in this research work:**

Before signing the consent form from you, the details of managing the research project will be presented to you in detail through this participation note. If you want to participate in this study, you will have to agree to participate in the study. If you ensure participation, a copy of your consent will be given. After a representative of collection data till by the researcher will call you. At any given time taken from you by a question paper information will be collected. Your participation in this research project is optional. If you do not agree then you do not have to participate. Despite your consent, you can withdraw your participation at any time without giving any explanation to the researcher.

**The Benefits and Risks of Participation:**

You will not get any benefit directly to participate in this research project. Participation in this study can lead to many difficulties in your daily work. However, we are hopeful that the benefits direct from the results of this research will remove the disadvantages. Don't worry about your identity, it's request. Patient's name, address will not be included in the data analysis software to reduce the risk of uncover identity.

**Confidentialities of Information:**

By signing this agreement, you are allowing the research staff to study this research project to collect and use your resources. Any information gathered for this research project, which can identify you, will be confidential. The information collected about you will be able to access this information directly. Symbolic ways identified data will be used for the next data analysis. Information sheets will be kept in a locker drawer. The Electronics versions of the data analysis will be collected in BHPI's Occupational Therapy department and on the research's laptop. It is expected that the results of this research project will be published and presented in different forums. In any publication and presentation, the information will be provided in such a way that you cannot be identified in any way without your consent. Data will be initially collected over phone.

**Information about Promotional Result:**

The result of this study will be published in various social media, websites, conference, discussion, and reviewed journals.

**Participant's Fees:**

There is no stimulus and remuneration for participation in this study.

**Source of Funding to Manage Research:**

The cost of this research will be spent entirely by the researcher's funds. This study will be done in small areas and no money comes from an external source.

**Information about Withdrawal from Participation:**

Despite your consent, you can withdraw your participation within one week after giving information without giving any explanation to the researcher. If the information can be used after the cancellation, its permission will be mentioned in the participant's withdrawal letter (application only volunteer withdrawal).

**Contact Address with the Researcher:**

If you have any questions about the research, you can ask me now or latter. If you wish to ask a question later, you may contact any of the following: Md. Nurul Amin, 4$^{th}$ Year, Student of B.Sc. in Occupational Therapy, Department of Occupational Therapy, BHPI, CRP, Savar, Dhaka and Cell No: 01849262997, Gmail: sfsakib238@gmail.com

**Complaints:**

If there is any complaint regarding the conduct of this research project, contact with the Association of Ethics (77454645). This proposal has been reviewed by the institutional Reviewed Board (IRB), Bangladesh Health Professions Institute (BHPI). CRP, Savar, Dhaka-1343, Bangladesh, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the IRB, contact Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka-1343, Bangladesh.

## Appendix C : Information Sheet (Bengali Version)

**বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)**
**অকুপেশনাল থেরাপি বিভাগ**
সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, টেলি : ০২-৭৭৪৫৪৬৪-৫, ৭৭৪১৪০৪, ফ্যাক্স : ০২-৭৭৪৫০৬

**অংশগ্রহণকারীদের তথ্য এবং সম্মতিপত্র**

**গবেষণার বিষয় :** "মানসিক সমস্যা বিশিষ্ট কিশোর-কিশোরীদের মধ্যে শৈশবের ট্রমার পরিস্থিতি সম্পর্কিত তথ্য বের করার জন্য একটি ক্রস-সেকশনাল স্টাডি"।

**গবেষক :** মো. নুরুল আমিন, বি.এস.সি ইন অকুপেশনাল থেরাপি (৪র্থ বর্ষ), সেশন : ২০২০-২১, বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩

**তত্ত্বাবধায়ক :** কানিজ ফাতেমা, প্রভাষক, অকুপেশনাল থেরাপি বিভাগ, বিএইচপিআই, সিআরপি, সাভার, ঢাকা

**গবেষণার স্থান :** এই গবেষণাটি পরিচালিত হবে জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট (এনআইএমএইচ), যা শেরে বাংলা নগর, ঢাকা-তে অবস্থিত, সিআরপি - রাবিয়া নূর মেন্টাল হেলথ্ ডে সেন্টার, যা নবীনগর, সাভার, ঢাকা-তে অবস্থিত এবং পাবনা মানসিক হাসপাতাল, যা হেমায়েতপুর, পাবনা সদর, পাবনা-তে অবস্থিত।

**ভূমিকা :**

আমি মো. নুরুল আমিন, ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা অনুষদের অধীনে বাংলাদেশ হেলথ্ প্রফেশনস ইন্সটিটিউটে বি.এস.সি ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের ছাত্র হিসেবে (২০২০-২১) সেশনে অধ্যয়নরত আছি। বিএইচপিআই থেকে অকুপেশনাল থেরাপি বি.এস.সি শিক্ষা কার্যক্রমটি সম্পূর্ণ করার জন্য একটি গবেষণা প্রকল্প পরিচালনা করা বাধ্যতামূলক। এ গবেষণা প্রকল্পটি বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট এর অকুপেশনাল থেরাপি বিভাগের প্রভাষক কানিজ ফাতেমা এর তত্ত্বাবধায়নে সম্পন্ন করা হবে। এ অংশগ্রহণকারী তথ্যপত্রের মাধ্যমে গবেষণার প্রকল্পটির উদ্দেশ্য, উপাত্ত সংগ্রহের প্রণালী গবেষণাটির সাথে সংশ্লিষ্ট বিষয়ে কিভাবে রক্ষিত হবে তা বিস্তারিত ভাবে আপনার কাছে

উপস্থাপন করা হবে। যদি এই গবেষণায় অংশগ্রহণ করতে আপনি ইচ্ছুক থাকেন, সে ক্ষেত্রে এ গবেষণার সম্পৃক্ত বিষয় সম্পর্কে স্বচ্ছ ধারণা থাকলে সিদ্ধান্তগ্রহণ সহজতর হবে। অবশ্য এখন আপনার অংশগ্রহণ আমাদের নিশ্চিত করতে হবে না, যেকোনো সিদ্ধান্ত গ্রহণের পূর্বে, যদি চান আপনার আত্মীয়-স্বজন বন্ধু অথবা আস্থাভাজন যে কারো সাথে এই ব্যাপারে আলোচনা করে নিতে পারেন। অপরপক্ষে, অংশগ্রহণকারী তথ্যপত্রটি পড়ে, যদি কোনো বিষয়বস্তু বুঝতে সমস্যা হয় অথবা যদি কোন কিছু সম্পর্কে আরও বেশি জানা প্রয়োজন হয় তবে নির্দ্বিধায় প্রশ্ন করতে পারেন।

**গবেষণার প্রেক্ষাপট ও উদ্দেশ্য :**

আপনাকে এই গবেষণার অংশ হওয়ার জন্য আমন্ত্রণ জানানো হচ্ছে কারণ, বাংলাদেশে মানসিক অসুস্থতায় আক্রান্ত কিশোর-কিশোরীদের মধ্যে শৈশবকালীন নির্যাতনের মাত্রা নির্ণয়ের উপর কোন গবেষণা নেই। এটি বাংলাদেশের মানসিক অসুস্থতায় আক্রান্ত কিশোর-কিশোরীদের মধ্যে শৈশবকালীন নির্যাতনের মাত্রা নির্ণয় করতে এবং নির্যাতনের বিভিন্ন ক্ষেত্র ও মাত্রার সঙ্গে তাদের সামাজিক ও জনসংখ্যাগত বৈশিষ্ট্যের সম্পর্ক মূল্যায়ন করতে সহায়তা করবে। আপনার তথ্য এই গবেষণায়, আপনার স্বেচ্ছায় অংশগ্রহণের মাধ্যমে মানসিক অসুস্থতায় আক্রান্ত কিশোর-কিশোরীদের মধ্যে শৈশবকালীন নির্যাতনের মাত্রা নির্ণয় করতে সহায়ক হবে বলে আমরা আশাবাদী।

**এই গবেষণা কর্মটিকে অংশগ্রহণের সাথে সম্পৃক্ত বিষয় সমূহ কি সেই সম্পর্কে জানা যাক :**

আপনার থেকে অনুমতি পত্রে স্বাক্ষর নেবার আগে, এই অংশগ্রহণকারী তথ্যপত্রের মাধ্যমে গবেষণা প্রকল্পটির পরিচালনা করার তথ্যসমূহ বিস্তারিত ভাবে আপনার কাছে উপস্থাপন করা হবে। আপনি যদি এই গবেষণায় অংশগ্রহণ করতে চান, তাহলে সম্মতিপত্রে আপনাকে স্বাক্ষর করতে হবে। আপনি যদি স্বাক্ষর জ্ঞান সম্পন্ন না হন বা অন্য কোনো কারণে স্বাক্ষর প্রদানের ব্যর্থ হন, সে ক্ষেত্রে আপনার কাছ থেকে একজন সাক্ষীর উপস্থিতিতে বৃদ্ধাঙ্গুলির ছাপ সম্মতি পত্রে নেওয়া হবে। আপনি অংশগ্রহণ নিশ্চিত করলে, আপনার সংরক্ষণের জন্য সম্মতিপত্রটির একটি অনুলিপি দিয়ে দেওয়া হবে। পরবর্তীতে গবেষক কর্তৃক গঠিত তথ্য-উপাত্ত একটি দলের প্রতিনিধি আপনার কাছে যাবে। আপনার থেকে চেয়ে নেওয়া যে কোন একটি নির্দিষ্ট সময়ে একটি প্রশ্নপত্রের মাধ্যমে তথ্য সংগ্রহ করা হবে। এই গবেষণার প্রকল্পে

আপনার অংশগ্রহণ ঐচ্ছিক। যদি আপনি সম্মতি প্রদান না করেন তবে আপনাকে অংশগ্রহণ করতে হবে না। আপনি সম্মতি প্রদান করা সত্ত্বেও যে কোনো সময় গবেষককে কোন ব্যাখ্যা প্রদান করা ছাড়াই নিজের অংশগ্রহণ প্রত্যাহার করতে পারবেন।

**অংশগ্রহণ এর সুবিধা ঝুঁকিসমূহ কি?**

গবেষণা প্রকল্পটিতে অংশগ্রহণের জন্য আপনি সরাসরি কোনো সুবিধা পাবেন না। এই গবেষণায় অংশগ্রহণে আপনার দৈনন্দিন কাজে সাময়িক অসুবিধার কারণ হতে পারে। তবে আমরা আশাবাদী যে, এ গবেষণার ফলাফল থেকে প্রাপ্ত উপকারিতা এই অসুবিধাকে অতিক্রম করবে। যে সমস্থ প্রশ্নের মাধ্যমে আপনার পরিচয় সম্পর্কে অন্যরা জানতে পারে সেই বিষয়ে উদ্বিগ্ন না হবার জন্য অনুরোধ করা হচ্ছে। অংশগ্রহণকারীর নাম, ঠিকানা উপাত্ত বিশ্লেষণের সফটওয়ারে উল্লেখ না করে পরিচয় উন্মুক্ত হবার ঝুঁকি কমানো হবে।

**তথ্যের গোপনীয়তা কি নিশ্চিত থাকবে?**

এ সম্মতি পত্রের স্বাক্ষর করার মধ্য দিয়ে, আপনি এই গবেষণা প্রকল্পের অধ্যয়নরত গবেষণা কর্মীকে আপনার ব্যক্তিগত তথ্য সংগ্রহ ও ব্যবহার করার অনুমতি দিয়েছেন। এই গবেষণা প্রকল্পের জন্য সংগৃহীত যেকোনো তথ্য, যা আপনাকে শনাক্ত করতে পারে তা গোপনীয় থাকবে। শুধুমাত্র এর সাথে সরাসরি সংশ্লিষ্ট গবেষক ও তার তত্ত্বাবধায়ক এই তথ্যসমূহে প্রবেশাধিকার পাবেন। সাংকেতিক উপায়ে চিহ্নিত উপাত্ত সমূহ পরবর্তী উপাত্ত বিশ্লেষণের কাজে ব্যবহৃত হবে। তথ্য পত্রগুলো তালাবদ্ধ ড্রয়ার এ রাখা হবে। বিএইচপিআই এর অকুপেশনাল থেরাপি বিভাগে ও গবেষকের ব্যক্তিগত ল্যাপটপে উপাত্ত সমূহের ইলেকট্রনিক ভার্সন সংগৃহীত থাকবে। প্রত্যাশা করা হচ্ছে যে, এই গবেষণা প্রকল্পের ফলাফল বিভিন্ন ফোরামে প্রকাশিত এবং উপস্থাপিত হবে। যেকোনো ধরনের প্রকাশনা ও উপস্থাপনার ক্ষেত্রে তথ্যসমূহ এমন ভাবে সরবরাহ করা হবে, যেন আপনার সম্মতি ছাড়া আপনাকে কোনো ভাবেই সনাক্ত করা না যায়। তথ্য-উপাত্ত প্রাথমিকভাবে কাগজপত্র সংগ্রহ করা হবে।

**ফলাফল প্রচার সম্পর্কিত তথ্য :**

এই গবেষণার ফলাফল বিভিন্ন সামাজিক মাধ্যম, ওয়েবসাইট, সম্মেলন, আলোচনা সভায় এবং পর্যালোচিত জার্নালে প্রকাশ করা হবে।

**অংশগ্রহণকারীর পারিশ্রমিক :**

এই গবেষণায় অংশগ্রহণের জন্য কোন উদ্দীপনা ও পারিশ্রমিক দেওয়ার ব্যবস্থা নেই।

**গবেষণা পরিচালনার ব্যয়কৃত অর্থের উৎস :**

এই গবেষণাটি খরচ সম্পূর্ণ গবেষকের নিজস্ব তহবিল থেকে ব্যয় করা হবে। এই গবেষণাটি ছোট পরিসরে করা হবে এবং এখানে কোন অর্থ বহিরাগত উৎস থেকে আসবে না।

**অংশগ্রহণ থেকে প্রত্যাহার সম্পর্কিত তথ্যসমূহ :**

আপনি সম্মতি প্রদান করা সত্ত্বেও তথ্য দেওয়ার এক সপ্তাহের মধ্যে যে কোনো সময় গবেষককে কোনো ব্যাখ্যা প্রদান করা ছাড়াই নিজের অংশগ্রহণ প্রত্যাহার করতে পারবেন। বাতিল করার পর তথ্যসমূহ কি ব্যবহার করা যাবে কি যাবে না তার অনুমতি অংশগ্রহণকারীর প্রত্যাহারপত্রে (শুধুমাত্র স্বেচ্ছায় প্রত্যাহারকারীর জন্য প্রযোজ্য) উল্লেখ করা থাকবে।

**গবেষকের সাথে যোগাযোগের ঠিকানা :**

গবেষণা প্রকল্পটির বিষয়ে যোগাযোগ করতে চাইলে অথবা গবেষণা প্রকল্পটির সম্পর্কে কোন প্রশ্ন থাকলে, এখন অথবা পরবর্তীতে যেকোনো সময়ে তা জিজ্ঞাসা করা যাবে। সেক্ষেত্রে আপনি গবেষকের সাথে উল্লেখিত নাম্বারে (০১৮৪৯২৬২৯৯৭, মো. নুরুল আমিন) অথবা ইমেইলে (sfsakib238@gmail.com) যোগাযোগ করতে পারেন।

**অভিযোগ**

এই গবেষণা প্রকল্প পরিচালনার বিষয়ে কোন অভিযোগ থাকলে, এসোসিয়েশন অফ এথিক্স (৭৭৪৫৪৬৪-৫) এর সাথে যোগাযোগ করুন। এই প্রস্তাবটি ইনস্টিটিউশনাল রিভিউড বোর্ড (আইআরবি), বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ দ্বারা পর্যালোচনা করা হয়েছে, যেটি একটি কমিটি যার কাজ হল গবেষণায় অংশগ্রহণকারীদের ক্ষতি থেকে রক্ষা করা নিশ্চিত করা। আপনি যদি আইআরবি সম্পর্কে আরও জানতে চান, তাহলে বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট, সিআরপি, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ-এ যোগাযোগ করুন।

## Appendix D : Consent Form (English Version)

### Consent Form (English & Bengali Version)

**(For Interview Participants)**

Assalamualaikum. I am Md. Nurul Amin, a 4th year student of the B.Sc. in Occupational Therapy program (Session: 2020–2021) at Bangladesh Health Professions Institute under the Faculty of Medicine, University of Dhaka. To fulfill my B.Sc. degree, I am required to conduct a research project, which is a part of my academic curriculum. The title of my research is **"The Status of Childhood Trauma among the Adolescents with Mental Illness : A Quantitative Study"**. The purpose of the study is to identify the level of abuse and find out the socio-demographic profile of the adolescent participants and assess the relationship between socio-demographic characteristics & different domains and levels of childhood trauma among adolescents with mental illness. To complete my research project, I need to collect some information from you. Therefore, you may become an esteemed participant in this study. Information will be collected through face-to-face interviews, and the conversation will last approximately 15–20 minutes.

I would like to inform you that this is purely an academic study and will not be used for any other purpose. I assure you that all information will be kept confidential. Your participation is entirely voluntary. You have the right to withdraw your consent at any time within one week of data collection. However, withdrawal will not be possible after one week from the date of data collection.

If you have any questions about this research, you may contact the researcher Md. Nurul Amin or the supervisor Kaniz Fatema (Lecturer, Department of Occupational Therapy, BHPI, CRP, Savar, Dhaka).

Do you have any questions before we begin the interview?
Yes ☐ No ☐

So, may I have your consent to proceed with the interview?
Yes ☐ No ☐

Signature and Date of Participant:_____

Signature and Date of Researcher: _____

Signature and Date of Carer: _____

## Appendix D : Consent Form (Bengali Version)

### সম্মতিপত্র

### (যারা ইন্টারভিউতে অংশ নিচ্ছেন তাদের জন্য)

আসসালামু আলাইকুম। আমি মো. নুরুল আমিন, ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা অনুষদের অধীনে বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউটে বি.এস.সি ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের ছাত্র হিসেবে ২০২০-২১ সেশনে অধ্যয়নরত আছি। আমার বি.এস.সি ডিগ্রী সম্পন্ন করতে, আমাকে একটি গবেষণা প্রকল্প পরিচালনা করতে হবে এবং এটি আমার অধ্যয়নের একটি অংশ। আমার গবেষণার শিরোনাম হলো **"মানসিক সমস্যা বিশিষ্ট কিশোর-কিশোরীদের মধ্যে শৈশবের ট্রমার পরিস্থিতি সম্পর্কিত তথ্য বের করার জন্য একটি ক্রস-সেকশনাল স্টাডি"**। আমার গবেষণার লক্ষ্য হলো – মানসিক সমস্যায় আক্রান্ত কিশোর-কিশোরীদের মধ্যে শৈশবকালীন নির্যাতনের মাত্রা নির্ধারণ করা এবং নির্যাতনের বিভিন্ন ক্ষেত্র ও মাত্রার সঙ্গে তাদের সামাজিক ও জনসংখ্যাগত বৈশিষ্ট্যের সম্পর্ক মূল্যায়ন করা। আমার গবেষণার প্রকল্পটি পূরণ করতে, ডেটা সংগ্রহ করার জন্য আমার আপনার কাছ থেকে কিছু তথ্য দরকার। সুতরাং, আপনি এই গবেষণার একজন সম্মানিত অংশগ্রহণকারী হতে পারেন। সামনা সামনি কথা বলার মাধ্যমে তথ্যগুলো সংগ্রহ করা হবে এবং কথোপকথনের সময় হবে ১৫-২০ মিনিট।

আমি আপনাকে জানাতে চাই যে এটি একটি সম্পূর্ণরূপে একাডেমিক অধ্যয়ন এবং অন্য কোন উদ্দেশ্যে ব্যবহার করা হবে না। আমি আশ্বাস দিচ্ছি যে সমস্ত তথ্য গোপন রাখা হবে। আপনার অংশগ্রহণ স্বেচ্ছায় হবে। তথ্য সংগ্রহের এক সপ্তাহের মধ্যে যে কোন সময় আপনার সম্মতি প্রত্যাহার করার অধিকার থাকবে। তবে তথ্য সংগ্রহের এক সপ্তাহ পরে প্রত্যাহার করতে পারবেন না।

এই গবেষণা সম্পর্কে আপনার কোন প্রশ্ন থাকলে, আপনি গবেষক মো. নুরুল আমিন অথবা সুপারভাইজার কানিজ ফাতেমা (প্রভাষক, অকুপেশনাল থেরাপি বিভাগ, বিএইচপিআই, সিআরপি, সাভার, ঢাকা) এর সাথে যোগাযোগ করতে পারেন।

তথ্য প্রদান শুরু করার আগে আপনার কোন প্রশ্ন আছে?

☐ হ্যাঁ ☐ না

তাহলে, ইন্টারভিউ নেওয়ার জন্য আমি কি আপনার সম্মতি পেতে পারি?

☐ হ্যাঁ ☐ না

অংশগ্রহণকারীর স্বাক্ষর/টিপসই এবং তারিখ : _____

তথ্য সংগ্রহের স্বাক্ষর এবং তারিখ : _____

স্বাক্ষীর স্বাক্ষর/টিপসই এবং তারিখ : _____

## Appendix E : Withdrawal Form (English Version)

**Participant's Withdrawal Form**

**(Applicable only for voluntary withdrawal)**

Participant's Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Reason for withdrawal:

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Signature and Date of Participant:

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## Appendix E : Withdrawal Form (Bengali Version)

**অংশগ্রহণকারীর প্রত্যাহার পত্র**

**(শুধু মাত্র স্বেচ্ছায় প্রত্যাহারকারীর জন্য প্রযোজ্য)**

অংশগ্রহণকারীর নাম : ----------

প্রত্যাহার করার কারণ :

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অংশগ্রহণকারীর স্বাক্ষর ও তারিখ :

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## Appendix F : Questionnaire (English Version)

### Questionnaire (English & Bangla Version)

### Section – 1

### Socio-Demographic Questions (English Version)

Participant's Name : _____

Mobile No : _____ Date : _____

1. Age (in years) : _____

2. Gender

- ☐ Male
- ☐ Female
- ☐ Other: _____

3. Educational Status

- ☐ Currently studying_____
- ☐ Dropped out
- ☐ Never attended school

4. Current Living Arrangement

- ☐ With both parents
- ☐ With single parent
- ☐ With relatives
- ☐ Orphanage/shelter
- ☐ Alone or with peers

5. Father's Qualification _____

6. Mother's Qualification _____

7. Father's Occupation _____

8. Mother's Occupation _____

9. Number of Siblings _____

10. What is your birth order in the family?_____

11. Monthly Family Income (Approx.)

- ☐ < 5,000 BDT
- ☐ 5,000 – 10,000 BDT
- ☐ 10,001 – 20,000 BDT
- ☐ > 20,000 BDT

12. Parental Marital Status

- ☐ Married and living together
- ☐ Separated
- ☐ Divorced
- ☐ One/both deceased

13. Who is the Primary Caregiver?

- ☐ Mother
- ☐ Father
- ☐ Both parents
- ☐ Relative
- ☐ Institutional caregiver
- ☐ Other: _____

14. History of Mental Illness in the Family

- ☐ Yes
- ☐ No
- ☐ Not Sure

15. Family Type

- ☐ Nuclear family
- ☐ Joint/Extended family
- ☐ Single-parent family
- ☐ Other: _____

16. Types of Mental Illness / Disorders:_____

17. Duration of Mental Health Problem :

- ☐ Less than 1 Year
- ☐ 1-3 Years
- ☐ 3-5 Years
- ☐ More than 5 Years

18. Do you have any physical complications?

- ☐ Yes
- ☐ No

If yes, please mention the types of complications (You may select more than one)

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Others_____

19. Previous History of Counseling or Psychiatric Treatment

- ☐ Yes
- ☐ No

If yes, please mention this (You may select more than one)

- ☐ Therapy
- ☐ Counseling
- ☐ Others _____

# Childhood Trauma Questionnaire

**Patient's full name:** _____ **Date accomplished:** _____

**Name of attending professional:** _____

**Instructions:** Please rate yourself based on the options below in relation to the following possible traumatic experiences that you may have experienced. Take your time and be honest with your answers. This will be kept confidential.

| Item | Never True | Rarely True | Sometimes True | Often True | Very Often True |
|---|---|---|---|---|---|
| 1. I did not have enough to eat. | ○ | ○ | ○ | ○ | ○ |
| 2. I had someone to take care of me and protect me. | ○ | ○ | ○ | ○ | ○ |
| 3. I've been called "stupid," "lazy," and/or "ugly. | ○ | ○ | ○ | ○ | ○ |
| 4. My parents were too drunk/high to take care of me. | ○ | ○ | ○ | ○ | ○ |
| 5. Someone helped me feel important. | ○ | ○ | ○ | ○ | ○ |
| 6. I had to wear dirty clothes. | ○ | ○ | ○ | ○ | ○ |
| 7. I felt loved. | ○ | ○ | ○ | ○ | ○ |
| 8. I felt/thought that my parents wished I had never been born. | ○ | ○ | ○ | ○ | ○ |
| 9. I got hit so hard that I had to see a doctor. | ○ | ○ | ○ | ○ | ○ |
| 10. There is nothing I want to change in my family. | ○ | ○ | ○ | ○ | ○ |
| 11. I've been hit so hard that it left bruises and marks. | ○ | ○ | ○ | ○ | ○ |
| 12. I was punished with a belt, board, cord, or another hard object. | ○ | ○ | ○ | ○ | ○ |
| 13. My family looked out for each other. | ○ | ○ | ○ | ○ | ○ |
| 14. My family said hurtful or insulting things to me. | ○ | ○ | ○ | ○ | ○ |
| 15. I was physically abused. | ○ | ○ | ○ | ○ | ○ |
| 16. I had a perfect childhood. | ○ | ○ | ○ | ○ | ○ |

Bernstein D., Fink L. (1998). Childhood Trauma Questionnaire. A Retrospective Self-Report Questionnaire and Manual. San Antonio, The Psychological Corporation.

| Item | Never True | Rarely True | Sometimes True | Often True | Very Often True |
|---|---|---|---|---|---|
| 17. I got hit badly and it was noticed by a teacher, neighbor, and/or doctor. | O | O | O | O | O |
| 18. Someone in my family hated me. | O | O | O | O | O |
| 19. My family felt close to each other. | O | O | O | O | O |
| 20. Someone tried to touch me in a sexual way or tried to make me touch them. | O | O | O | O | O |
| 21. Someone threatened to hurt me unless I did something sexual with them. | O | O | O | O | O |
| 22. I have the best family in the world. | O | O | O | O | O |
| 23. Someone made me try to do sexual things/watch sexual things. | O | O | O | O | O |
| 24. Someone molested me. | O | O | O | O | O |
| 25. I was emotionally abused. | O | O | O | O | O |
| 26. Someone took me to see the doctor when I needed to/if I needed to | O | O | O | O | O |
| 27. I was sexually abused. | O | O | O | O | O |
| 28. My family gave me strength and support. | O | O | O | O | O |

**Scoring:**

- **Never true = 1**
- **Rarely true = 2**
- **Sometimes true = 3**
- **Often true = 4**
- **Very often true = 5**

Some items have the inverse, though. These specific items are items 2, 5, 7, 13, 19, 26, and 28. So, "Never true" is equal to 5, and "Very often true" is equal to 1.

**SCORE TALLIES** ⟶

Bernstein D., Fink L. (1998). Childhood Trauma Questionnaire. A Retrospective Self-Report Questionnaire and Manual. San Antonio, The Psychological Corporation.

**Score Tallies:**

| | Physical Abuse | Emotional Abuse | Sexual Abuse | Physical Neglect | Emotional Neglect |
|---|---|---|---|---|---|
| | 9.) _____ | 3.) _____ | 20.) _____ | 1.) _____ | *5.) _____ |
| | 11.) _____ | 8.) _____ | 21.) _____ | *2.) _____ | *7.) _____ |
| | 12.) _____ | 14.) _____ | 23.) _____ | 4.) _____ | *13.) _____ |
| | 15.) _____ | 18.) _____ | 24.) _____ | 6.) _____ | *19.) _____ |
| | 17.) _____ | 22.) _____ | 27.) _____ | *26.) _____ | *28.) _____ |
| Sum: | _____ | _____ | _____ | _____ | _____ |

**The * means that the scoring is inversed for them.**

To calculate the section below, you only need to look at items 10, 16, and 22. For each of these, if the patient answers "Very often true," it's equivalent to 1 point. If they picked other answers, then it's equivalent to 0. The maximum score that they can get for Minimization/Denial is 3. _____

| Minimization/Denial |
|---|
| 10.) _____ |
| 16.) _____ |
| 22.) _____ |
| Sum: _____ |

| Level of abuse | Physical Abuse | Emotional Abuse | Sexual Abuse | Physical Neglect | Emotional Neglect |
|---|---|---|---|---|---|
| None | 7 | 8 | 5 | 7 | 9 |
| Low | 9 | 12 | 8 | 9 | 14 |
| Moderate | 12 | 15 | 12 | 12 | 17 |
| Severe | 13+ | 16+ | 13+ | 13+ | 18+ |

Bernstein D., Fink L. (1998). Childhood Trauma Questionnaire. A Retrospective Self-Report Questionnaire and Manual. San Antonio, The Psychological Corporation.

## Appendix F : Questionnaire (Bengali Version)

### সেকশন - ১

### সামাজিক ও জনসংখ্যাতাত্ত্বিক প্রশ্নাবলী

অংশগ্রহণকারীর নাম: _____

মোবাইল নম্বর: _____ তারিখ: _____

১. বয়স: _____

২. লিঙ্গ

- ☐ পুরুষ
- ☐ মহিলা
- ☐ অন্যান্য: _____

৩. শিক্ষাগত অবস্থা

- ☐ বর্তমানে পড়াশোনা করছেন_____
- ☐ পড়াশোনা ছেড়ে দিয়েছেন
- ☐ কখনো স্কুলে যাননি

৪. বর্তমান বসবাসের অবস্থা

- ☐ মা-বাবার সাথে
- ☐ একজন অভিভাবকের সাথে
- ☐ আত্মীয়দের সাথে
- ☐ অনাথ আশ্রম/শেল্টারে
- ☐ একা বা বন্ধুদের সাথে

৫. বাবার শিক্ষাগত যোগ্যতা _____

৬. মায়ের শিক্ষাগত যোগ্যতা _____

৭. বাবার পেশা _____

৮. মায়ের পেশা _____

৯. ভাইবোনের সংখ্যা _____

১০. আপনি পরিবারের কত তম সন্তান?_____

১১. আনুমানিক মাসিক পারিবারিক আয়

- ☐ ৫,০০০ টাকার কম
- ☐ ৫,০০০ - ১০,০০০ টাকা
- ☐ ১০,০০১ - ২০,০০০ টাকা
- ☐ ২০,০০০ টাকার বেশি

১২. পিতামাতার বৈবাহিক অবস্থা

- ☐ বিবাহিত ও একসাথে বসবাসরত
- ☐ আলাদা থাকে
- ☐ বিবাহবিচ্ছিন্ন
- ☐ একজন/উভয়েই মৃত

১৩. বর্তমানে আপনার প্রধান অভিভাবক কে ?

- ☐ মা
- ☐ বাবা
- ☐ উভয়
- ☐ আত্মীয়
- ☐ প্রতিষ্ঠানের অভিভাবক
- ☐ অন্যান্য: _____

১৪. পরিবারে মানসিক অসুস্থতার ইতিহাস আছে কি?

- ☐ আছে
- ☐ নেই
- ☐ নিশ্চিত নই

১৫. পরিবারে সদস্যের ধরন

- ☐ যৌথ/বৃহৎ পরিবার
- ☐ একক পরিবার
- ☐ অন্যান্য: _____

১৬. মানসিক রোগের ধরণ_____

১৭. মানসিক রোগের সময়কাল :

- ☐ ১ বছরের কম
- ☐ ১-৩ বছরের কম
- ☐ ৩-৫ বছর
- ☐ ৫ বছরের বেশি

১৮. আপনার স্বাস্থ্যগত কোন জটিলতা আছে?

- ☐ হ্যাঁ
- ☐ না

উত্তর হ্যাঁ হলে, কি ধরনের স্বাস্থ্যগত জটিলতা রয়েছে তা উল্লেখ করুন (একাধিক উত্তর দিতে পারেন)

- ☐ হৃদরোগ
- ☐ উচ্চ রক্তচাপ
- ☐ ডায়াবেটিস
- ☐ উচ্চ কোলেস্টেরল
- ☐ অতিরিক্ত ওজন
- ☐ অন্যান্য _____

১৯. আপনি কি আগে কখনো মনোরোগ চিকিৎসা নিয়েছেন?

- ☐ হ্যাঁ
- ☐ না

উত্তর হ্যাঁ হলে, কি ধরনের মনোরোগ চিকিৎসা নিয়েছেন তা উল্লেখ করুন (একাধিক উত্তর দিতে পারেন)

- ☐ থেরাপি
- ☐ কাউন্সেলিং
- ☐ অন্যান্য _____

## সেকশন - ২

## চাইল্ড-হুড ট্রমা প্রশ্নাবলী

রোগীর পূর্ণ নাম..... ফর্ম পূরণের তারিখ.....

উপস্থিত পেশাদারের নাম.....

**নির্দেশনা:** অনুগ্রহ করে নিচে দেওয়া প্রশ্নগুলোর ভিত্তিতে নিজেকে মূল্যায়ন করুন – আপনি নিচে উল্লেখিত যেকোনো সম্ভাব্য ট্রমাটিক (আঘাতজনক) অভিজ্ঞতার সম্মুখীন হয়েছেন কিনা তা বিবেচনা করে সময় নিয়ে ধীরে ধীরে চিন্তা করুন এবং আপনার উত্তরগুলোতে সৎ থাকুন।

| আইটেম | কখনো সত্য নয় | খুব কমই সত্য | কিছুটা সত্য | প্রায়ই সত্য | বেশিরভাগই সত্য |
|---|---|---|---|---|---|
| ১. খাওয়ার মতো যথেষ্ট খাবার আমার কাছে ছিল না | | | | | |
| ২. আমার সুরক্ষা এবং দেখাশোনা করার মতো কেউ ছিলেন | | | | | |
| ৩. আমাকে 'মূর্খ,' 'অলস,' এবং 'কুৎসিত' বলা হয়েছে | | | | | |
| ৪. আমার যত্ন নেওয়ার ক্ষেত্রে আমার মা-বাবা অনেক কঠোর ছিলেন | | | | | |
| ৫. গুরুত্বপূর্ণ মনে করে কেউ আমাকে সাহায্য করেছিলেন | | | | | |
| ৬. আমাকে অপরিষ্কার জামাকাপড় পরতে হয়েছিল | | | | | |
| ৭. আমি ভালোবাসা অনুভব করেছি | | | | | |
| ৮. আমি অনুভব করেছি যে আমার বাবা-মা চাইতেন না যেন আমার জন্ম হোক | | | | | |
| ৯. আমাকে এত জোরে আঘাত করা হয়েছিল যে আমাকে ডাক্তার দেখাতে হয়েছিল | | | | | |
| ১০. আমার পরিবারে আমি কিছুই পরিবর্তন করতে চাই না | | | | | |
| ১১. আমাকে এত জোরে আঘাত করা হয়েছে যে এখনো দাগ ও ফোলা রয়েছে | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ১২. আমাকে বেল্ট, কাঠের বোর্ড, তার বা অন্য কোনো শক্ত জিনিস দিয়ে শাস্তি দেওয়া হয়েছিল | | | | | |
| ১৩. আমার পরিবার একে অপরের খেয়াল রাখতেন | | | | | |
| ১৪. আমার পরিবার আমাকে কষ্টদায়ক বা অপমানজনক কথা বলেছিলেন | | | | | |
| ১৫. আমি শারীরিক নির্যাতনের শিকার হয়েছি | | | | | |
| ১৬. আমার একটি চমৎকার শৈশব ছিল | | | | | |
| ১৭. আমি গুরুতরভাবে আঘাতপ্রাপ্ত হয়েছিলাম এবং এটি একজন শিক্ষক, প্রতিবেশী অথবা ডাক্তার লক্ষ্য করেছিলেন | | | | | |
| ১৮. আমার পরিবারে কেউ একজন আমাকে ঘৃণা করতেন | | | | | |
| ১৯. আমার পরিবারের সদস্যদের মধ্যে ঘনিষ্ঠ সম্পর্ক ছিল | | | | | |
| ২০. কেউ আমাকে যৌন সম্পর্কের জন্য স্পর্শ করেছিল বা আমাকে দিয়ে তাদের স্পর্শ করানোর চেষ্টা করেছিল | | | | | |
| ২১. যৌন সম্পর্ক না করার কারণে কেউ আমাকে আঘাত করার হুমকি দিয়েছিল | | | | | |
| ২২. পৃথিবীতে আমার পরিবারই শ্রেষ্ঠ পরিবার | | | | | |
| ২৩. কেউ আমাকে যৌন কর্ম করতে বা যৌন বিষয়ক কিছু দেখতে বাধ্য করেছিল | | | | | |
| ২৪. কেউ আমাকে যৌনভাবে হেনস্তা করেছিল | | | | | |
| ২৫. আমি মানসিক নির্যাতনের শিকার হয়েছিলাম | | | | | |
| ২৬. যদি আমার প্রয়োজন হত, কেউ আমাকে ডাক্তারের কাছে নিয়ে যেতেন | | | | | |
| ২৭. আমি যৌন নির্যাতনের শিকার হয়েছিলাম | | | | | |
| ২৮. আমার পরিবার আমাকে সাহস দিয়েছেন ও সাহায্য করেছেন | | | | | |

**স্কোরিং নির্দেশিকা:**

- কখনো সত্য নয় = ১
- খুব কমই সত্য = ২
- মাঝে মাঝে সত্য = ৩
- প্রায়ই সত্য = ৪
- বেশিরভাগই সত্য = ৫

তবে কিছু নির্দিষ্ট প্রশ্নের (২, ৫, ৭, ১৩, ১৯, ২৬ ও ২৮ নম্বর আইটেম) ক্ষেত্রে স্কোরিং উল্টোভাবে করতে হবে। এসব প্রশ্নে "কখনো সত্য নয়" হলে স্কোর হবে ৫, আর "বেশিরভাগই সত্য" হলে স্কোর হবে ১

**স্কোরের তালিকা :**

| | শারীরিক নির্যাতন | মানসিক নির্যাতন | যৌন নির্যাতন | শারীরিক অবহেলা | মানসিক অবহেলা |
|---|---|---|---|---|---|
| | ৯) _____ | ৩) _____ | ২০) _____ | ১) _____ | *৫) _____ |
| | ১১) _____ | ৮) _____ | ২১) _____ | *২) _____ | *৭) _____ |
| | ১২) _____ | ১৪) _____ | ২৩) _____ | ৪) _____ | *১৩) _____ |
| | ১৫) _____ | ১৮) _____ | ২৪) _____ | ৬) _____ | *১৯) _____ |
| | ১৭) _____ | ২২) _____ | ২৭) _____ | *২৬) _____ | *২৮) _____ |
| মোট স্কোর | _____ | _____ | _____ | _____ | _____ |

যেসব প্রশ্নের পাশে * চিহ্ন রয়েছে, সেগুলোর স্কোরিং উল্টোভাবে করতে হবে।

নিচের অংশটি হিসাব করার জন্য কেবলমাত্র ১০, ১৬ এবং ২২ নম্বর প্রশ্নগুলোর উত্তর বিবেচনা করতে হবে। এই তিনটি প্রশ্নের মধ্যে যদি রোগী "বেশিরভাগই সত্য" উত্তরটি দিয়ে থাকেন, তাহলে প্রতিটির জন্য ১ পয়েন্ট গণনা করতে হবে। যদি অন্যান্য কোনো উত্তর দিয়ে থাকেন, তাহলে সেটার জন্য ০ পয়েন্ট গণনা হবে। অস্বীকার/হ্রাসকরণ উপবিভাগে সর্বোচ্চ স্কোর হতে পারে ৩।

| অস্বীকার/হ্রাসকরণ |
|---|
| ১০) _____ |
| ১৬) _____ |
| ২২) _____ |
| মোট _____ |

| নির্যাতনের মাত্রা | শারীরিক নির্যাতন | মানসিক নির্যাতন | যৌন নির্যাতন | শারীরিক অবহেলা | মানসিক অবহেলা |
|---|---|---|---|---|---|
| কোনো নির্যাতন নয় | ৭ | ৮ | ৫ | ৭ | ৯ |
| কম মাত্রার নির্যাতন | ৯ | ১২ | ৮ | ৯ | ১৪ |
| মাঝারি মাত্রার নির্যাতন | ১২ | ১৫ | ১২ | ১২ | ১৭ |
| তীব্র/গুরুতর নির্যাতন | ১৩+ | ১৬+ | ১৩+ | ১৩+ | ১৮+ |

Bernstein D., Fink L. (1998). Childhood Trauma Questionnaire. A Retrospective Self-Report Questionnaire and Manual. San Antonio, The Psychological Corporation.

## Appendix G : Permission for using Childhood Trauma Questionnaire (CTQ)

Gmail SF Sakib <sfsakib238@gmail.com>

**(no subject)**
2 messages

**SF Sakib** <sfsakib238@gmail.com> Thu, May 29, 2025 at 11:49 AM
To: j.kenardy@uq.edu

Dear Sir ,

I hope you are well. I am Nurul Amin, 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 " The status of childhood trauma among the adolescents with mental health illness ". I want to use the childhood trauma questionnaire, 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, Kaniz Fatema, Lecturer in Occupational Therapy of BHPI. I look forward to hearing from you! Thank you very much!

Regards,

Name : Md. Nurul Amin

4th year student B.Sc. in Occupational therapy

Sessions: 2020-21

Bangladesh Health Professions Institute, CRP, Chapain, Savar, Dhaka-1343

Phone No: 01849262997

**Mail Delivery Subsystem** <mailer-daemon@googlemail.com> Thu, May 29, 2025 at 11:50 AM
To: sfsakib238@gmail.com

## Appendix H : Supervisor Contact Sheet

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

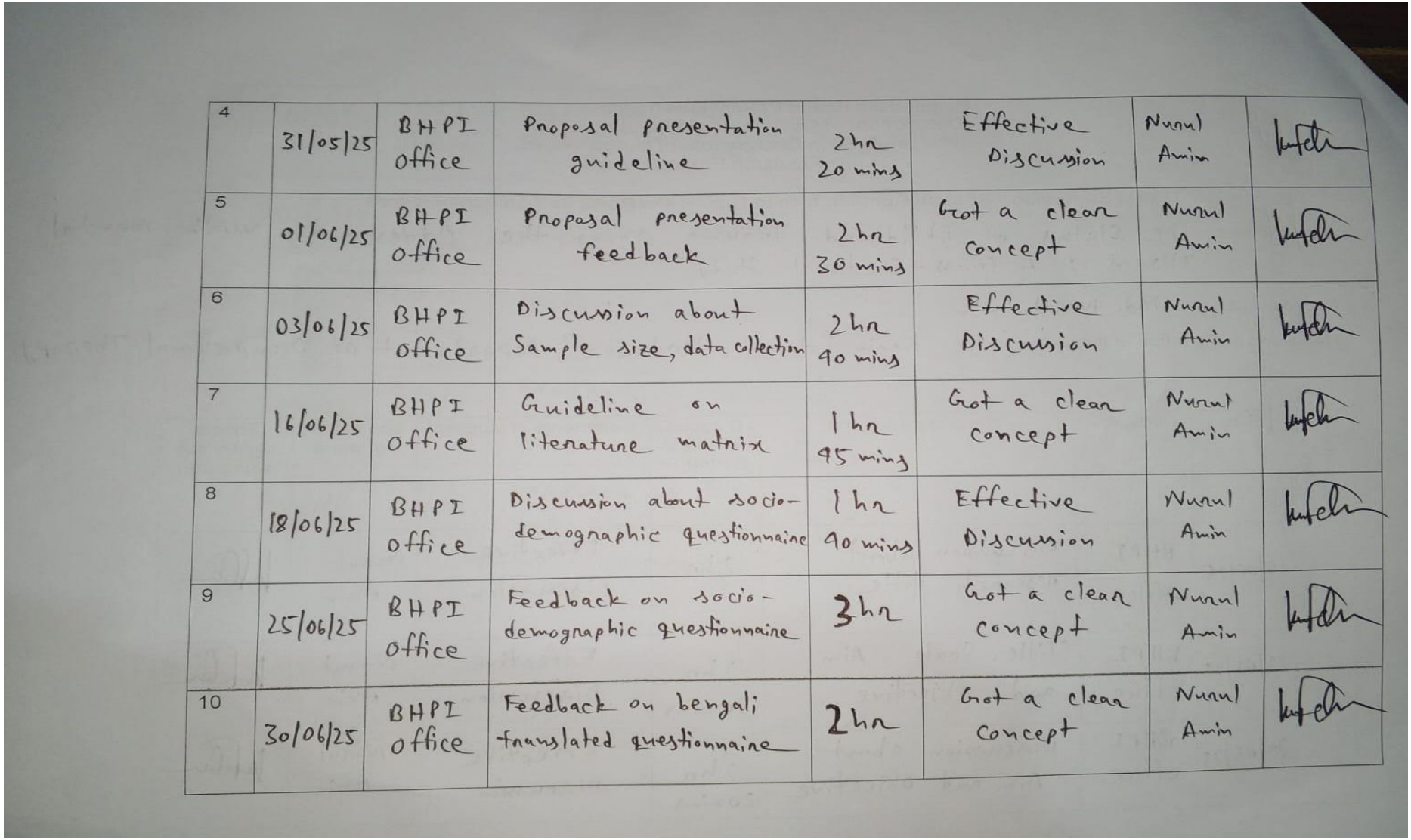
**Thesis Supervisor- Student Contact; face to face or electronic and guidance record**

Title of thesis: The Status of Childhood Trauma among the Adolescents with Mental Illness : A Cross - Sectional Study

Name of student: Md. Nurul Amin

Name and designation of thesis supervisor: Kaniz Fatema , lecturer, Department of Occupational Therapy

| Appointment No | Date | Place | Topic of discussion | Duration (Minutes/ Hours) | Comments of student | Student's signature | Thesis supervisor signature |
|---|---|---|---|---|---|---|---|
| 1 | 25/05/25 | BHPI office | Discussion about research title | 3hr | Effective Discussion | Nurul Amin | |
| 2 | 28/05/25 | BHPI Office | Title, Scale, Aim and objective | 2hr 30mins | Effective Discussion | Nurul Amin | |
| 3 | 29/05/25 | BHPI office | Discussion about Aim and objective | 2hr 20mins | Effective Discussion | Nurul Amin | |



| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4 | 31/05/25 | BHPI office | Proposal presentation guideline | 2hr 20 mins | Effective Discussion | Nurul Amin | |
| 5 | 01/06/25 | BHPI office | Proposal presentation feedback | 2hr 30 mins | Got a clear concept | Nurul Amin | |
| 6 | 03/06/25 | BHPI office | Discussion about Sample size, data collection | 2hr 40 mins | Effective Discussion | Nurul Amin | |
| 7 | 16/06/25 | BHPI office | Guideline on literature matrix | 1 hr 45 ming | Got a clear concept | Nurul Amin | |
| 8 | 18/06/25 | BHPI office | Discussion about socio-demographic questionnaire | 1 hr 40 mins | Effective Discussion | Nurul Amin | |
| 9 | 25/06/25 | BHPI office | Feedback on socio-demographic questionnaire | 3hr | Got a clear concept | Nurul Amin | |
| 10 | 30/06/25 | BHPI office | Feedback on bengali translated questionnaire | 2hr | Got a clear concept | Nurul Amin | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 11 | 02/07/25 | BHPI office | Discussion on data collection status | 2 hr 30 mins | Got a clear concept | Nurul Amin | |
| 12 | 07/07/25 | BHPI office | Guideline on data collection status | 2 hr 20 mins | Got a clear concept | Nurul Amin | |
| 13 | 10/07/25 | BHPI office | Discussion about data entry | 2 hr 10 mins | Effective discussion | Nurul Amin | |
| 14 | 16/07/25 | BHPI office | Guideline on data analysis | 2 hr 20 mins | Got a clear concept | Nurul Amin | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 15 | 06/12/25 | BHPI Office | Discussion and guideline about result | 2 hr 20 mins | Effective discussion | Nurul Amin | |
| 16 | 07/12/25 | BHPI office | Feedback on research methods. | 2 hr 40 mins | Got a clear concept | Nurul Amin | |
| 17 | 16/12/25 | BHPI office | Feedback on 1st draft | 2 hr 30 mins | Effective discussion | Nurul Amin | |
| 18 | 19/01/26 | BHPI office | Feedback on 1st draft | 2 hr | Effective discussion | Nurul Amin | |
| 19 | 15/01/26 | BHPI office | Feedback on result and give guidelines | 2hr 40 mins | Got a clear concept | Nurul Amin | |
| 20 | | | | | | | |

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.