



## **Identifying Traumatic Experiences and Their Effects on Grade 8 Students at Community Schools**

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### **Abstract**

#### **Background**

Trauma is any event that causes a person to experience intense negative and disruptive feelings, ultimately affecting the person's functioning in various areas of life. Children and adolescents with trauma are susceptible to develop Post-Traumatic Stress Disorder (PTSD) and other mental disorders. This study aimed to identify the traumatic experiences of the Grade 8 students in community schools; examine the types of Post-Traumatic Stress Symptoms (PTSS) and their severity in those students.

#### **Methods**

The study sample (n=166) of Grade 8 students of 3 community schools were purposively selected. The data was collected using Child and Adolescents Trauma Screen (CATS) questionnaire.

#### **Results**

The 3 most common trauma types are: witnessing and experiencing physical aggression and serious natural disaster. The mean number of traumatic events is 3.84. PTSS is seen in 50.6%



of the respondents. The severity is higher in females (54.1%) than in males (45.6%) and in younger adolescents (52.0%) compared to older ones (50.0%). The number of traumatic events experienced and severity of PTSS is significantly correlated. Majority of respondents reported having arousal and reactivity symptoms compared to other types of post-traumatic symptoms.

### **Conclusion**

Nepali adolescents experience in average 4 traumatic events and their serious after effects. More studies on wider population are needed to examine the influence of various factors including the impact of onset and duration of trauma exposure on the severity of PTSD.

### **Novelty**

This study can provide insight into the prevalence of trauma; its effects on the adolescents and highlight the importance of students' access to mental health services. In addition, this study can act as a baseline to promote trauma-informed practices in schools.

**Keywords:** trauma exposure, adolescents' mental health, post-traumatic stress,

### **Introduction**

American Psychological Association ([APA, 2018](#)) describes trauma as any disturbing event that causes a person to experience intense amount of fear, helplessness, dissociation, confusion, or other disruptive feelings that can negatively affect a person's attitudes, behavior, and other aspects of functioning in the long run. Natural events such as earthquake, flood, hurricane, landslide as well as events caused by human behavior such as war, accidents, abuse, injury are traumatic events and challenge an individual's view of the world as a just, safe, and predictable place ([APA, 2018](#)). Exposure to war, threatened or actual physical assault (physical attack, robbery, childhood physical abuse), threatened or actual sexual violence (forced sexual penetration, abusive sexual contact, noncontact sexual abuse), being kidnapped or taken hostage, terrorist attack, torture, natural or human-made disasters, severe vehicle accidents and injury, medical catastrophe, witnessing serious accident, injury, violent or unnatural death, physical or sexual abuse of another person and domestic violence can be regarded as potentially traumatic events ([Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; American Psychiatric Association, 2013](#)). Even though human beings have found ways to rebound from wars, disasters and violence, traumatic experiences leave traces on histories, cultures, communities, families and on minds and emotions of individuals, their capacity for joy, intimacy, biology and immune systems ([Van der Kolk, 2014](#)).

Individuals are likely to develop trauma and stressor-related disorders following exposure to a traumatic or stressful event ([American Psychiatric Association, 2013](#)). While around 70% of people in the world experience lifetime traumas, sexual violence (rape, other sexual assault, stalking) is the trauma type with high Post-Traumatic Stress Disorder (PTSD) risk ([Kessler et al, 2017](#)). Globally approximately 3.9% of people experience PTSD at some point in their lives, and among them, 5.6% will develop PTSD ([Koenen et al., 2017](#)). Nepalese experience at least 2 traumatic events in their lifetime, natural disaster being the most common trauma type (84%) and rape being the most traumatizing. PTSD and other trauma-related illnesses are found to be



highly prevalent among trauma-affected patients. While 83% of those patients suffered from PTSD at some point in their life, 15% were found to have PTSD at the time of study ([Koirala et al., 2020](#)). Among the earthquake survivors the PTSD prevalence was found to be 18.9% three years after the incident. ([Acharya Pandey et al., 2023](#)). 9.6% of the adults showed PTSD after the end of Maoist insurgency ([Luitel et al., 2013](#)). Children with trauma have a high probability of developing PTSD and other disorders, including depression, generalized anxiety disorder, panic attacks, borderline personality disorder and substance abuse. Early exposure to stress and trauma has been known to affect neurodevelopment which increases the chances of developing mental disorders and changes the way a person responds to stress ([Lubit et al., 2003](#)).

Children usually suffer from Post-traumatic Stress Disorder (PTSD) after traumatic experiences along with other comorbid conditions, including mood and sleep disturbances, anxiety, problems in conduct, learning and attention ([Caffo & Belaise, 2003](#)).

Prevalence of mental disorders among Nepali children is 11.2% and suicidality is present among 8.7% children. Agoraphobia, major depressive disorder and anxiety disorders are the most common ones ([Jha et al., 2019](#)). 5.2% of adolescents suffer from mental disorders ([Nepal Health Research Council, 2020](#)). PTSD has been found among 46.7% of Nepali children aged 11-14 years, studying in Grade 4-8 ([Checa et al., 2020](#)). PTSD was found in 55.3% of the former child soldiers along with other mental health problems ([Kohrt et al., 2008](#)). Other studies reported prevalence of 10.7% to 51% of Post-Traumatic Stress Symptoms (PTSS) in children and adolescents affected by earthquake. Similarly, the prevalence of emotional and behavioral problems in school children was found to be 12.9% to 17.03% ([Chaulagain et al., 2019](#)).

In Nepal 33% of children are spanked, hit or slapped on the bottom, 25% are hit or slapped on the face and approximately 3% are beaten up hard ([Kandel et al., 2017](#)). Regardless of socioeconomic background, children are exposed to violent discipline. While 70% of children in Nepal receive psychological punishment, over 50% of children undergo physical punishment and among them, 14% face the most severe forms of physical punishment. The consequences of these forms of discipline are wide ranging and long term in nature, including learning disabilities; behavioral disorders; and depression ([UNICEF, 2018](#)). 8% to 31% girls and 3% to 17% boys have been found to be victims of sexual violence based on data from 24 countries ([United Nations, 2020](#)). In the year 2023-24 reportedly 3,489 females experienced sexual violence in Nepal. The highest number of victims (22%) were 11-14 years old female, followed by 15-16 years old female (19%). Most of such incidents took place at the house. 91.1% of the offenders were someone the victims knew. ([Nepal Police, 2024](#)).

Violence against children is associated with various mental health problems including anxiety, depression, suicidal thoughts, post-traumatic stress disorder, substance misuse, aggressive behavior and impaired cognitive functioning ([United Nations, 2020](#)). Children and adolescents with a history of sexual abuse develop trauma. It negatively affects their behavioral, social and emotional development causing problems in cognitive, behavioral, and social areas ([Araujo &](#)



[Martins 2021](#); [Bernard-Bonnin et al. 2008](#)). The effect of abuse becomes more severe and long-lasting if the abuse starts at an early age and intensifies the PTSD symptoms over time ([Alves et al., 2024](#)). Adverse Childhood Experiences (ACEs) are significantly related to different types of behavioral problems in Nepali children and adolescents ([Raut & Dhakal, 2018](#)). 18% of school going children, aged 6-18 years, in Nepal have some form of mental health problems ([Ma et al., 2021](#)).

PTSD symptoms may have onset within three months of a traumatic event, but the onset may not occur until years after the event. The survivors of trauma can re-experience the incident years after the actual event triggering overwhelming unpleasant emotions, intense physical sensations, and impulsive and aggressive actions ([Van der Kolk, 2014](#)). The DSM-5 ([American Psychiatric Association, 2013](#)) has classified PTSD symptoms into four categories:

1. Intrusion symptoms:

Distressing memories, nightmares, flashbacks related to the event(s), dissociative reactions like numbing, depersonalization/derealization, psychological distress and physiological symptoms such as pain, sweating, nausea, increased heart rate, trembling at the real or symbolic reminders of trauma.

2. Avoidance symptoms:

Avoiding or trying to avoid memories, thoughts, feelings, and/or reminders (people, places, activities, objects, and situations) related to trauma.

3. Negative changes in thinking and mood:

Unable to remember important details about traumatic event(s). Negative beliefs or expectations about oneself, others or the world. Blaming oneself or others for what happened. Having negative feelings such as fear, horror, anger, guilt or shame, and difficulty feeling positive emotions such as happiness, love, satisfaction. Loss of interest in previously enjoyable activities. Socially withdrawn or detached.

4. Arousal and reactivity symptoms:

Having aggression or anger outbursts, displaying self-destructive behavior, hyper vigilance, feeling jumpy or easily startled, problems in concentrating, sleep disturbances.

The risk of developing PTSD in individuals is dependent on several factors like age, gender, marital status, education level, income and employment ([Koenen et al., 2017](#)). The risk of developing PTSD and the severity of the PTSD symptoms are also closely associated with the number of traumatic experiences ([Kube et al., 2023](#); [Gonzalez et al., 2016](#); [Park et al., 2015](#)). The reaction of children and adolescents towards traumatic events are influenced by several factors like developmental level, ethnicity/culture, previous trauma exposure, available resources, and preexisting child and family problems. Sometimes they can also show adaptive behavior to cope with the difficulties ([APA, 2008](#)). Many children show resiliency and do not develop long-lasting trauma symptoms. Developmental level, age, inherent or learned resiliency, learned coping mechanisms, external sources of physical, emotional, and social support play major roles in this matter. In younger children, for short-lived traumas, their



response to disturbing events is mostly determined by their parents' reaction to that trauma than older children. Nevertheless, traumas that begun in early stages of life have more potential to alter a child's development than the chronic traumas that started later in adolescence ([Cohen et al., 2006](#)). The support system decreases the likelihood of developing PTSD after a traumatic event in children and the absence of social support increases the chances of acute stress disorder with or without PTSD ([Torrico & Mikes, 2024](#)).

Adolescent females have shown higher PTSD rates in low-middle income countries as well as high income countries ([Hiscox et al., 2021](#)). Gender differences play major role in development of PTSD and the associated symptoms. It starts to emerge during adolescence and can be contributed to the changes that happens during this period ([Garza & Jovanovik, 2017](#); [Hiscox et al., 2023](#)). Findings of research on effect of age on PTSD are still inconclusive, but some studies have shown that PTSD symptoms are found to be higher among females and among the younger participants. ([Bokszczanin, 2007](#); [Kongshøj & Berntsen, 2023](#)).

### **Objective**

There are only limited number of studies in Nepal about child and adolescent mental health. Most of the well-studied children and adolescents groups in Nepal include those involved in war, those exposed to earthquake, homeless and school-going children ([Chaulagain et al., 2019](#)). There is even less research on trauma and its various aspects. Hence, this study was carried out with following objectives:

- (a) Identify the types of traumatic experiences of students studying in Grade 8;
- (b) Recognize the nature of post-traumatic stress symptoms (PTSS) in those students; and
- (c) Examine the severity of PTSS among those students.
- (d) Assess the gender difference and age-related variation in the types of traumatic experiences; PTSS and its severity.

### **Methods**

#### **Participants**

The study sample consisted of Grade 8 students of 3 community schools in Lalitpur Metropolitan City Ward 22. The participants were selected using a purposive sampling procedure. Age and developmental level played a crucial role in selecting this population. Grade 8 students are just beginning to transition into adolescence and are able to self-report personal experiences. Another factor was that they were more likely to remain in the same school until Grade 10 and would be able to attend mental health awareness and intervention sessions to be carried out by the researchers.

All the students of Grade 8 who reported exposure to traumatic events were included while those who didn't report any exposure to such events were excluded. Similarly, the incomplete responses were also excluded from the study. From the 175 responses, 9 of them were excluded. 7 of the responses didn't report any traumatic events and 2 of the responses had incomplete answers, resulting in a final sample of 166 students. The data collection was carried out on September 2024.



The [table 1](#) shows the characteristics of the respondents of this study. The sample consisted of 59.0% (98) female and 41.0% (68) male students. None of the respondents identified themselves as any other gender besides male and female. The respondents from School A were 158 (95.2%), from School B were 1.2% (2) and School C were 3.6% (6). Gender wise, female respondents are higher in number (59.0%) compared to the male.

The age range of the respondents was between 12-22 years. Adolescence has been classified into three stages: early adolescents (11-13 years), Middle adolescence (14-17 years) and late adolescents (18-19 years) ([Salmela-Aro, 2011](#)). There is a growing trend of early puberty onset, which has also affected the onset of adolescence around the world. Hence, adolescent can be considered to be the period between 10 to 24 years ([Sawyer et al., 2018](#)). Based on these references, in this study, the age of respondents has been classified as: Early adolescents (12-13 years); Middle adolescents (14-17 years) and; late adolescents (18-22 years). The middle adolescent group consisted of higher number of samples in this study (110) and the late adolescent group consisted of lowest number of samples (4). These two groups has been merged into one and categorized as older adolescents, together they make up 68.7% (114) of respondents while younger (early) adolescent group make up 31.3% (52) of respondents. The mean age of the participants is 14.12 years.

*Table 1 Sample distribution*

<b>Characteristics</b>	<b>Total (n=166)</b>	<b>Male (n=68)</b>	<b>Female (n=98)</b>
<b>School</b>			
School A	95.2%(158)	39.9% (63)	60.1% (95)
School B	1.2% (2)	100% (2)	-
School C	3.6% (6)	50.0% (3)	50.0% (3)
<b>Age group</b>			
Younger Adolescents (12-13 years)	31.3% (52)	25.0% (13)	75.0% (39)
Older Adolescents (14-17 years) and (18-22 years)	68.7% (114)	48.2% (55)	51.8% (59)
<b>Total Respondents</b>	<b>100% (166)</b>	<b>41.0% (68)</b>	<b>59.0% (98)</b>
<b>Mean age</b>	14.12 years		

**Procedure**

All the Grade 8 students present on the day of data collection were asked to fill out the questionnaire. The data was collected by the trained counselors in the classroom setting who provided specific instruction to the respondents. Two counselors were present in each class to facilitate the process. The day and time for the data collection was pre-arranged by coordinating with respective school principals. Informed consent was acquired from the principals of the three participating schools. Before the participants filled out the questionnaire, they were explained about the purpose of the research and written assent was acquired for their voluntary participation. They were also advised to contact the counselors in case they experienced



uncomfortable feelings and thoughts while responding to the questionnaires or after they completed their response. All the participants completed a self-report questionnaire presented in both English and Nepali language for clarity. To help the participants better understand the statements and their meaning, each statements were read out and defined briefly.

### **Measures**

Data collection tool included Child and Adolescents Trauma Screen (CATS) questionnaire ([Goldbeck & Berliner, 2014](#)), self-report measure for 7–17-year-old children/youth. It is based on the DSM-5 criteria for PTSD and can be used to screen potentially traumatic events and posttraumatic stress symptoms. It has good psychometric properties ([Sachser et al. 2017](#); [Nilsson et al. 2020](#); [Akkus et al. 2021](#)). The questionnaire has 3 sections. The first section has 15 items measuring potentially traumatic events; the second section has 20 items measuring DSM-5 (Post-Traumatic Stress Disorder) PTSD symptoms, and the final section has 5 items measuring psychosocial functioning. The first and the final section uses dichotomic scale, requiring Yes or No answers, while the second section uses a four-point scale ranging from Never (0) to Almost always (3). A total symptom score is calculated by summing up the raw scores of items in the second section (possible range = 0-60). The score below 15 is considered normal and clinically not significant, while the score >15 is considered clinically significant. The score ranging 15 to 20 is interpreted as moderate trauma-related distress and the score higher than 20 is interpreted as probable PTSD.

The questionnaire was translated into Nepali and then back translated into English. The data collection form included original statements in English language as well as Nepali translation of those statements. The first section questionnaire was slightly modified as the item no. 4 "Slapped, punched or beat up in your family" and item no. 5 "Slapped, punched or beat up by someone not in your family", which measure experience of physical aggression were merged into single item. The modified statement stated "Slapped, punched or beat up (in your family and/or someone not in your family)". The item no. 6 "Seeing someone in your family get slapped, punched or beat up" and item no. 7 "Seeing someone in the community get slapped, punched", which measure witnessing physical aggression were also merged into single item. The modified statement stated " Seeing someone get slapped, punched or beat up (someone in your family and/or community)". Hence, the first section of the questionnaire used in this study only had 13 items. Similarly, item no. 8 of the original questionnaire "Someone older touching your private parts when they shouldn't" was rephrased as "Someone touching your private parts when they shouldn't". This was done to allow the participants to report instances of sexual violence (sexual assault/harassment/abuse) from their peer group and not just limit to someone older to them. The Nepali version for this statement stated "Someone touching your private parts without any reasons. In addition to the original statements, the data form also had a section for demographic information that included the name, gender and age of the participants.

### **Data analysis**

The data was directly tabulated in Statistical Package for Social Science (SPSS, Ver. 27). Descriptive analysis was carried out to calculate frequency and percentage of the types of



traumatic events, post-traumatic stress symptoms, PTSS severity of the respondents based on gender and age group. In addition to a numerical data value, the necessary coding of the score was done categorically for age and post-traumatic symptoms. Age was first categorized into early adolescents and middle and late adolescents and then into younger and older adolescents. PTSS scores were coded to indicate normal, moderate distress or probable PTSD. In the symptoms category, the ones rated ‘once in a while’, ‘half of the time’ and ‘almost always’ were calculated. Microsoft Excel was also used for additional computation. Pearson correlation was carried out to examine the relationship between the number of traumatic events and severity of PTSS.

Results

Types of potentially traumatic events reported

The table 2 shows that the most common traumatic event reported is witnessing physical aggression in family, school and community (71.1%) followed by serious natural disaster (70.5%), and experiencing physical aggression through family members, relatives, teachers and friends (65.7%). Across the gender, experiencing and witnessing physical aggression is the most common event along with natural disasters. However, the proportion of male experiencing and witnessing physical aggression is high (72.1% and 75.0%) compared to the female (61.2% and 68.4%). Higher number of older adolescents reported experiencing serious natural disaster (72.8%) and witnessing physical aggression (70.2%) the most compared to early adolescents who reported witnessing the physical aggression the most (73.1%) followed by experiencing physical aggression (67.3%). Equal proportions of male and female have reported experiencing sexual violence (13.2% and 13.3%) while this proportions in higher in older adolescents (14.9%) compared to younger adolescents (9.6%). The mean number of traumatic events reported is 3.84.

Table 2 Types of Potentially Traumatic Events Reported

Table with 6 columns: Types of traumatic events, Total, Gender (Male, Female), and Age Group (Younger Adolescent, Older Adolescent). Rows include various event types like Serious Natural disaster, Sexual violence, etc.



Being around war	8.4 (14)	11.8 (8)	6.1 (6)	1.9 (1)	11.4 (13)
<b>Mean no. of traumatic events</b>	<b>3.84</b>				

**Post-Traumatic Stress Symptoms (PTSS)**

The [table 3](#) shows that higher number of respondents experienced upsetting feelings (60.8%) and upsetting thoughts or pictures (56.6%). Females have reported having upsetting feelings (67.4%) and physical signs of stress (55.1%) more than the males. Older as well as younger adolescents have reported upsetting feelings (59.6% and 63.4%) more than other symptoms and this proportion is slightly higher in younger adolescents.

*Table 3 Post-traumatic Stress Symptoms (PTSS) - Intrusion symptoms (Re-experiencing)*

Intrusion symptoms	Total	Gender		Age Group	
		Male	Female	Younger Adolescent	Older Adolescent
Upsetting thoughts or pictures	56.6 (94)	60.3 (41)	54.1 (53)	60.8 (31)	55.2 (63)
Nightmares	46.3 (77)	38.2 (26)	52.0 (51)	42.3 (22)	48.3 (55)
Flashbacks	39.1 (65)	35.0 (24)	41.8 (41)	42.3 (22)	37.7 (43)
Upsetting feelings	60.8 (101)	51.5 (35)	67.4 (66)	63.4 (33)	59.6 (68)
Physical signs of stress	46.9 (78)	35.3 (24)	55.1 (54)	55.7 (29)	42.9 (49)

The [table 4](#) shows that both male and female respondents scored high on avoidance of places, objects and events that reminded them of trauma more than avoidance of thoughts, which is also the case for older adolescents. However, the early adolescents reported avoiding thoughts related to events more (50.0%).

*Table 4 Post-traumatic Stress Symptoms (PTSS) - Avoidance symptoms*

Avoidance symptoms	Total	Gender		Age Group	
		Male	Female	Younger Adolescent	Older Adolescent
Avoiding thoughts related to events	37.6 (62)	31.4 (21)	41.9 (41)	50.0 (26)	31.9 (36)
Avoiding places, objects and events related to events	45.2 (75)	35.3 (24)	52.1 (51)	46.2 (24)	44.7 (51)

[Table 5](#) shows symptoms related to thinking and mood, having negative emotions (61.8%) is reported to be the most experienced symptoms followed by negative thoughts about oneself or others (59.7%). While higher number of males reported loss of interest in activities (61.8%) higher number of females reported negative thoughts about oneself or others as well as having negative emotions (66.3%). The large number of young adolescents reported having negative emotions (60.8%) in comparison to older adolescents, who scored high in having negative thoughts about oneself or others (65.8%).

*Table 5 Post-traumatic Stress Symptoms (PTSS) - Negative changes in thinking and mood*

Negative changes in thinking and mood	Total	Gender		Age Group	
		Male	Female	Younger Adolescent	Older Adolescent
Trouble remembering trauma details	44.5 (74)	44.1 (30)	44.8 (44)	50.0 (26)	42.2 (48)
Negative thoughts about oneself or others	59.7 (99)	50.1 (34)	66.3 (65)	46.1 (24)	65.8 (75)
Blaming oneself or others not responsible	44.3 (73)	38.3 (26)	48.5 (47)	49.1 (25)	42.1 (48)
Negative emotions	61.8 (102)	55.2 (37)	66.3 (65)	60.8 (31)	62.3 (71)
Loss of interest in activities	59.0 (98)	61.8 (42)	57.2 (56)	53.8 (28)	61.4 (70)
Feelings of isolation	56.1 (93)	48.6 (33)	61.2 (60)	53.8 (28)	57.0 (65)
Difficulty feeling positive emotions	42.1 (70)	38.2 (26)	44.9 (44)	34.6 (18)	45.6 (52)

*Table 6 Post-traumatic Stress Symptoms (PTSS) - Arousal and Reactivity*

Arousal and Reactivity	Total	Gender		Age Group	
		Male	Female	Younger Adolescent	Older Adolescent
Irritable behavior, angry or aggressive outbursts	66.3 (110)	50.1 (34)	77.5 (76)	76.9 (40)	61.4 (70)
Harmful/Risky behavior	17.4 (29)	22.0 (15)	14.2 (4)	7.6 (4)	21.9 (25)
Hyper vigilance (on guard)	61.4 (102)	52.9 (36)	67.3 (66)	71.1 (37)	57.0 (65)
Startled (on-edge)	64.5 (107)	53.0 (36)	72.4 (71)	57.7 (30)	67.5 (77)
Difficulty concentrating	65.7 (109)	63.3 (43)	67.4 (66)	61.5 (32)	67.5 (77)
Sleep problems	48.2 (80)	41.2 (28)	53.1 (52)	44.3 (23)	50.0 (57)

The data in [table 6](#) shows that angry outbursts are reported to be experienced the most (66.3%), followed by difficulty concentrating (65.7%), and being on-edge (64.5%). Among all the four categories of post-traumatic symptoms, these 3 symptoms are also the ones experienced the most by the respondents. The higher number of male respondents has difficulty concentrating (63.3%) while the higher number of females has angry outbursts (77.5%). It can be seen that large proportion of early adolescents (76.9%) has angry outbursts while most of the older adolescents feel startled and have difficulty concentrating (67.5%) more than aggressive outbursts (61.4%).

**Association between PTSS Severity, gender, age and number of traumatic events**

*Table 7 PTSS Severity based on gender and age-group*

Factors	PTSS Severity		
	Normal	Moderate trauma-related distress	Probable PTSD
Gender			
Male	54.4 (37)	16.2 (11)	29.4 (20)



Female	45.9 (45)	16.3 (16)	37.8 (37)
<b>Age Group</b>			
Early adolescents	48.1 (25)	21.2 (11)	30.8 (16)
Middle and Late adolescents	50.0 (57)	14.0 (16)	36.0 (41)
<b>Total</b>	<b>49.4 (82)</b>	<b>16.3 (27)</b>	<b>34.3 (57)</b>

The [table 7](#) shows that 50.6% of the respondents have clinically significant PTSS scores, among which 34.3% have scores indicating probable PTSD. Gender-wise, higher number of females have clinically significant level of PTSS scores, with 37.8% indicating probable PTSD. Age-wise almost similar proportions of younger adolescents (52.0%) and older adolescents (50.0%) have clinically significant level of PTSS scores, with older adolescents scoring high on probable PTSD 36.0% compared to young adolescents. A significant and positive correlation between the number of traumatic events experienced and severity of PTSS amongst the respondents,  $r(164) = .307, p < .001$  was found.

## Discussion

The result showed that half of the respondents are suffering from moderate to severe level of post-traumatic stress symptoms. [Koirala et al. \(2020\)](#) revealed that Nepalese experience at least 2 traumatic events in their lifetime, natural disaster being the most common trauma type. In this study, students on average have experienced approximately 4 potentially traumatic events in their lives. The most common trauma type is witnessing physical aggression, followed by serious natural disaster and experiencing physical aggression. Physical aggression in the form of discipline and punishment is very common in Nepal as well as around the world ([Kandel et al., 2017](#); [UNICEF, 2018](#)). The data from this study also supports this fact as more than half of the respondents have reported experiencing as well as witnessing physical aggression in the family and community. A significant number of Nepali children and adolescents suffer from mental health problems ([Jha et al., 2019](#); [Ma et al., 2021](#)) and PTSD ([Checa et al., 2020](#)). Hence the result of this study matches with the results of previous studies.

The children and adolescents who suffered from adverse childhood experiences and violence have shown behavioral problems as well as various mental health problems such as anxiety, depression, post-traumatic stress disorder ([Raut & Dhakal, 2018](#); [United Nations, 2020](#)). Exposure to serious natural disaster has been found to have significant risk factor for PTSS ([Newnham et al. 2022](#)). Children and adolescents who are exposed to sexual abuse and other types of traumatic events not only develop trauma but also suffers from problems in cognitive, behavioral, and social areas ([Araujo & Martins, 2021](#); [Kolaitis, 2017](#); [Bernard-Bonnin et al., 2008](#)). A significant number of respondents in this study reported of having arousal and reactivity symptoms (irritable behavior, angry or aggressive outbursts, problems in concentration, being on guard and jumpy). Apart from those symptoms, large number of respondents also reported feeling loss of interest in previously enjoyable activities, having other negative emotions such as guilt, shame, fear; feelings of isolation; negative thoughts about oneself or others, suggesting that they are struggling in various areas of their lives.



Adolescents experience intense positive and negative emotions and tend to react strongly against the life stressors ([McLaughlin et al., 2015](#)). They frequently experience anger and in comparison to other age groups, they struggle more with regulating anger ([Akbaş & Yiğitoğlu, 2022](#)). Anger can evoke aggressive behavior. Evidence suggests that interaction of biological, psychological and social predictors like family dynamics, peer relationships, and individual emotional regulation skills, school and community environment can influence aggressive behavior among adolescents and adverse experience in one of area of life can intensify aggression in another area ([Jaleel & Kotian, 2024](#); [Fauzi et al., 2023](#)). The significant number of respondents reporting negative emotions like anger and aggressive outbursts in this study indicates that anger and aggression in adolescents need to be considered in reference to their history of trauma exposure not just as a behavior caused by developmental changes.

Higher proportions of females in this study show clinically significant PTSS scores compared to males, which is consistent with previous studies that also found that adolescent females show higher PTSD rates ([Hiscox et al., 2021](#); [Garza & Jovanovik, 2017](#)). The young and old adolescents, both groups have shown clinically significant scores of PTSS with older adolescents scoring more on probable PTSD. But as the effect of age on PTSD are still undetermined ([Kongshøj & Berntsen, 2023](#); [Bokszczanin, 2007](#)), no inference can be drawn from this result. The result also indicates that the higher number of traumatic events increases the severity of PTSS. Previous studies ([Park et al, 2015](#); [Gonzalez et al, 2016](#); [Kube et al, 2023](#)) have shown that the exposure to multiple trauma experiences can impact the severity of PTSD symptoms.

Despite being exposed to potentially traumatic events children may not develop long-lasting trauma symptoms. Developmental level, age, inherent or learned resiliency, learned coping mechanisms, external sources of physical, emotional, and social support play major roles in this matter. ([Cohen et al., 2006](#)). This might be one of the reasons why many of the respondents have not developed severe trauma-related stress symptoms even after facing traumatic events. Sexual violence (rape, sexual assault, stalking, sexual abuse) is a trauma type with high PTSD risk, with girls more susceptible to develop severe symptoms compared to the boys (Kessler et al, 2017, Alves et al, 2024). Hence, for this reason, special sessions were held for those respondents who reported of having experienced sexual violence to ensure that they were no longer under risk and to aware them that they need to report such incidents to a trusted adult for their safety and well-being. They were also provided information on mental health service providers in case they needed additional support. This was done discreetly by informing the principals of respective schools, without compromising the privacy of the students.

This study has several limitations as it only included students in Grade 8 from 3 community schools and only used single standardized self-report questionnaire. The sample cannot be considered to be representative of adolescent population and this could limit the generalizability of the findings of this research. This study didn't consider other factors such as family and other interpersonal relationships, socio-economic factors, and onset and duration of trauma exposure, which play significant roles in development and severity of PTSD. This study



has not focused on the functional impairments the respondents have experienced. There are not many studies that have focused on the functional impairments that are related to the trauma symptoms. These functional impairments can affect the daily activities and quality of life as PTSD is associated with functional impairments ([Jellestad et al., 2021](#))

Regardless of the limitations, this study can provide insight into the prevalence of trauma and its effects on the adolescents. Here are the recommendations based on the findings of this study:

- Awareness programs for the students about trauma to help them understand its impact and to normalize the need of seeking service/support for mental health.
- Awareness programs and trainings for the school teachers on various topics related to mental health, including trauma and trauma-informed approach. The government need to find ways to include trauma-informed approach in training curriculums designed for the school teachers.
- Students need to have adequate information and access to mental health service to help them deal with issues related to mental health. This can happen through government introducing policy to appoint school counselor in each school.

## **Conclusion**

The result showed that the mean number of traumatic events experienced by the respondents in this study is 3.84. The most common traumatic event reported by 71.1% of respondents is witnessing physical aggression. The second most common event is serious natural disaster reported by 70.5%, and the third most common is experiencing physical aggression by 65.7%. Experiencing and witnessing physical aggression is higher in male compared to female. Equal percentage of male (13.2%) and female (13.3%) have endured sexual violence while higher percentage of older adolescents (14.9%) have reported experiencing sexual violence.

Amongst the four categories of posttraumatic symptoms: intrusion (re-experiencing) symptoms; avoidance symptoms; negative changes in thinking and mood; and, arousal and reactivity, large percentage of respondents reported the higher symptoms of arousal and reactivity, where 66.3% reported irritable behavior, angry or aggressive outbursts.

The result showed that 50.6% of the respondents have clinically significant PTSS scores (16.3% moderate trauma-related distress and 34.3% probable PTSD). PTSS scores are higher in female respondents (50.1%) compared to male respondents (45.6%). There is not much difference among younger and older adolescents in severity of PTSS (52.0% and 50%).

Hence, it can be concluded that Nepali adolescents experience in average 4 traumatic events and suffer from their effects. Higher number of adolescents witness physical aggression at home or community. There is no gender difference in experience of sexual violence however, older adolescents experience it more than younger adolescents. Half of the respondents have shown moderate to severe post-traumatic symptoms. Comparatively female show higher degree of post-traumatic symptoms. There is a correlation between the number of traumatic events experienced and severity of PTSS. As the significant number of respondents have reported anger and aggressive outbursts, such emotions and behavior in adolescents need to be



understood in the context of their history of trauma exposure and not just as a change due to developmental phase.

More studies need to be carried out in wider population to examine the prevalence of trauma on Nepali children and adolescents; influence of age, gender, family and socio-economic factors, onset and duration of trauma exposure along with how various types of trauma can impact the severity of PTSD. The reports from guardians and teachers also need to be considered. Moreover, functional impairment associated with the PTSD symptoms also needs to be examined closely. This study shows that Nepali adolescents are suffering from the effects of trauma. They need awareness programs about mental health and trauma to understand its impact, with information on when, where and how to access mental health services. The school teachers also require trainings on various mental health topics include trauma and trauma-informed approach. The government need to find ways to make school counselors available at each school and also to incorporate trauma-informed approach as a part of training curriculums for the school teachers.

### **Conflict of Interest**

The authors have no conflicts of interest associated with the material presented in this paper.

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### **Author contributions**

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Data Curation SS

Data analysis SS

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Writing – original draft SS

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