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Understanding Perceived Parental Rejection in Borderline Personality Disorder: A Qualitative Study

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ABSTRACT

Background*:* Borderline Personality Disorder (BPD) is characterized by emotional instability, impulsivity, and interpersonal relationship issues. Parental rejection has been a significant psychosocial risk factor influencing the development and severity of BPD symptoms. However, there has been minimal research on this issue in the Bangladeshi cultural setting. Objective: The aim of the study was to understand the nature of perceived parental rejection in Bangladeshi patients diagnosed with Borderline Personality Disorder (BPD).

Method: A qualitative study was conducted using a grounded theory approach. Semi-structured in-depth interviews were carried out with 22 purposively selected adult participants diagnosed with BPD. Data were analyzed to gain an in-depth understanding of the nature of perceived parental rejection.

Results: Data analysis revealed seven categories of perceived parental rejection based on participants' subjective experiences: authoritarianism, neglect, hostile behavior, lack of acceptance, lack of affection, lack of validation, and lack of protection. These behaviors, though sometimes culturally normalized, were interpreted by participants as emotionally rejecting.

Conclusion: The study provides a subtle description of the way individuals with BPD in Bangladesh internalize and assign meaning to parental actions as rejection. The seven categories identified highlight the relational and affective features of rejection as experienced by the participants. They highlight the necessity of cultural sensitivity in clinical assessment and intervention by placing particular emphasis on targeting early relational experiences in BPD treatment..

Keywords: *Borderline Personality Disorder, Perceived Parental Rejection, Grounded Theory, Qualitative Study, Authoritarianism, Emotional Neglect, Hostile Behavior, Lack of Acceptance, Lack of Affection, Lack of Validation, Lack of Protection, Parenting Styles.*

1. INTRODUCTION

Borderline Personality Disorder (BPD) is a serious psychiatric illness characterized by chronic emotional dysregulation, impulsivity, unstable relationships, and a fragmented sense of identity [1]. Present in approximately 1.6% to 5.9% of the general population, BPD is a considerable burden to mental health clinicians due to its high comorbidity, repeated crises, and chronic functional disabilities [2]. BPD patients are particularly vulnerable to self-injury behavior, suicidality, and psychosocial dysfunction, emphasizing the necessity to further research its underlying processes [3]. Causation of BPD has been widely accepted to be multifactorial, comprising genetic risks, neurobiological vulnerabilities, and psychosocial adversities. Among them, early adverse experiences—and most saliently the subjective experience of perceived parental rejection—have been consistently implicated as core psychosocial determinants of the onset and course of BPD [4].

Perceived parental rejection is the child's experience and feeling of caregiver behaviors such as emotional unavailability, neglect, hostility, or coldness that frustrate the development of secure attachment and stable emotional regulation. Although numerous quantitative investigations have demonstrated associations between perceived parental rejection and,

increased severity of BPD symptoms [5], such findings offer limited insight into the underlying psychosocial processes and subjective experiences that underlie this association [6]. The manner in which early experiences of rejection influence cognitive schemas, emotional reactivity, and interpersonal behavior in individuals with BPD are imperfectly captured through statistical analysis alone [7]. The pathway from early rejection to adult psychopathology is dynamic, subtle, and highly personal—a phenomenon more amenable to qualitative inquiry [8]. To this end, grounded theory offers an appropriate methodology for inductively generating theory from dense, first-person accounts of individuals with BPD [9]. By enabling respondents to describe their experiences in their own words, qualitative research gives voice to marginalised perspectives and demonstrates the culturally embedded nature of how early psychosocial environments shape adult mental health [10]. These insights are crucial for clinicians wishing to develop sensitive, culturally responsive, and trauma-informed interventions. Rather than merely listing BPD correlates, qualitative approaches uncover the lived meanings, coping strategies, and relational patterns that underpin the maintenance of the disorder [11]. This study specifically examines the lived experiences of perceived parental rejection in BPD patients in Bangladesh—a sociocultural context where family dynamics, social roles, and mental health stigma strongly shape emotional development and help-seeking behaviors. Bangladesh still lacks mental health infrastructure, and personality disorders remain unfamiliar. Therefore, culturally sensitive qualitative research is essential to inform clinical practice and adjust interventions to local realities. Using the grounded theory approach, the study will attempt to develop an analysis of how parental rejection as experienced by the patient affects the long-term psychosocial functioning of BPD patients in Bangladesh. Through in-depth interviews and simultaneous data analysis, the study will attempt to delineate the emotional, cognitive, and relational processes through which early rejection manifests in adulthood. The findings are expected to make a regional and international contribution to the understanding of BPD, with implications for prevention efforts—i.e., parental education and early psychosocial intervention—and for culturally relevant clinical practice. Last, this research aims to bridge the gap between empirical investigation and therapeutic practice, providing mental health professionals with a richer, contextualized knowledge of perceived parental rejection. These results may also benefit parents themselves by helping them become cognizant of rejecting behaviors and altering their parental style to facilitate healthier emotional development.The study provides a subtle description of the way individuals with BPD in Bangladesh internalize and assign meaning to parental actions as rejection. The seven categories identified highlight the relational and affective features of rejection as experienced by the participants. They highlight the necessity of cultural sensitivity in clinical assessment and intervention by placing particular emphasis on targeting early relational experiences in BPD treatment

2. METHODOLOGY

The study employed a qualitative approach with grounded theory to explore the nature of perceived parental rejection in individuals with Borderline Personality Disorder (BPD). A purposive sample of 22 adult participants (3 males, 19 females) aged between 18 and 46 years was recruited from psychiatric outpatient departments of some hospitals and clinics in Dhaka, Bangladesh. The recruitment sites included Dhaka Medical College Hospital, Sir Salimullah Medical College and Mitford Hospital, the National Institute of Mental Health, Bangladesh Medical University, and Prottoy Medical Clinic Ltd. Participants represented a variety of socioeconomic and education statuses ranging from primary level to postgraduate level. Participants were selected based on theoretical sampling principles in accordance with the guidelines of grounded theory method until reaching data saturation.

Inclusion Criteria:

- Adults 18 years and above with clinical diagnosis of BPD.
- Physically and psychologically able to participate in in-depth interviews.

Exclusion Criteria:

- Below 18 years of age.
- Severe physical or mental illness that would interfere with participation.
- Illiteracy.
- Co-diagnoses with bipolar disorder, schizophrenia, or current substance use disorder

Data were collected through detailed, in-depth, semi-structured interviews conducted over long periods of time using a topic guide developed by the lead researcher, a professional clinical psychologist. Interviews lasted 1 hour 20 minutes to 2 hours 10 minutes. The guide included 27 open-ended questions that prompted participants' accounts of parental rejection and its psychological effects. For the patients who were experiencing emotional distress, shorter interviews were done and follow-

up interviews organized as needed. All the interviews were audio-recorded with informed consent and accompanied by copious field notes of non-verbal behaviors and affective responses. Thematic data analysis and data collection went hand in hand, following grounded theory procedures. Interviews were transcribed verbatim and analyzed using NVivo 10 software to facilitate systematic coding and theme development.

Steps to Data Analysis

1. Open Coding: Preliminary line-by-line coding to establish salient ideas and patterns around perceived parental rejection.
2. Axial Coding: Grouping and linking codes into broader conceptual categories. Microsoft Excel was also used alongside NVivo to visualize and organize code interrelations.
3. Selective Coding: Integration and tweaking of categories to decide on overarching themes and to develop a theoretical model bridging parental rejection experiences with BPD symptomatology.
4. Memo Writing: Ongoing chronic recording of new ideas, thoughts, and theoretical observations throughout the entire analytic process.
5. Constant Comparison: Continued comparison of new data against codes and categories that already exist in order to verify consistency and depth of understanding.
6. Triangulation: Use of multiple data sources, analytic methods, and researcher perspectives to provide credibility and trustworthiness to findings.

Continued theoretical sampling until saturation point was reached, indicated by no longer any emergence of new themes or categories. Ethical approval was obtained from the Faculty of Biological Sciences and Department of Clinical Psychology, University of Dhaka, Ethical Review Committee. Written consent was obtained from the collaborating clinical settings. Informed written consent was obtained from all participants prior to inclusion. Confidentiality was maintained through anonymizing data and secure handling of transcripts. Participants were informed about their right to withdraw at any time without penalties. Emotional support and follow-up referral were provided for the participants who exhibited distress in or after the interviews.

3. RESULTS

This qualitative study explored the character of perceived parental rejection felt by individuals diagnosed with Borderline Personality Disorder (BPD). The participants gave detailed accounts that revealed habitual patterns of emotional and behavioral rejection by their caregivers, producing a persistent sense of not feeling wanted, valued, or emotionally secure. Most of the subjects rated these experiences as severe punishment, no displays of love, not minding their emotional or mental well-being, blaming them readily for everything, very anger at minor mistakes, physical abuse, minimal freedom, corporal punishment in public areas, no safe place to share feelings, and no emotional support. In contrast, fewer participants reported experiencing blame and punishment for parental conflict, broken promises made to them, criticism from extended family, having epilepsy stated as them faking it, indifference shown to their talents, being left at homes locked behind them, receiving no academic assistance of any kind, being met with a failure to adapt to their uniqueness, and even being ridiculed for good behavior.

Emergent Behavioral Themes of Rejection

Seven common patterns of perceived parental rejection were identified through thematic analysis:

• Authoritarianism

• Neglect

• Hostile Behavior

• Lack of Acceptance

• Lack of Affection

• Lack of Validation

• Lack of Protection

These patterns were obtained from a total of 790 coded references. These experiences collectively contributed to shame, low self-esteem, emotional dysregulation, and compromised interpersonal relationships.

Contextual and Cultural Influences

Broader socio-cultural processes, including patriarchal family dynamics, rigid gender roles, and inter-parental conflict,

intensified participants' experiences of rejection. The majority of them coped by disconnecting emotionally, rebelling, or internalizing the belief that they were unlovable or burdensome.

Developmental Trajectories and Lifelong Effects

A developmental sequence was observed in participants' narratives. Rejection was internalized as self-blame in childhood; in adolescence, blame was externalized onto parents. In adulthood, the unresolved trauma was manifested in persistent low self-esteem, trust issues with others, and self-destructive or avoidant behavioral patterns.

Table 1: Demographics of Participants

Demographic	Frequency	Percent
Age Category		
18-19	3	13.6
20-29	10	45.5
30-39	8	36.4
40 and above	1	4.5
Sex		
Male	3	13.6
Female	19	86.4
Education		
Class 1 to SSC	4	18.2
After SSC to graduate	10	45.5
Postgraduate or above	8	36.4
Marital Status		
Married	9	40.9
Unmarried	11	50.0
Other	2	9.1
Socioeconomic Status		
Low	4	18.2
Middle	15	68.2
High	3	13.6
Total	22	100

Table 2: List of Nodes Describing the Subjective Experience of Perceived Parental Rejection of BPD participants

Name of Node	Sources Referenced
Abandoned at boarding school	P16, P18
Absence of father	P24, P38
Abusive towards mother (father)	P8, P13, P22, P24, P32
Allowed others to intervene in life decisions	P9, P22, P38

Blamed and punished for parental conflict	P24,
Blamed for always ruining everything	P13, P24, P29, P33
Blamed for getting sick	P26, P24
Broke promises	P9
Busy with other things	P5, P28, P29
Comparison	P8, P17, P19, P24, P25, P28
Criticism about physical features	P32, P19, P24
Criticism about the whole person	P17, P24, P26, P27, P32, P33
Criticism by extended family	P27, P32
Did not address child's life problem	P1, P13, P38, P22, P29, P26
Did not attend to basic needs	P1, P16,
Did not defend	P13, P22, P38, P27
Did not protect from sexual abuse	P20, P21, P22, P25, P38, P24
Did not seek treatment even after a suicidal attempt	P20, P27
Easily blamed for everything	P13, P20, P24, P28, P32, P29, P33
Enforcing conformity through threats and fear	P32, P24
Epilepsy labelled as acting	P38
Extreme anger for the silly mistake	P21, P27, P28, P29, P33, P24
Extreme anger if authority questioned	P27, P28, P24, P08
Extreme punishment	P5, P08 P17, P18, P19 P24, P27, P28
Forced to live away from home	P1, P16, P38
Frequent punishment over small things	P5, P19, P20, P21, P27
Gender discrimination	P8, P25, P38
Gender-based restrictions	P8, P25, P27, P32
Grim atmosphere	P22, P29, P33
High expectations	P21, P24, P25, P08
Highly conditional love	P8, P17, P21, P25, P24
Hurtful comments	P13, P17, P19, P24, P25, P27, P33
Inconsistent fulfilment of economic duties	P1, P16, P27
Lack of acknowledgment about achievements	P8, P24, P26
Indifference about talents	P26
Lack of acknowledgment of good behaviour	P34, P26, P24
Lack of appreciation and praise	P5, P8, P26, P27, P29, P24
Lack of care when sick	P1, P26

Lack of expressions of love	P13, P24, P26, P28, P27, P29, P01, P33, P38, P16, P09
Lack of guidance about life	P1, P9, P13, P16
Lack of concern about the mental state	P1, P13, P20, P27, P28
Lack of warmth	P9, P34, P38, P01, P27, P28, P29, P38, P24, P25,P26, P33, P19
Left alone in the locked house	P27
Love decreased	P1, P17
Negative labelling of the child	P19, P25, P13, P33
Never helped with homework	P29
No acknowledgment of emotions	P13, P29, P33, P24, P26, P22, P16
No emotional support	P9, P13, P01, P22, P33, P19, P27, P38
No safe space to share	P8-9, P13, P16, P17, P20, P22, P25-27, P32-34
Noes	P24, P29, P13, P32
Not adjusting to child's characteristics	P24
Not fulfilling simple desires	P5, P9, P16, P20, P27, P34
Not valuing perspectives or opinions	P5, P16, P18, P24
Overprotection	P13, P24, P33, P26
Physical abuse	P5, P17, P18, P27, P28, P19, P13, P22, P24, P34
Physical punishment in front of others	P5, P13, P20, P21, P24, P32, P34
Preferential treatment of sibling	P5, P34
Pressurized about studies	P28, P24
Prioritized societal pressure	P25, P27, P24, P13, P38
Humiliation in front of others	P34, P38, P13
Lack of quality time	P8, P24, P27, P28, P33, P29, P26, P13
Restricted freedom	P13, P20, P21, P24, P25, P27, P29, P32, P33, P38
Ridiculed positive behaviours	P34
Strict routine	P24, P26, P28
Treated as a burden	P5, P18, P20, P24, P32, P38

Table 3: Nodes representing Authoritarianism

Nodes
Restricted Freedom
Strict routine
Not valuing perspectives or opinions
Not fulfilling simple desires
Gender-based restrictions
Overprotection
Noes
Extreme anger if authority questioned
Grim atmosphere

Table 4: Nodes representing Neglect

Nodes
Absence of father
Abandoned at boarding school
Did not address child's life problem
Did not attend to basic needs
Lack of guidance about life
Lack of concern about the mental state
Busy with other things
Lack of mental support
Never helped with homework
Did not seek treatment even after a suicidal attempt
Inconsistent fulfilment of economic duties
Broke promises
Epilepsy labelled as acting
No acknowledgment of emotions
Forced to live away from home

Table 5: Nodes representing Hostile Behaviour

Nodes
Physical abuse
Physical punishment in front of others
Extreme punishment
Frequent punishment over small things
Hurtful comments
Extreme anger
Humiliation in front of others
Easily blamed for everything
Enforcing conformity through threats and fear
Blamed and punished for parental conflict
Father was abusive towards mother
Left alone in a locked house

Table 6: Nodes representing Lack of Acceptance

Nodes
High expectations
Criticism about physical features
The belittlement of the whole person
Criticism by extended family
Comparison
Treated as a burden
Prioritized societal pressure
Preferential treatment of sibling
Pressurized about studies
Negative labelling of the child
Gender discrimination
Highly conditional love
Blamed for always ruining the happiness
Blamed for getting sick
Not adjusting to child's characteristics

Table 7: Nodes representing Lack of Affection

Nodes
Lack of expressions of love
Lack of warm behaviours (warm touch or care)
Lack of quality time
Lack of care when sick
Love decreased
No emotional support

Table 8 Nodes representing Lack of Validation

Nodes
Lack of acknowledgment of good behaviour
Lack of appreciation and praise
Indifference about achievements
Indifference about talents
Ridiculed positive behaviours

Table 9: Nodes representing Lack of Protection

Nodes
No safe space to share
Did not protect from sexual abuse
Did not defend
Allowed others to intervene in life decisions

4. DISCUSSION

Extreme self-harm and suicidal behavior in BPD patients remain high-priority public health concerns in Bangladesh, just like globally [12]. According to national reports from 2017 to 2023, suicides are 3.36% among men and 4.17% among women, necessitating the comprehension of psychosocial correlates of such events [13]. While these epidemiological statistics of the issue depict its gravity, they inform us very little about individuals' real-life experience with Borderline Personality Disorder. This qualitative research bridges the gap by employing the grounded theory approach, striving to tap into the subjective and emotional elements of the experience of felt parental rejection among BPD patients. Our findings illustrate a complex and often painful trend of rejection that is shaped by the participants' family and cultural contexts. Even though some participants said their parents loved them, their life stories told a different story — one filled with emotional neglect, controlling behavior, and inconsistency. These nuanced experiences illustrate the limits of formal measures to capture culturally situated emotional realities which is supported by another study too [14]. For instance, parenting practices interpreted by parents as protective or normative—such as overcontrol, harsh punishment, or withholding of emotions—were most commonly identified by participants as rejection. This implies a psychosocial process that is culturally specific wherein accepted parenting traditions in Bangladeshi culture may potentially lead to internalized states of feeling unloved, unwanted, or emotionally unsafe [15]. These rejection episodes were correlated with long-term emotional insecurity, low self-esteem, and relationship difficulties in adulthood. Through open-ended and culturally sensitive interviewing, the research marked common patterns of behavior—such as emotional unavailability, harsh punishment, neglectful affect, and the absence of a safe space to label distress—as dominant themes in participants' lives. Such testimony is indicative of a broader cultural narrative in which parental authority supersedes emotional experience, often outweighing children's inner needs. Although these traditions become institutionalized or even obligatory in Bangladeshi households, their psychological

manifestations are exposed only through narrative analysis. By positioning patients' voices first, this research contributes to a culturally sensitive understanding of parental rejection as being felt and internalized. It underscores the utility of qualitative approaches to make visible emotionally complex and context-specific dynamics that are not seen in routine evaluations. Other studies also support this study's findings that will help raise awareness among parents about how culturally accepted parenting practices may be experienced as emotional rejection, emphasizing the need for more nurturing, supportive, and emotionally attuned caregiving to promote healthier psychosocial development in children [16].

5. CONCLUSION

This study describes the complex nature of perceived parental rejection in Borderline Personality Disorder patients in Bangladesh. It outlines how culturally influenced parenting practices contribute to the development of perceptions of rejection that impact on emotional and social life. It is necessary to understand such culturally embedded experiences in order to inform sensitive interventions that can address the unique challenges of this group.

6. LIMITATION OF THE STUDY

Limited sample size from urban clinic & hospitals, reliance on self-report, and qualitative study design restrict generalizability and causal conclusions.

CONFLICT OF INTEREST

The authors do not have any conflict of interest to declare regarding the publication of this study.

ABBREVIATIONS

- **BPD** – Borderline Personality Disorder
- **PARQ** – Parental Acceptance-Rejection Questionnaire
- **DSM-5** – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
- **NSSI** – Non-Suicidal Self-Injury (if mentioned elsewhere)
- **APA** – American Psychiatric Association (if cited)
- **FGD** – Focus Group Discussion (if used in qualitative methods)

REFERENCES

[1] D'Aurizio, G., Di Stefano, R., Socci, V., et al. (2023). The role of emotional instability in borderline personality disorder: A systematic review. Annals of General Psychiatry, 22(9). https://doi.org/10.1186/s12991-023-00439-0

[2] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

[3] Thakur, B., Pathak, M., Strenth, C., Wilmoth, K., & Arnold, E. M. (2024). The relationship between borderline personality disorder and self-injurious/suicidal behaviors in adolescents and young adults: A protocol for systematic review and meta-analysis. Health Science Reports, 7(6), e2143. https://doi.org/10.1002/hsr2.2143

[4] Gunderson, J. G., Zanarini, M. C., Choi-Kain, L. W., Mitchell, K. S., Jang, K. L., & Hudson, J. I. (2011). Family study of borderline personality disorder and its sectors of psychopathology. Archives of General Psychiatry, 68(7), 753–762.

[5] Bungert, M., Liebke, L., Thome, J., Haeussler, K., Bohus, M., & Lis, S. (2015). Rejection sensitivity and symptom severity in patients with borderline personality disorder: Effects of childhood maltreatment and self-esteem. Borderline Personality Disorder and Emotion Dysregulation, 2, 4. https://doi.org/10.1186/s40479-015-0025-x

[6] Foxhall, M., Hamilton-Giachritsis, C., & Button, K. (2019). The link between rejection sensitivity and borderline personality disorder: A systematic review and meta-analysis. British Journal of Clinical Psychology, 58(3), 289–326. https://doi.org/10.1111/bjc.12216

[7] Khaleque, A., & Rohner, R. P. (2011). Pancultural associations between perceived parental acceptance and psychological adjustment of children and adults: A meta-analytic review of worldwide research. Journal of Cross-Cultural Psychology, 43(5), 784–800. https://doi.org/10.1177/0022022111406120

[8] Stepp, S. D., Whalen, D. J., Scott, L. N., Zalewski, M., Loeber, R., & Hipwell, A. E. (2014). Reciprocal effects of parenting and borderline personality disorder symptoms in adolescent girls. Development and

Psychopathology, 26(2), 361–378. https://doi.org/10.1017/S0954579413001041

[9] Charmaz, K. (2006). Constructing grounded theory. Sage.

[10] Zalewski, M., Stepp, S. D., Whalen, D. J., & Scott, L. N. (2015). A qualitative assessment of the parenting challenges and treatment needs of mothers with borderline personality disorder. Journal of Psychotherapy Integration, 25(2), 71–89. https://doi.org/10.1037/a0038877

[11] Steele, K. R., Townsend, M. L., & Grenyer, B. F. S. (2019). Parenting and personality disorder: An overview and meta-synthesis of systematic reviews. PLoS ONE, 14(10), e0223038. https://doi.org/10.1371/journal.pone.0223038

[12] Arafat, S. M. Y. (2023). Mental health and suicide in Bangladesh. In S. M. Y. Arafat & M. M. Khan (Eds.), Suicide in Bangladesh (pp. 31–). Springer. https://doi.org/10.1007/978-981-99-0289-7_3

[13] Samad, M., Rehana, Z., Farha, A., & Sen, S. (2024). A prevalence survey on attempted suicides and suicidal deaths in a selected rural area of Bangladesh. M Abdur Rahim Medical College Journal, 17(1), 41–52. https://doi.org/10.69861/marmcj.2024.v17.i1.07

[14] Razavi, P., Gorur, K., Iyer, A., & Silan, M. (2023, July 3). Complexities and lessons in researching culture-specific experiences. Observer. Association for Psychological Science. https://www.psychologicalscience.org/observer/complexities-and-lessons-in-researching-culture-specific-experiences

[15] Jasmine, U. H., Nduna, M., & Nkala-Dlamini, B. (2025). Intergenerational continuity of protective parenting practices in Dhaka, Bangladesh. PLOS ONE, 20(2), e0300160. https://doi.org/10.1371/journal.pone.0300160

[16] Haque, M. A., Moniruzzaman, S., Janson, S., Rahman, A. K. M. F., Mashreky, S. R., & Eriksson, U.-B. (2020). Children's exposure to psychological abuse and neglect: A population-based study in rural Bangladesh. Acta Paediatrica, 109(3), 617–625. https://doi.org/10.1111/apa.15340