Childhood Trauma and its Relation to Resilience among Psychiatric Patients

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Abstract

Background: Childhood represents a crucial period in an individual's life, laying the groundwork for future well-being, resilience and development. However, for many, childhood may be marred by adverse incidents, including emotional neglect, physical abuse, or exposure to violence. These traumatic events can have lasting effects. **Aim:** To explore childhood trauma and its relation to resilience among psychiatric patients. **Subjects and methods:** A cross-sectional study design was used. This study was conducted in Egypt; at the outpatient clinics of Minia psychiatric health and addiction treatment hospital, and of El-Abbasiya mental health hospital. A convenient sample of 150 adult psychiatric patients was enrolled. Three tools were used for data collection; Tool 1: Socio-demographic and medical data questionnaire, Tool 2: Childhood Trauma Questionnaire and Tool 3: Connor–Davidson Resilience Scale. **Results**: The finding of the present study revealed that slightly more than two thirds and slightly less than one half of the studied patients had severe level of physical neglect, physical abuse and emotional neglect, nearly fifty percent had moderate level of emotional abuse, and slightly more than one half had lower level of sexual abuse and low resilience level in all domains. **Conclusion** A negative significant association between resilience and emotional and physical abuse of childhood trauma, as well as a positive significant association between resilience and emotional and physical neglect of childhood trauma are detected. **Recommendations:** This study recommends implementation of resilience-focused interventions to mitigate the adverse effects of childhood trauma on mental health outcomes.

Keywords: Childhood Trauma, Psychiatric Patients, Resilience.

Introduction

Childhood is a crucial time in a persons' life, because it establishes the framework for their social, emotional, and personal growth **(Maconochie, 2024). .** Three out of every four children suffer abuse at the hands of their parents or other primary carers **(Okpara and Okoro, 2024)**. A person's adult life is greatly influenced by their childhood trauma experiences (**Prachason et al., 2024)**.

Childhood trauma" refers to a poor early life event that is a psychosocial element that can have a detrimental impact on health. It is strongly linked to conditions like depression and anxiety and has a significant impact on the course and prognosis of these conditions **(Petruccelli et al., 2019).**

Adverse Childhood Experiences (ACEs) that happen to children between the age of 0 and 17 are potentially stressful and can have an adverse effect on future wellness and health **(Center for Disease Control and Prevention, 2019; Felitti et al., 2019).** Additionally, negative events experienced in early childhood may make the individual more prone to the development of psychopathologies later in life (**Prachason et al., 2024)**, **Yılmaz and Karaaziz., 2023).** Psychiatric illnesses including major depressive disorder (MDD), anxiety disorders, bipolar I and II disorder (BD I and BD II) are frequently associated with childhood trauma, regardless of the type of abuse experienced **(Alkema et al., 2024)**.

Adversities suffered throughout childhood, such as being exposed to sexual and physical violence, as well as neglect which include both emotional and physical neglect, have been shown to raise the likelihood of developing mental illnesses **(McKay et al., 2021).** The adverse childhood events also include being exposed to abuse, neglect, or watching or experiencing violence. In addition to exposure to community violence or other traumatic events that take place outside of the carer and family setting **(Center for Disease Control and Prevention, 2019; Felitti et al., 2019; Karatekin and Hill, 2019).**

Adult persons' life and development of psychopathology later in life are greatly influenced by their childhood experiences, and adverse interactions **(Prachason et al., 2024).** Adversities such as inadequate resources, poverty, orphanhood, institutionalization, insufficient nutrition, inability to find safe housing, unsanitary living conditions, multiple barriers to education, exposure to environmental toxins and pathogens, marriage between children, community and social assault, unstable politics, forced migration, and complex humanitarian emergencies are some of the more common challenges that children in low-to-middle-income countries (LMIC) face **(Bhutta et al., 2023).** In the same context, the beginning and severity of psychiatric problems have been linked to the lifetime of traumatic experiences and childhood trauma (CT) as environmental variables **(Bossert et al., 2024; Etain and Aas 2021).**

There may be certain environmental characteristics in LMICs that are protective against adversity in contrast to HICs, even if environmental elements in high income countries (HICs) may offer less risk for adversity. Strong social support networks, collectivism, intergenerational living, and religion, for instance, may encourage resilience and protect young people from some types of exploitation as well as assault **(Treleaven, 2023; Wu et al., 2023; and Yuan et al., 2022).** Psychological traits such as high stress sensitivity, learnt helplessness, and poor coping strategies can have long-term effects of childhood trauma. Yet, a thorough understanding of the connection between psychological resilience and childhood trauma has to be established. **(Yıldız and Yüksel, 2024).**

Resilience is “a dynamic process encompassing positive adaptation within the context of significant adversity.” It is a product of interacting factors—biological, psychological, social, and cultural—that determine how a child responds to traumatic events **(Mohammed, et al., 2024)**. Resilience has a safeguarding influence on subsequent mental health

outcomes (**Samji et al., 2024)**. It is essential to preserving the best possible health result given how often trauma is in the world's population at large (**Peterson et al., 2019**).

According to (**Oltlans et al. (2021)**, resilience is the "ability to adapt and improve when facing adversity or other stressors," or the capacity to recover from stress. Resilience is only one of many components that make up mental health, which primarily consists of two levels: biological and psychological. Biological resilience is the ability to quickly and fully recover from deviations from normal physiological states or damage brought on by stressors or unfavorable health events is known as. Examples of this ability include the speed and quality of DNA repair, the capacity to quickly heal wounds, the ability to return blood pressure or glucose levels to normal following a stressor-induced deviation **(Ukraintseva et al., 2021).** Psychological resilience is an adaptation in a person's psychological traits and experiences that allows them to regain or remain in a healthy mental state during crises/chaos without long-term negative consequences **(Denckla et al., 2020).**

There are several factors that can contribute to resilience, including - having a supportive family and community, having strong coping skills, having a positive outlook on life, and having a sense of purpose **(Singh and Mukherjee, 2024)**. Resilient children can cope with trauma and adversity in a healthy way, and they are less likely to develop mental health problems because of their experiences, resilient people are declared to have better psychological attributes **(Mejia-Lancheros et al., 2021)**.

Research has shown that, when evaluating the mitigating and moderating effect of resilience, those with higher levels of resilience tend to report less mental health symptoms after stressful life events and bad childhood experiences **(Liu et al., 2019)**. It is also addressed that resilience may lessen the symptoms of poor mental health, as well as buffer the impact of childhood trauma adversities **(Rodman et al., 2019)**.

Significance of the study

Worldwide, many people face various forms of childhood trauma at both high and low income communities. The prevalence of CT in (HICs) is said to vary by nation. In Europe, rates were higher for both genders, reaching up to 6% for boys and 14% for girls. In the US, rates were even higher, ranging from 25% for females to 16% for boys **(Gervin et al., 2022)**. In Egypt, rates are even higher as reported by **(Mohammed, et al., 2024)** who stated that 18.6% of the studied subjects experienced 3 or more ACEs, 46% had psychological abuse, 17%) had witnessing domestic violence, 95.4% had psychological aggression, 79% had minor physical assault, and 52% had neglect.

Individuals' psychological functioning is negatively impacted by childhood trauma for a long time. A previous study by **(Vieira et al., 2020**) recommended resilience to moderate and mediate the impact of childhood trauma on mental diseases. Resilience to trauma varies in several ways: positive child outcomes despite exposure to trauma, prevention of trauma recurrence despite high risk for further exposure, or avoidance of traumatic experiences altogether in the face of significant risk. Scarce researches exist in this area **(Srivastava et al., 2024).**

Thus, it was crucial to explore childhood trauma and its relation to resilience among psychiatric patients.

Aim of the study

The aim of this study was to explore childhood trauma and its relation to resilience among psychiatric patients.

Research questions:

To achieve the study aim, the following questions were tested.

Question I: What are the childhood trauma levels among psychiatric patients?

Question II: What are the resilience levels among psychiatric patients?

Question III: Is there an association between childhood trauma and resilience among psychiatric patients?

Subjects and method:

Research design:

Across-sectional study design was utilized to achieve the aim of this study. It is a research design in which the data were gathered from a large number of diverse participants of the studied subjects at one time, and the researchers observe the variables without changing them.

Research setting:

The study was conducted in Egypt at the out-patients' clinics of two different locations. The first set was Minia psychiatric health and addiction treatment hospital, which is affiliated to General Secretariat of Mental Health in Egypt and situated in New Minia City. The second set was El-Abbasiya mental health, which is the largest psychiatric hospital in Egypt.

Research subjects:

A convenient sample of 150 adult psychiatric patients was included in the study. The inclusion criteria of the studied subjects were as follows: Psychiatric patients who attended the outpatient clinics of the previously mentioned study settings for their monthly regular follow up and medication refills. Patients who are suffering any other disorder as mental retardation, epilepsy, cognitive impairment, and patients with active symptoms who are unable to comprehend the content of the study questionnaires were excluded. The study sample size was determined using the following statistical formula of **Thompson, (2012)**: $n = \frac{N}{(N-1)B2+1}$ .n= sample size, N= total population number, B= proportion of error (0.05).

Tools of data collection:

To achieve the aim of this study the following three tools were used.

Tool I: Socio-demographic and medical data questionnaire.

It was developed by the researchers after reviewing of recent related literatures **(**Bari **et al., 2024).** It consisted of age, gender, marital status, education level, occupation, history of hospitalization and duration, duration of illness, and the diagnosis.

Tool II: Childhood Trauma Questionnaire Short Form.

It was adopted by the researchers from **(Bernstein & Fink, 1998)** and translated by the researchers into Arabic language. It was a shortened version of the 70-item Childhood Trauma Questionnaire. It included 28 items measuring the individual's retrospective experience of child abuse and neglect. The items are separated into five subscales with five items for each; emotional, physical, and sexual abuse, as well as emotional and physical neglect.

Scoring system

All items were answered as following: 1= never true, 2= rarely true, 3= sometimes true, 4= often true and 5= very often true. The items (Q2, Q5, Q7, Q13, Q19, Q 26 &

Q28) were reversely coded before summing. Moderate-severe cutoff scores for each subscale were for Emotional Abuse > 13, for Physical Abuse >10, for Sexual Abuse > 8, for Emotional Neglect > 15 and for Physical Neglect > 10.

Tool III: Connor–Davidson Resilience Scale (2003)

This scale was developed by (**Connor and Davidson, 2003)** and adapted by the researchers to measure the overall score of individual's aspects of resilience which includes 25 statements rated on a 7-point Likert scale as: Never true =0, rarely true =1, sometimes but infrequently true =2, neutral =3, sometimes true =4, usually true =5 and always true= 6. This Likert scale was modified by the researchers to five-points as: 0= not at all true, 1= rarely true, 2= sometimes true, 3= often true and 4= true nearly all of the time.

Scoring system:

The total score ranged from 0 to 100 point. High scores indicated high resilience. The score of the resilience levels was as the following: Low resilience level (0-33), moderate resilience level (34-66), and high resilience level (67 to 100).

Method:

The current study was implemented according to the following steps:-

1. **Administrative Design**:
   Official letter stating the purpose of the study was sent to the directors of the previously mentioned study settings to obtain their consents to conduct the study.
2. **Ethical consideration:**
   Approval code (REC202445) of the ethical committee of the nursing faculty was obtained. A written consent form was signed by each of the study subjects after explanation of the study's nature, objectives, and components of the study tools for the patients and their family members. They were also told that they are free to decline taking part in the study without giving a reason. They received assurances that their information will be kept very private and will be used only for the purpose of the current study.
3. **Tools' development:**
   Tool (I) was developed by the researchers based on recent review of related literatures. Tool (II) was adopted from **(Bernstein & Fink, 1998**), Tool (III) was adopted by the researchers from **(Connor and Davidson, 2003)**.
   Tools' validity was tested by a panel of five specialists in the field of psychiatric nursing, and all required adjustments were made.
   Tools' reliability was tested by the Cronbach's alpha that indicated high reliability. The Cronbach's alpha value of the Childhood Trauma Questionnaire regarding emotional abuse was 0.901, regarding physical abuse was 0.893, for sexual abuse is 0.896, for emotional neglect was 0.899, regarding physical neglect was 0.903, and of the Connor Davidson Resilience Scale is 0.903.
   Pilot study was carried out on 10% of the overall studied subjects (15 psychological patients) development of the study tools, and before the actual data collection. The aim of the pilot study was to assess the effectiveness and comprehensibility of the study's instruments, and to estimate the time needed to fill in the study tools. The data of the pilot study was excluded from the main research data.
4. **Data collection procedure:** Official consents were obtained from El-Abbasiya mental health and Minia psychiatry and mental health. The researchers had two weekly meetings during the morning shift

from 9 a.m. to 1 p.m with the participants at El-Abbasiya and Minia outpatient. The researchers introduced themselves to each of the studied subjects. A consent form was signed by each study participant after explanation of the purpose of the study. Data were collected by using the pre developed study tools individually. Tool I was used to collect the socio-demographic and medical data of the studied pregnant women. Tool II was utilized to measure the individual's retrospective experience of childhood trauma. Tool III was used to measure the individual's aspects of resilience. The studied subjects who can read and write self-filled the study tools, however the researchers filled them for the illiterate individuals who couldn't after asking them. Filling the questionnaires needed approximately twenty minutes. Data collection was carried out over a period of 3 months started from February to April 2024.

Statistical Analysis:

The statistical software for social sciences, version 20.0 (SPSS), was used to analyzes the recorded data. The continuous data were presented as mean ± standard deviation (SD) and had a normal distribution. Numbers and percentages were used to convey categorical data as frequency and percentage. Variables were compared using the chi-square test (or, if appropriate, the Fisher's exact test). The variables that have the greatest potential to influence resilience of the studied subjects were predicted using linear regression analysis.

Results

Table (1): Clarifies distribution of the studied subjects according to their socio-demographic and medical data. It illustrates that (38%) are between the age of (31-40 years), with Mean ±SD (37.8 ±12.1), 55.3% are males, (48%) are single, (40.7%) have secondary education, and (60%) are unemployed. It also reveals that (56.7%, 57.3%, 39.5%, and 37.2% respectively) have disorder for more than 3 years, entered the psychiatric hospital before, entered the hospital 2 times before, and for more than 3 months.

Figure (1): Displays distribution of the studied subjects according to their medical diagnosis. It explains that slightly more than one half (51.3%) of them has schizophrenia, and 27.3% have depression.

Figure (2): Shows distribution of the studied subjects according to their childhood trauma domains. It indicates that (82.7%, & 43.3%, 31.3%, and 28.0% respectively) have severe levels of physical neglect, physical abuse, emotional abuse and emotional neglect. Additionally, (49.3% & 32.0%, 32.0%, and 30.0% respectively) of the studied subjects have moderate level of emotional abuse, sexual abuse, and emotional neglect.

Figure (3): Illustrates distribution of the studied subjects according to resilience domains. It demonstrates that more than one half (58.0%, 56.7%, 55.3%, 53.3%, and 50.7% respectively) of the studied subjects have low resilience level in all resilience domains. Moreover, more than one half (54.7%) of them have low total resilience level.

Table (2): Determines association between childhood trauma domains and resilience levels among studied subjects. It elucidates that there is a highly significant correlation between emotional abuse and resilience level, as well as between physical abuse and resilience ($p < 0.001^{**}$, and $p = 0.015^{*}$ respectively).

Table (3): Verifies correlation between the total domains of childhood trauma and the studied subjects' resilience. It demonstrates that, there is a negative significant correlation between resilience and emotional and physical abuse of childhood trauma (p=0.004*, and 0.017* respectively), while there is positive significant correlation between resilience and emotional n and physical neglect of childhood trauma (p=0.011*, and <0.001** respectively).

Table (4): Proves association between the studied subjects' medical data of and childhood trauma domains. It illuminates that there is a significant relation between duration of the disorder and emotional abuse (p=0.041*), as well as between patient diagnosis and emotional, physical, and sexual abuse (p=0.031*, p=0.016*, and p<0.001** respectively).

Table (5): Confirms association between the studied subjects' medical data and resilience. It shows a high significant relation between resilience and duration of the disorder (p<0.001**).

Table (6): Clarifies prediction of factors affecting resilience among the studied subjects. It establishes that there is a negative significant relation between resilience and occupation, duration of disorders, emotional and physical abuse (p=0.004*, p=0.018*, 0.014*, and 0.011* respectively). On the other hand, there is a positive significant relation between resilience and emotional and physical neglect (p=0.027*, and 0.008* respectively).

Table (1): Distribution of the studied subjects according to their socio-demographic and medical data (no=150).

Socio-demographic ad medical data	N	%
Age (Years)		
30 or lower	47	31.3
31 – 40	57	**38.0**
41 – 50	23	15.3
> 50	23	15.3
Mean ±SD	37.8 ±12.1	
Gender		
Males	83	**55.3**
Females	67	44.7
Marital Status		
Single	72	**48.0**
Married	62	41.3
Divorced	16	10.7
Educational Level		
Illiterate	26	17.3
Basic	27	18.0
Secondary	61	**40.7**
University or higher	36	24.0
Occupation		
Employee	20	13.3
Worker	21	14.0
Free jobs	19	12.7
Unemployed	90	**60.0**
Duration of disorder (Years)		
< 1	36	24.0
1 - < 2	19	12.7
2 - < 3	10	6.7
3 or More	85	**56.7**
Have you interned in a psychiatric hospital before?		
Yes	86	**57.3**
No	64	42.7
If yes, how many times? (n=86)		
1	30	34.9
2	34	**39.5**
3	5	5.8
4 or More	17	19.8
Duration of stay in a psychiatric hospital before (Months) (n=86)		
Less than 1	31	36.0
1 – 3	23	26.7
More than 3	32	**37.2**

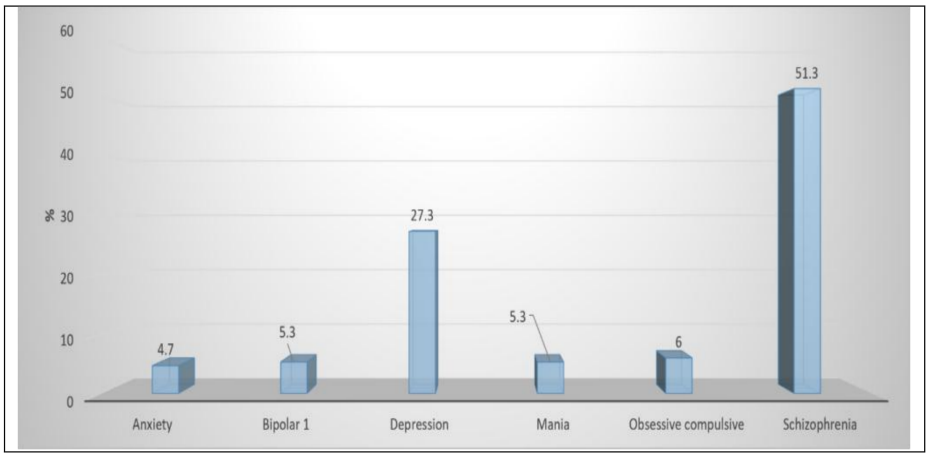

Figure (1): Distribution of the studied subjects according to their medical diagnosis (no=150).

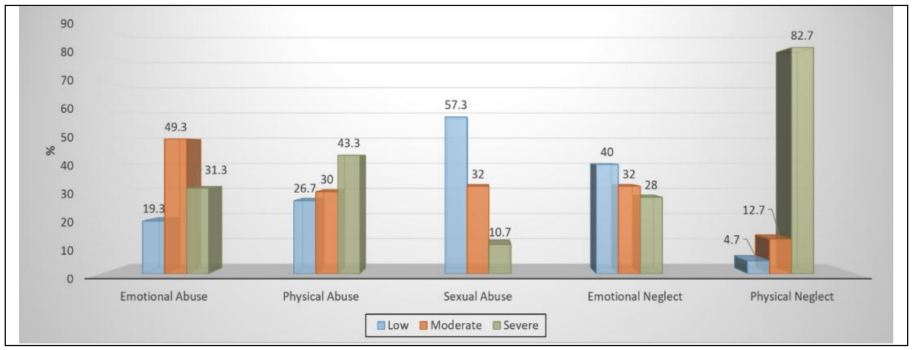

Figure (2): Distribution of the studied subjects according to their childhood trauma domains (no=150).

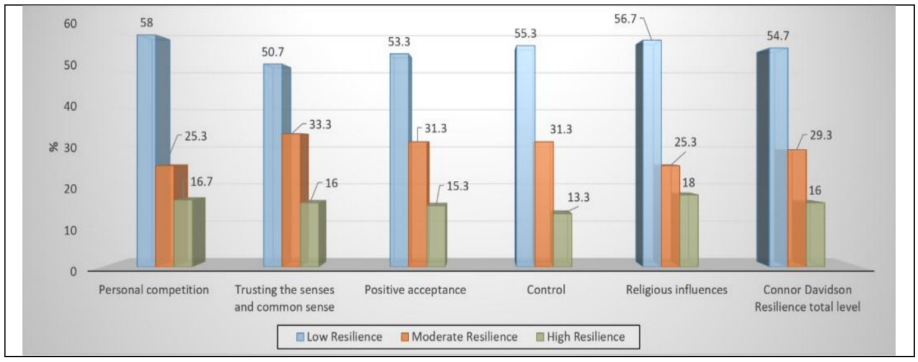

Figure (3): Distribution of the studied subjects according to resilience domains (no=150).

Table (2): Association between childhood trauma domains and the studied subjects' resilience levels (no=150).

Resilience levels and Childhood trauma domains	Low resilience		Moderate resilience		High resilience		Chi – Square Test	
	n	%	N	%	N	%	X^2	P
Emotional Abuse								
Low	14	17.1	4	9.1	11	45.8	18.445	**<0.001****
Moderate	38	46.3	24	54.5	12	50.0		
Severe	30	36.6	16	36.4	1	4.2		
Physical Abuse								
Low	22	26.8	8	18.2	10	41.7	12.406	**0.015***
Moderate	20	24.4	14	31.8	11	45.8		
Severe	40	48.8	22	50.0	3	12.5		
Sexual Abuse								
Low	54	65.9	22	50.0	10	41.7	7.204	0.125
Moderate	20	24.4	16	36.4	12	50.0		
Severe	8	9.8	6	13.6	2	8.3		
Emotional Neglect								
Low	35	42.7	20	45.5	5	20.8	7.491	0.112
Moderate	29	35.4	11	25.0	8	33.3		
Severe	18	22.0	13	29.5	11	45.8		
Physical Neglect								
Low	6	7.3	1	2.3	0	0.0	5.894	0.207
Moderate	13	15.9	5	11.4	1	4.2		
Severe	63	76.8	38	86.4	23	95.8		

Table (3): Correlation between the total domains of childhood trauma and the studied subjects' resilience (no=150).

Resilience and total childhood trauma domains	R	P
Childhood Trauma Questionnaire domains		
Emotional Abuse	- 0.232	**0.004***
Physical Abuse	- 0.195	**0.017***
Sexual Abuse	0.092	0.262
Emotional Neglect	0.208	**0.011***
Physical Neglect	0.334	**<0.001****

Table (4): Association between the studied subjects' medical data and childhood trauma domains (no=150).

Medical and childhood trauma domains	Emotional Abuse	Physical Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect
	Mean ±SD	Mean ±SD	Mean ±SD	Mean ±SD	Mean ±SD
Duration of disorder (Years)					
< 1	11.1 ±4.5	11.3 ±5.1	8.6 ±3.6	14.2 ±4.5	20.7 ±4.3
1 - < 2	14.9 ±3.5	12.9 ±5.2	8.6 ±4.3	12.7 ±3.4	19.8 ±5.5
2 - < 3	13.8 ±5.3	16.3 ±5.7	7.8 ±3.4	12.2 ±3.8	17.9 ±4.9
3 or More	13.3 ±5.6	12.3 ±6.4	7.8 ±3.3	15.1 ±5.4	19.3 ±4.8
One-way ANOVA	F=2.820, **P=0.041***	F=1.945, P=0.125	F=0.601, P=0.615	F=2.032, P=0.112	F=1.151, P=0.331
Have you interned in a psychiatric hospital before?					
Yes	13.7 ±5.8	12.6 ±5.5	7.9 ±2.3	14.3 ±5.4	19.5 ±5.2
No	12.1 ±4.1	12.1 ±5.3	8.3 ±3.7	14.5 ±4.2	19.8 ±4.2
Student's T – Test	T=1.872, P=0.063	T=0.559, P=0.576	T=0.813, P=0.417	T=0.142, P=0.887	T=0.374, P=0.709
Diagnosis					
Anxiety	12.4 ±5.6	9.4 ±4.4	8.3 ±2.9	19.6 ±3.7	18.6 ±4.5
Bipolar 1	9.3 ±3.8	7.9 ±3.4	10.9 ±4.6	15.1 ±8.1	21.4 ±5.0
Depression	14.0 ±4.6	13.8 ±5.1	8.1 ±3.9	13.8 ±4.2	19.4 ±5.1
Mania	9.8 ±3.5	10.8 ±4.6	14.5 ±4.1	13.8 ±1.6	21.5 ±4.6
Obsessive compulsive	10.3 ±1.7	10.0 ±5.0	5.0 ±0.0	14.9 ±3.4	18.6 ±2.4
Schizophrenia	13.5 ±5.7	12.8 ±5.5	7.5 ±3.7	14.1 ±5.2	19.6 ±4.9
One-way ANOVA	F=2.537, **P=0.031***	F=2.890, **P=0.016***	F=7.399, **P<0.001****	F=1.820, P=0.113	F=0.626, P=0.680

Table (5): Association between the studied subjects' medical data and resilience (no=150).

Association between medical data and resilience	Mean ±SD
Duration of disorder (Years)	
< 1	55.3 ±22.3
1 - < 2	48.4 ±17.1
2 - < 3	38.1 ±13.9
3 or More	39.0 ±17.9
One-way ANOVA	F=7.052, **P<0.001****
Have you interned in a psychiatric hospital before?	
Yes	43.0 ±21.4
No	45.5 ±20.3
Student's T – Test	T=0.723, P=0.471
Diagnosis	
Anxiety	59.7 ±20.9
Bipolar 1	53.4 ±25.2
Depression	43.8 ±19.1
Mania	51.5 ±23.5
Obsessive compulsive	40.3 ±19.7
Schizophrenia	41.4 ±20.3
One-way ANOVA	F=1.694, P=0.139

Table (6): Prediction of factors affecting resilience among the studied subjects by the Linear regression data analysis technique (no=150).

Factors affecting resilience	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
Socio-demographic and medical factors					
(Constant)	69.493	16.845		4.125	**<0.001****
Age (Years)	- 3.132	1.698	- 0.155	- 1.845	0.067
Gender	- 0.105	3.568	- 0.003	- 0.030	0.976
Marital Status	0.015	2.426	0.002	0.006	0.995
Educational Level	0.228	1.569	0.011	0.145	0.885
Occupation	- 4.518	1.553	- 0.241	- 2.909	**0.004***
Duration of disorder (Years)	- 3.482	1.452	- 0.215	- 2.397	0.018*
Previous internship in a psychiatric hospital	- 6.797	3.589	- 0.161	- 1.894	0.060
Diagnosis	-1.839	0.969	- 0.145	- 1.897	0.060
Childhood trauma factors / domains					
Emotional Abuse	- 0.889	0.442	- 0.172	- 2.655	**0.014***
Physical Abuse	- 0.896	0.400	- 0.227	- 2.239	**0.011***
Sexual Abuse	0.285	0.363	0.061	0.785	0.434
Emotional Neglect	0.820	0.401	0.175	2.596	**0.027***
Physical Neglect	0.981	0.362	0.225	2.714	**0.008***

Discussion

The aim of the study was to explore childhood trauma and its relation to resilience among psychiatric patients. The result of the study illustrated that regarding socio-demographic and medical data, the Mean ±SD age of patients was (37.8 ± 12.1), about slightly more than on half of patients were males and slightly more than two fifths had secondary education, as well as three fifths were unemployed. This might be related to many factors including severity of the symptoms, onset of the disorder and frequent hospitalization which had negative effect on patients' abilities on completing their education, have work, and get married.

These findings are consistent with the study done by **(Shalanda et al., 2019**), who conducted that the mean age of the patients in their study was 35.5 ± 9.7, and more than three quarters of them were males, and unemployed, and slightly more than one third had secondary educational level. In addition, the findings of the present study are in line with the study of (**Mohamed et al., 2024**) ,who illustrated that more than two-fifths of the studied patients were in age group (27-37) years old with a mean age of (33.37 ± 6.8). Concerning gender, more than three-quarters of the studied patients were males and one half of them had secondary educational level.

The findings of the study illustrated that nearly three fifths of the studied patients had psychiatric disorder before for more than 3 years, and entered the psychiatric hospital. This may be related to the severity of the disorder and may be explained by that the majority of the participants had schizophrenia and this disorder take place in late adolescence and early stage adulthood. These results agree with **(Rossiter et al., 2015**), who indicated that more than two thirds of their study participants within the outpatient group had previously admitted one or more time to an acute inpatient psychiatric unit and the mean number of admissions was 4 times.

The findings of the present study explained that slightly more than one half of the studied patients had schizophrenia and average percentages had depression, obsessive compulsive, mania bipolar 1 and anxiety disorder. This result is consistent with the study of **(Mohamed et al., 2024**, who clarified that slightly less than one half of the studied patients were diagnosed with schizophrenia **(Hanafy et al., 2022)** also supported the current study findings. They postulated that slightly more than two thirds of the studied patients had schizophrenia.

In the same vein, **(Manea et al., 2020)** reported that schizophrenia was the most common chronic psychotic disorder in Egypt that affects about 1.5 million people, and represents the major bulk of patients in mental hospitals. The current findings are also consistent with several studies have investigated the consequences associated with childhood trauma on mental health and cognition in adult individuals **(Kim et al., 2024 and Bing-Canar et al., 2024)**.

Regarding frequency distribution of childhood trauma among the studied patients, the present study revealed that the vast majority of them had severe level of physical neglect and abuse, and nearly one half had moderate level of emotional abuse. Additionally, around one half of the patients had low level of sexual abuse and emotional neglect. The explanation of these differences between childhood trauma domains among the studied patients could be related to environmental, cultural and religious motives and factors. Additionally it could be related to parents in our society often use corporal punishment and neglect as a means of punishing their children or modifying their behaviors.

These results agree with **(Devi et al., 2019)**, who found that physical and emotional neglect were the two most types of trauma reported

among those with anxiety and psychotic disorders. Moreover, emotional abuse and physical neglect were the most frequent types of trauma reported in the mood disorder patients. This result is in congruent with **(Vivalya et al., 2023**), who found that physical and, mental abuse, bullying, and witnessing violence against family members were the most frequent unfavorable childhood experiences.

Additionally, **(Chigiji et al., 2018)** proposed that over 50% of kids report having experienced physical abuse as children, and the frequency varies by country and location. On the other hand, **(Maheshwari et al., 2024**) was slightly inconsistent with the present study. They postulated that the most familiar aspect of CT was emotional abuse, then physical abuse and emotional neglect. As well as a study of **(Subramaniam et al., 2020)** reported that the most common type of adverse childhood experiences reported by their overall sample was emotional neglect.

Regarding frequency distribution of resilience among the studied subjects, the result indicated that more than one half of the patients had low resilience level in all domains. This might be related to childhood trauma that they had before and its consequent effect on their ability to endure psychologically and confront the problems and life changes. This in turn has negative impacts on their health leading to emergence of various psychological illnesses, and reduced their ability to cope with stress and life events consequently reduced their resilience level.

This study result is in the same line of **(Park et al., 2023**), who demonstrated that those who suffered emotional abuse and emotional neglect as children had greater connections with resilience than those who had not. Additionally, a study conducted by **(Nunes and da Rocha, 2022)** revealed that resilience is higher in patients with serious mental illnesses such as major depression, bipolar disorder, and schizophrenia; in people is higher than in stable patients. This is dependent on the severity of the psychiatric symptoms. However, the present study finding is inconsistent with the study of **(Bhosale, 2022)**, who found that most participants indicated moderate or strong level of resilience. This may be due to differences in the study setting, and in the study subjects' inclusion criteria.

The findings of the current study explained that there was a high significant correlation between emotional abuse and physical abuse domains of childhood trauma with levels of resilience. From the researchers' point of view, perhaps this may be because physical and emotional abuse are among the most common problems that children face in middle eastern societies and impact their resilience domains. This result agree with the study of (**Li et al., 2023**) ,who found that emotional abuse in childhood had an association with worse tenacity among patients with major depressive disorders.

At the same line a prior research found that, after controlling for psychological distress, emotional abuse had the largest impact on resilience **(Finch et al., 2024 and Li et al., 2023).** Another research found correlations between emotional abuse and greater levels of adverse traits and lower levels of beneficial traits **(Sudbracke et al., 2015).** The following were some plausible explanations: According to **(Cecil et al. 2017)**, emotional abuse can interfere with a person's ability to regulate their emotions, disrupt their self-concept, and result in negative self-perceptions. These psychological effects can also have an adverse effect on long-term adjustment by making a person less confident in their ability to overcome obstacles **(Nishimi et al., 2020).**

In the same context, the current study illustrated presence of a negative significant correlation between resilience levels and emotional and

physical abuse of childhood trauma. This is consistent with the study of **(Park et al., 2023**) ,who observed that there was a significantly negative association between childhood trauma and resilience. From the researcher point of view it could be related to that resilience is the individual's ability to adapt to different situations and to cope with traumatic events. When the individuals hold trauma, this may lose their abilities to manage emotions, thoughts, and behaviors in a healthy way to support their overall well-being after the trauma. So, the individual who confront traumatic stress may have low level of resilience.

Meanwhile, the present study also illustrated presence of positive significant correlation between resilience levels and emotional neglect, as well as physical neglect of child hood trauma. From researchers' point of view, it might be related to rearing children pattern differs across cultures, and what considered normal in one culture may appear abusive in another. Similarly, values difference and use of corporal punishment are seen differently among individuals, all these things may help a person to be psychologically resilient and have the ability to recover.

As pointed in the present study regarding association between medical data of and childhood trauma domains. It illuminates that there is a significant relation between duration of the disorder and emotional abuse, as well as between patient diagnosis and emotional, physical, and sexual abuse. This is slightly similar to (**Li et al., 2014**), who explained a significant negative correlations existence between age of onset and emotional abuse, as well as emotional neglect score. Additionally, study conducted by **(Li et al., 2015)** summarized that there was a significant negative correlations between age of onset and the emotional abuse scores.

Moreover, this result agrees with the study of **(Lovric et al., 2023)**, who showed that childhood trauma was a major contributing factor in the development of psychotic illnesses in a sizable portion of the subjects. The same authors also noted that those who had seen abuse exhibited more severe clinical presentations, including more prominent psychotic symptomatology, a lower degree of functioning, and an earlier onset and longer duration of disease. Being physically abused or witnessing abuse is linked to decrease functioning.

In the same line, (**Copeland et al., 2018)** found that mental illnesses were associated to higher scores of childhood trauma and lower social support; after controlling demographic data. Furthermore, another study demonstrated that a noteworthy correlation has been seen between the subsequent childhood exposures (emotional abuse, physical neglect, parental loss, bullying (victimhood, perpetration, and frequency); general maltreatment, exposure to various traumas or nonspecific abuse) and mental disorders in adults **(McKay, et al., 2021)**. In addition, a study conducted by **(Ashaba et al., 2022)** concluded that childhood trauma was associated to mental disorders in adults and adolescents. In the same context, the present study findings agree with study of **(Shalanda et al., 2019**), who stated that prevalence of childhood trauma among patients was high as the studied patients had 3 or more types of trauma.

As regarding to the relation between medical data of the studied patients and resilience levels; the present study found a high significant relation between resilience and the disorder duration. This finding was also to some-what in agreement with **(Atef et al., 2021)**, who reported that a statistical significant relationship between the total resilience of the patients under study and the frequency and length of their prior

hospital stays., the age of the patients at the beginning of the disease and their overall resilience were also shown to have statistical significant correlated. On the other hand, (**Deng et al., 2018)** reported no significant relation between resilience and age at onset of disease of the patients and resilience. From one point of view, all appear to affect resilience levels differently depending on the condition, most likely because each disorder is unique in terms of its psychopathology, course, and features.

The current findings illustrated that there was no significant relation between resilience and diagnosis of mental disorders. This is contradicted with the study performed by **(Nunes & da Rocha, 2022**), who reported that resilience has been linked to clinical parameters in hospitalized individuals with mental illnesses, like major depression, bipolar disorder, and schizophrenia,.

The current findings showed that, occupation and duration of disorders had great effect on resilience. This is to some extent agree with **(Elsaied et al., 2022),** who demonstrated that resilience was significantly influenced by the employment status of the participants, current living location, and sex. Furthermore, all childhood trauma domains had a great effect on resilience; except sexual abuse. This agrees with **Bonanno et al.,2007**, who reported that having past and recent life stressors, number of comorbid and chronic conditions, social support, income change, and level of exposure to the traumatic disorder were associated with resilience.

Conclusion:

This study revealed that the studied subjects had severe level of physical, emotional, and sexual neglect and abuse, as well as low resilience level. There was also a significant correlation between the studied subjects' resilience and emotional and physical abuse of childhood trauma, as well as between diagnosis of childhood trauma domains except for emotional and physical neglect domains. Moreover, here was significant relation between resilience and duration of the disorder.

Recommendations:

Trauma-informed care, interventions that emphasize resilience, cognitive-behavioral therapy, and mindfulness-based approaches should be implemented. Additionally, it is imperative to continue development of empirical research related to resilience in individuals, couples, and families with a history of childhood trauma**,** as well as to investigate the function of resilience intervention programs as mediators between mental diseases and childhood trauma.

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