POST-TRAUMATIC STRESS DISORDER AMONG HELP SEEKING TORTURE SURVIVORS OF ERITREAN REFUGEES AT MAI AYNI AND ADI HARUSH REFUGEE CAMPS.

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POST TRAUMATIC STRESS DISORDER AMONG HELP SEEKING TORTURE SURVIVORS OF ERITREAN REFUGEES AT MAI AYNI AND ADI HARUSH REFUGEE CAMPS

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A thesis submitted to the School of Psychology, Addis Ababa University in partial fulfillment of the requirements for the Degree of Masters of Arts in Counseling Psychology.

June, 2019
Addis Ababa, Ethiopia
DECLARATION

I, Amare Worku Assefa, the undersigned, hereby declare that the thesis entitled with *Post Traumatic Stress Disorder among Help Seeking Torture Survivors of Eritrean Refugees at Mai Ayni and Adi Harush Refugee Camps, Tigray, Ethiopia* is my original work and the thesis contains no material previously published by any other person except where proper citation and acknowledgments have been made. I do further affirm that this thesis has not been presented as part of the requirements of any other academic degree. To better assurance, I signed below.

_______________________                                      _______________________
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## APPROVAL SHEET

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ABSTRACT

The general objective of this study was to examine post-traumatic stress disorder among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps. Accordingly, five specific objectives were established. These were 1) identify types of torture among help-seeking torture survivors 2) analyze the prevalence of PTSD symptom severity 3) examine the statistically significant difference between PTSD and demographic variables (i.e. gender, age, and marital status) 4) describe the distribution of behavioral functioning difficulties and 5) investigate the relationship between PTSD symptoms and behavioral functioning problems. To achieve these research objectives a cross-sectional survey design and quantitative approach were implemented. A sample of 516 torture survivor participants, 348 males and 168 females adolescent and adult clients were used from the clinical database of the Center for Victim of Trauma Ethiopia through population census. The measures for data collection were a checklists, post-traumatic stress diagnosis scale and behavioral functioning problem scale. The data were analyzed through independent sample t-test, one-way ANOVA, percentage, frequency, mean, standard deviation, and linear regression using SPSS version 25. Thus, the results of the present study revealed that: The participants were exposed to more than one types of torture and the majority of the respondents reported that 406 (78.7%) they had been beaten and 232 (45%) psychologically tortured. Regarding the severity of posttraumatic stress disorder, from the total 516 participants, 478 (92.7%) had moderate to severe symptoms of post-traumatic stress disorder. There was a statistically significant difference in post-traumatic stress disorder symptom severity in gender in which female suffered more than male. However, there were no statistically significant differences in post-traumatic stress disorder symptom severity among the age and marital status categories. Majority of the participants had faced behavioral functioning problems in their daily living as a result of their traumatic experience. A moderate positive relationship between PTSD and behavioral and functional difficulty was found with 32 percent of the variance. Finally, based on the results of the present study recommendations were made to respective stakeholders.

Keywords: Post-traumatic stress disorder, Torture survivor, help-seeking, and Eritrean refugees
ACRONYMS AND ABBREVIATIONS

ANOVA: Analysis of variance
ARRA: Administration for Refugee and Returnee Affairs of Ethiopia
BFS: Behavioral Functioning Scale
CVT: Center for Victims of Trauma-Ethiopia
SD: Standard Deviation
DSM: Diagnostic and Statistical Manual for Mental Disorders
HTQ: Harvard Trauma Questionnaire
PTSD: Post-Traumatic Stress Disorder
PD-S: Post-Traumatic Stress Diagnosis Scale
SGBV: Sexual and Gender Based Violence
UNCAT: United Nations Convention against Torture
UNHCR: United Nation Higher Commissioner for Refuge
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CHAPTER ONE: INTRODUCTION

1.1. Background of the Study

Globally, the forcibly displaced population was 65.5 million in 2017, which increased to 68.5 million by the end of the year. The forcibly displaced population worldwide was 68.5 million, an increase of 2.9 million from 2017. By the end of the year, 68.5 million individuals were forcibly displaced as a result of persecution, conflict, or generalized violence. A result of the forcibly displaced population remaining at a record high (United Nations High Commissioner for Refugees, 2017). According to UNHCR (2018), Ethiopia is a host of the second largest refugee population in Africa, sheltering over 928,663 registered refugees and asylum seekers as of 31 July 2018, of which 172,798 are Eritrean refugees. Further, the research has revealed that the refugees who experience war and forced migration have a high burden of psychiatric morbidity, in particular, post-traumatic stress disorder (PTSD) events (Karunakara, Neuner, Schauer, Singh, Hill, Elbert & Burnha, 2004). PTSD encompasses symptoms of intrusive recollections of the traumatic events, avoidance behavior, general hyperarousal and reduced functioning, and is associated with the experience or witnessing of life-threatening traumatic events (Karunakara et al., 2004).

The studies conducted by Ibrahim, Hassan, Pepe, and Schneeberger (2017) illustrated that political violence is a notorious cause of psychological distress and draw correlations between war trauma, torture, and PTSD. In 1980, post-traumatic stress disorder (PTSD) was introduced into the official classification of psychiatric disorders, the Diagnosis Statistical Manual for Mental Disorder three (DSM-III). This marked the beginning of contemporary research on the psychiatric response of traumatic event victims. The Diagnosis Statistical Manual for Mental Disorder three (DSM-III) and subsequent DSM definitions of PTSD are based on a conceptual model that brackets traumatic events from other stressful experiences and brackets PTSD from other responses to stress (American Psychiatric Association, 2013).
In contrast to “ordinary” stressful experiences, traumatic or catastrophic events are linked etiologically in the DSM to a specific syndrome—PTSD. The disorder’s criterion symptoms are defined in terms of their connection, in time and in content, with a distinct traumatic event. They include re-experiencing the event through intrusive thoughts and dreams, avoidance of stimuli that symbolize the event, numbing of general responsiveness, and increased arousal not present before the event. Many of these symptoms are among the characteristic features of other psychiatric disorders. However, it is the connection with a distinct event that renders the list of PTSD symptoms a specific syndrome (American Psychiatric Association, 2013).

Although different groups have different levels of exposure to traumatic events, the conditional probability of developing PTSD following a similar level of exposure may also vary across cultural groups. Rates of PTSD are higher among veterans and others whose vocation increases the risk of traumatic exposure (e.g., police, firefighters, emergency medical personnel). Highest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide (American Psychiatric Association, 2013).

The prevalence of PTSD may vary across development; children and adolescents, including preschool children, generally have displayed lower prevalence following exposure to serious traumatic events; however, this may be because previous criteria were insufficiently developmentally informed. The prevalence of full-threshold PTSD also appears to be lower among older adults compared with the general population; there is evidence that subthreshold presentations are more common than full PTSD in later life and that these symptoms are associated with substantial clinical impairment (American Psychiatric Association, 2013).
The concept of PTSD has been successfully applied in assessment and treatment following many types of traumatic experience. However, its applicability to non-western populations (including refugees who have often experienced multiple and severe traumas over prolonged periods) is controversial (Johnson & Thompson, 2008).

Since 1980, research on PTSD has focused primarily on Vietnam War veterans and, to a lesser extent, on victims of specific traumatic events, such as disaster or rape (Breslau, 2002). A meta-analysis of 181 studies of conflict-affected populations, including refugees and displaced persons, estimated that PTSD and depression are prevalent at 30.6 and 30.8 %, respectively (Steel & et al., 2009). The results of path analysis highlighted another potential or added explanation. While torture may be negatively associated with some of PTSD symptoms, it is associated with the more severe symptoms of dissociation, psychosis, and executive function deficits (Kira et al., 2013).

A representative survey conducted to assess refugee mental health in Ethiopia at Adi Harush and Mai Ayni refugee Camps by Golden (2017) depicted that after being offered a simple, brief definition of torture, a combined total of 40 percent of respondents reported that they had personally been tortured. This suggests that over 5,500 adults in these camps are likely to have experienced torture. Overall, 28 percent reported that someone in their family or in their household had been tortured. Finally, 60 percent speculated that they thought many people in their community had been tortured. The rates were significantly higher for Mai Ayni in all three areas. Because torture often results in very particular negative consequences for mental and physical health, a specialized interdisciplinary rehabilitation program is recommended to address these high rates of reported torture.
From the above indications, the researcher suspected that people experienced torture and witnessed others being tortured are susceptible to the mental health problem of post-traumatic stress disorder (PTSD). However, most of the studies have been focused on the general psychological distress among the refugee community rather than specific disorders like PTSD. Therefore, this research was conducted to assess post-traumatic stress disorder among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps, Tigray, Ethiopia.

1.2. Statement of the problem

Post-traumatic stress disorder (PTSD) is an anxiety disorder some people develop after seeing or living through an event that has caused or threatened serious harm or death threat (Caring for kids new Canadia and Canadian pediatric society, 2018). On the other hand, torture is the one which is a complex multilateral trauma as it consists of different trauma types that are focused on humiliating or annihilating the person’s personal and collective identities (Kira, Ashby, Odenat, & Lewandowsky, 2013). Torture is the intentional infliction of psychological, physical, and/or emotional pain or deprivation. It is a practice commonly used in a substantial array of societies for purposes of punishment, intimidation, interrogation, and coercion (Kira et al., 2013).

Torture is directed towards instilling and reinforcing a sense of powerlessness and terror in victims and their perspective communities, and/or political or religious groups. In this way, torture may be characterized as inter-group victimization with negative effects that go beyond individuals to families and communities. The similar story happens to clients who get psychosocial counseling in the Center for Victims of Trauma Ethiopia as the review of their intake assessment revealed. As an instance, the following two cases histories are taken to indicate this reality:
Case: 1

33 years old client was imprisoned in Northern Red Sea and tortured by the military officials through beating, forced to watch someone being tortured and forced postures, stretching. Moreover, they punish him physically specifically forced to sand on his bare foot for prolonged period of time in a very hot temperature. As a result, his foot became wounded and injured finally it is impaired; now he use physical aid to perform daily routine even when he come to the therapy session. Consequently, the clients has developed problems like flashbacks, irritability, sleeping problem, feeling of hopelessness, loss of sexual interest, nightmare, emotional disturbance and worthlessness.

Case: 2

41 years old client was forced to join and serve in military for several years. Unfortunately, he refused to stay there due the ban of visiting his families even though he went there without getting permission. Later on, the military officials took him back within short period of time. Then after, they tortured him like repeated beating, deprived from basic necessities and forced posture. These all leads the client to develop physical signs like stomach ache, headache, dizziness, sleeping problem, and psychological problems like, feeling of hopelessness, flashbacks, sadness, worries too much and worthlessness.

Therefore, the researcher realized that clients who get psychosocial counseling in the center for victims of trauma-Ethiopia were experienced torture while reviewing the intake assessments such as repeated beaten on arms and legs, forced posture, like stretching, hanging, deprivation from basic necessities and expose to watch others being tortured. As a result, some of them have been physically disabled and used Orthopedic aids like a wheelchair, crunch, and specially prepared shoes in their daily routines.
Fortunately, people in the refugee community have the opportunity to access mental health services from the center for victims of trauma Ethiopia for free. One of the objectives of CVT- Ethiopia is providing community sensitization program to the general refugee community at their place of residence which emphasis on the definition of torture and traumatic symptoms come as a result of torture. Then, immediately after a session on average 15 clients were registered as a potential client in the CVT waiting list for individual or group counseling. This indirectly confirmed that how the refugee community suffered in torture and resulting traumatic symptoms such as repeating bad dreams or nightmares, flashbacks, restricted to engage in enjoyable activities and irritability or angry in their daily living.

The above-stated circumstances as well as the researcher’s experience to the subject (i.e. post-traumatic stress disorder) and the site of the study inspired to carry out this research. More importantly, though an effort was made to intervene these traumatic symptoms by CVT-Ethiopia, to the best knowledge of the researcher, there was no an empirical research that attempted to depict the clear picture of post-traumatic stress disorder (PTSD) among the help-seeking torture survivors of Eritrean refugees in the Center for Victims of Trauma - Ethiopia. Therefore, the main reason behind conducting this study was to fill this knowledge gap and the results will have practical implications to the mental health practitioner.
1.3. **Basic research Questions**

The main purpose of the present study was to examine post-traumatic stress disorder (PTSD) among help-seeking torture survivors of Eritrean refugees in Center for Victims of Trauma at Mai Ayni and Adi Harush refugee camps, Tigray, Ethiopia. In order to address this purpose, the following research questions were formulated:

**Q1.** What are the types of torture among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps as a risk factor?

**Q2.** What is the prevalence of PTSD symptom severity among help-seeking torture survivors of Eritrean refugees in Center for Victims of Trauma at Mai Ayni and Adi Harush refugee camps?

**Q3.** Is there a statistically significant difference in PTSD between or/and among demographic variables (i.e. gender, age and marital status) among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps?

**Q4.** What is the prevalence of behavioral functioning difficulties among help-seeking torture survivors of Eritrean refugees face in their daily living.

**Q5.** Is there a relationship between PTSD and behavioral functioning problems of torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps?
1.4. Objectives of the Study

1.4.1. General Objective
The general objective of this study was to examine post-traumatic stress disorder among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps, Tigray, Ethiopia.

1.4.2. Specific objectives
- To identify the types of torture among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps as a risk factor.
- To analysis the prevalence of PTSD symptoms among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps.
- To examine the statistically significant difference between PTSD and demographic characteristics of the participant specifically gender, age, and marital status in terms of their resilience capacity.
- To identify the prevalence of behavioral functioning difficulties of torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps.
- To investigate the relationship between PTSD symptoms and behavioral functioning problems of torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps.
1.5. **Significance of the study**

The findings of this study are provides a valuable contribution to governmental and non-governmental agencies who are working in the mental health service. This enables to examine the mental health impact of torture and other traumatic events among refugees have possible implications for organizations managing rehabilitation programs for individuals who have been exposed to traumatic events especially for humanitarian interventions. It will increase the awareness of mental health needs and may provide an impetus for supporting the expansion of psychological services for Eritrean refugees as well as others in similar conditions. The researcher strongly believes that the outcomes of the study will add on to the existing knowledge in the area of study and give insight for researchers who wish to study further. Hence, it serves as baseline data for the scientific community.

1.6. **Delimitation or Scope of the Study**

This study was delimited to investigate post-traumatic stress disorder (PTSD) among help-seeking torture survivors of Eritrean refugees. So, in order to answer the basic research question effectively and efficiently; the research was delimited in terms of studying variables, studying site and time frame. Regarding the study variables, it focused on the types of torture, the prevalence of PTSD symptoms among help-seeking torture survivors and the behavioral functioning problems among help-seeking torture survivor clients. Though there are a number of demographic variables, this study addressed age, gender and marital status of the participants. In terms of the study site, this study was conducted only in Mai Ayni and Adi Harush refugee camps where Eritrean refugees are hosted. These are located in Tigray reginal state, Northern part of Ethiopia. Moreover, the research was concentrated on clients who registered in the clinical database of the Center Victims of Trauma-Ethiopia from 2013 to 2018.
1.7. **Limitations of the Study**

Although the present study strived to provide new knowledge regarding post-traumatic stress disorder (PTSD) among help-seeking torture survivors of Eritrean refugees, it has its own limitations. The study has not employed probability sampling technique to select the samples of the study. Therefore, generalizability of this study is limited to the study site due to the procedures of the selecting the research participants. More importantly, this study was limited to secondary clinical dataset from the Center for Victims of Trauma-Ethiopia which exclude the refugee community who were not takes part in psychotherapy. These data were entirely quantitative in nature that has not been sufficient to explore some qualitative variables of the study. Given the lack of experience on the part of the researcher was considered as a limitation to the current study.

1.8. **Operational Definition of Terms**

**Post-traumatic stress disorder**: Refers to developmental characteristic symptoms following exposure to an extreme traumatic stressor involving the direct personal experience of an event that involves actual and threatens death or serious injury, or other threats to one’s physical integrity, or witnessing an event (American Psychiatric Association, 2013).

**Behavioral functioning problem**: Refers to difficulties in behavioral functioning in daily life, such as difficulties in leaving the house, discussing new events, or doing domestic work that torture survivor Eritrean refugees faced.

**Help-seeking**: Clients who came to the healing site of the Center for Victim of trauma-Ethiopia and complete the intake assessment especially post-traumatic stress diagnostic scale and scale.

**Trauma**: Refers to an event that threatens the life or integrity of the individual such as physical abuse, death of a parent, witnessing violence, abandonment, and war.
**Torture:** It refers to a different type of traumas that are focused on humiliating a person’s personal and collective identities and the intentional infliction of psychological, physical, and/or emotional pain or deprivation (Kira, Ashby, Odenat, & Lewandowsky, 2013).

**Torture survivors:** Members of the refugee communities, who experienced torture or witnessed when others being tortured in their home county and during border crossing such as beating, hanging, deprived of basic necessities, humiliation and forced labor, raped and expose to watch other being tortured for different reasons.

1.9. **Organization of the Report**

This study report is organized in six main chapters. The first chapter contains and discussed the background of the study, statement of the problem, basic research questions, objectives of the study, delimitation of the study, limitation of the study, significance of the study, and operational definition of terms. The second chapter discussed the review of related literature in line with the objectives of the study. The third chapter elaborates the research design, the study sites, the participants of the study, measured used for data collection and data analysis procedures are clarified with sound justification. The fourth chapter presents the results of the study in light of the basic research question. The fifth chapter presents a discussion of the major findings of the study as compared to the review of related literature in detail. Conclusion and recommendation of the study are dealt with in chapter six. Finally, the list of references and the appendixes are attached next to chapter six.
CHAPTER TWO: REVIEW OF RELATED LITERATURES

In this chapter, the existing related literatures most relevant to the purpose of the study are summarized. It strived to address the definition of post-traumatic stress disorder (PTSD), the risk factors for post-traumatic stress disorder, symptoms of post-traumatic stress disorder, studies related to behavioral and functional problems as a result of post-traumatic stress disorder and studies of post-traumatic stress disorder in the refugee population.

2.1. Definition of Post-Traumatic Stress Disorder

According to American Psychiatric Association (2013) post-traumatic stress disorder (PTSD) is the developmental characteristic symptoms following exposure to one or more traumatic events and the emotional reactions to the traumatic event (e.g., fear, helplessness, and horror). The clinical presentation of PTSD varies. In some individuals, fear-based re-experiencing, emotional, and behavioral symptoms may predominate. In others, anhedonic or dysphoric mood states and negative cognitions may be most distressing. In some other individuals, arousal and reactive-externalizing symptoms are prominent, while in others, dissociative symptoms predominate. Finally, some individuals exhibit combinations of these symptom patterns (American Psychiatric Association, 2013). Post-traumatic stress disorder (PTSD) was first recognized following the devastating effects that war experiences had on soldiers serving in Vietnam. It is a condition resulting from exposure to a life-threatening event that is processed in such a way as to produce a sense of current threat (Ehlers & Clark, 2000).
According to Schiraldi (2009) post-traumatic stress disorder (PTSD) is results from exposure to an overwhelmingly stressful event or series of events, such as war, rape, or abuse. It is a normal response by normal people to an abnormal situation. The traumatic events that lead to PTSD are typically so extraordinary or severe that they would distress almost anyone.

As to the National Center for Posttraumatic Stress Disorder (2010) posttraumatic stress disorder (PTSD) is an anxiety disorder that can occur following the experience or witnessing of a traumatic event. A traumatic event is a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents, or physical or sexual assault in adult or childhood. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own or may even get worse over time. These individuals may develop posttraumatic stress disorder (PTSD).

According to American Psychiatric Association (2013) the directly experienced traumatic events such as exposure to war as a combatant or civilian, threatened or actual physical assault (e.g., physical attack, robbery, mugging, childhood physical abuse), threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents are considered as risk factors for PTSD.
2.2. **Symptoms of post-traumatic stress disorder**

People with PTSD experience three different kinds of symptoms. The first set of symptoms involves reliving the trauma in some way such as becoming upset when confronted with a traumatic reminder or thinking about the trauma when you are trying to do something else. The second set of symptoms involves either staying away from places or people that remind you of the trauma, isolating from other people, or feeling numb. The third set of symptoms includes things such as feeling on guard, irritable or startling easily. People with PTSD also may experience a wide variety of physical symptoms. This is a common occurrence in people who have depression and other anxiety disorders. Some evidence suggests that PTSD may be associated with an increased likelihood of developing medical disorders (National Center for Post-traumatic Stress Disorder, 2010).

2.3. **Risk factors for post-traumatic stress disorder**

The causes of PTSD include experiencing or witnessing serious physical, emotional, or sexual abuse, physical assault; sexual assault; major accidents or illnesses; drug addiction; and war situations, major natural or man-made disasters (Wimalawansa, 2016).

According to National Center for Posttraumatic Stress Disorder (2010) the risk for developing PTSD increases if people: were directly exposed to the traumatic event as a victim or a witness, seriously injured during the trauma, experienced a trauma that was long-lasting or very severe, saw themselves or a family member as being in imminent danger, had a severe negative reaction during the event, such as feeling detached from one's surroundings or having a panic attack and felt helpless and were unable to help themselves or a loved one. Furthermore, individuals are also more likely to develop PTSD if they: have experienced an earlier life-threatening event or trauma, have a current mental health issue, have less education, are younger, are a woman, lack social support, have recent stressful life changes.
PTSD is more prevalent among females than among males across the lifespan. Females in the general population experience PTSD for a longer duration than do males. At least some of the increased risk for PTSD in females appears to be attributable to a greater likelihood of exposure to traumatic events, such as rape, and other forms of interpersonal violence. Moreover, within populations exposed specifically to such stressors, gender differences in risk for PTSD are attenuated or nonsignificant (American psychiatric association, 2013).

2.3.1. Torture as a risk factor for post-traumatic stress disorder

Torture is widely prohibited--and widely practiced. Major documents prohibiting torture include Article 55 of the Universal Declaration of Human Rights, adopted December 10, 1948; Article 7 of the International Covenant on Civil and Political Rights, adopted by the U.N. on December 18, 1966; and the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted unanimously by the U.N. General Assembly on December 9, 1975.

More specifically, The United Nations Convention against Torture (UNCAT), adopted by the U.N. General Assembly on December 10, 1984, and ratified by 147 countries, holds that "Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction." Nothing justifies exceptions: "No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture. Unfortunately, despite these and other explicit prohibitions, torture is widespread (United Nations, 2010)."

The U.N. Special Rapporteur on Torture stated that "torture was practiced in most countries of the world" (United Nations, 2010). Amnesty International (2011) has documented torture and ill-treatment in 98 countries (Pope, 2013).
It is well-known that war in itself can lead to a range of other traumatic experiences, such as witnessing extreme violence, terrorist attacks, kidnappings, torture, separation from one’s family and forced migration (Johnson & Thompson, 2008). According to Kira et al. (2013) torture is the intentional infliction of psychological, physical, and/or emotional pain or deprivation. It is a practice commonly used in a substantial array of societies for purposes of punishment, intimidation, interrogation, and coercion. It may be characterized as inter-group victimization with negative effects that go beyond individuals to families and communities.

Torture is often used as a tool for reform to reshape a person’s views and convert a person to different ideas. Psychological torture is often a part of this process. For example, a victim may be disoriented by being blindfolded and isolated. He or she may not know what is expected from his or her captors and how to obtain release. Sexual torture and assaults are common, as well as random beatings and insulting comments. The use of fear is a very powerful tool in psychological torture (Isakson, 2008).

Moreover, Ibrahim & Hassan (2017) supported that political violence is known to cause psychological distress, and there is a large body of empirical studies drawing a significant association between war trauma, torture, and PTSD. In line with this torture and other potentially traumatic events (PTEs), play in the variation of reported prevalence rates of posttraumatic stress disorder (PTSD) and depression across epidemiologic surveys among post-conflict populations worldwide (Marnane & Ommeren, 2009).

The higher prevalence of PTSD in women is a function of the sex difference in the conditional probability of PTSD. Women are approximately twice as likely as men to succumb to PTSD following traumatic events. Even when cases with rape are excluded or when the event type is controlled, women have a higher rate of PTSD following traumatic experiences than do men (Breslau, 2002).
The study conducted to examine the prevalence of PTSD symptoms among Syrian Kurdish refugees in association with torture and other traumatic events. Of the total sample, 38.46% reported PTSD symptoms in the clinical range using the 45-item total scale, and 35.16% met criteria on the first 16 symptom items of HTQ using established clinical cutoff scores (Ibrahim & Hassan, 2017).

2.4. Post-traumatic stress disorder in the refugee population

According to the International Society for Traumatic Stress Studies (n.d.) refugees are typically exposed to multiple types of traumatic events in their countries of origin and during displacement. These events are often repeated, prolonged and interpersonal in nature, and have been demonstrated to have a deleterious effect on mental health. Likewise, potentially traumatic events commonly experienced by refugees and asylum-seekers in their home countries include interpersonal violence, sexual violence, life-threatening injuries, witnessing the murder of loved ones, and torture. While the extent of exposure to traumatic events may vary according to several factors including area/country of origin, characteristics of conflict and personal factors such as gender, age, ethnicity and sexual orientation, the dosage of exposure to traumatic events prior to displacement is commonly high amongst refugees.

This study also confirmed that displaced and resettled refugees and asylum-seekers report elevated rates of psychological disorders in comparison to host populations in many settlement countries. Other research also indicates that prevalence rates of psychological disorders in refugee groups are elevated compared to the general population (Tempany, 2009). Consistent with these finding refugees had demonstrated high rates of post-traumatic stress disorder (PTSD) and other psychological disorders. The recent increase in forcible displacement internationally necessitates the understanding of factors associated with refugee mental health (Li, Liddell, & Nickerson, 2016).
According to Vindbjerg et al. (2016) traumatized refugees are typically characterized by an extensive trauma history, exposure to torture and rape, and often conflict-related death of family members. Eventually forced to flee, their social network is disrupted and their personal ambitions for the future, such as building a career and a family, are challenged.

A meta-analysis of 181 studies of conflict-affected populations, including refugees and displaced persons, estimated that PTSD and depression are prevalent at 30.6 and 30.8 %, respectively (Steel & et al., 2009). The results of path analysis highlighted another potential or added explanation. While torture may be negatively associated with some of PTSD symptoms, it is associated with the more severe symptoms of dissociation, psychosis, and executive function deficits (Kira et al., 2013).

A research conducted entitled with factor structure of PTSD symptoms among west and central African refugees revealed that all participants reported at least one trauma experience related to political or ethnic violence. The most common experiences involved physical assault (n=343, 85.8%). Other experiences included deprivation of food, water, or medical needs (n=114, 28.5%), sexual assault (n=111, 27.8%), being forced to witness the abuse of others (n=95, 23.8%), extended forced postures (n=51, 12.8%), degradation (e.g., forced nakedness in front of family, abuse with excrement; n=50, 12.5%), being burned (n=39, 9.8%), stress to senses (e.g., being bound; exposure to extreme heat; n=38, 9.5%), electric shock (n=25, 6.3%), pharmacological manipulation (n=10, 2.5%), asphyxiation (n=6, 1.5%), and amputation (n=3, 0.8%) (Rasmussen, Smith, & Keller, 2007).
2.5. **Behavioral and functional problems as a result of post-traumatic stress disorder**

According to Wimalawansa (2016) post-traumatic stress disorder (PTSD) is a serious debilitating syndrome with significant personal, social, and economic consequences. People with PTSD experience one or more major symptoms that include flashbacks and paranoia, difficulty in interpersonal relationships, and problems engaging in work and activities of daily living. In severe cases, they can harm themselves or others.

Diagnosis and statistical manual for mental disorder depicted that PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical utilization. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains. In community and veteran samples, PTSD is associated with poor social and family relationships, absenteeism from work, lower income, and lower educational and occupational success (American psychiatric association, 2013).

PTSD is also well-characterized serious psychological and behavioral abnormality that occurs after exposure to one or more acute severe stressful events. It often occurs among soldiers returning from battlefields and the civilian victims of war (Wimalawansa, 2016) . However, it also occurs in non-war situations, such as terrorist attacks or serious accidents; sexual abuse, rape, or other violent acts; and school or workplace bullying, harassment, or retaliation. Nevertheless, the diagnosis of PTSD is made too infrequently, particularly in the post-conflict periods in developing countries ( Wimalawansa, 2016).
People with PTSD often have problems functioning. People with PTSD have more unemployment, divorce or separation, spouse abuse and the chance of being fired than people without PTSD. Vietnam veterans with PTSD were found to have many problems with family and other interpersonal relationships, problems with employment, and increased incidents of violence (National Center for Posttraumatic Stress Disorder, 2010).

Moreover, high-intensity arousal symptoms of PTSD produced sleep disturbance, irritability, angry outbursts, poor concentration, hypervigilant behavior and an exaggerated startle response. The syndrome is frequently complicated by alcohol abuse or dependence, and less frequently by other substance misuse disorders. There is a high rate of comorbid with depression. The combined effects of these psychopathologies on occupational function and interpersonal relationships can be devastating. Thus the syndrome not only affects the sufferer but also spouse, family, friends, and workmates (John & Sons, 1996).
2.6. Conceptual framework

The review of the related literatures enables to develop a general conceptual framework that leads to determine the research methods. This framework was designed based on the review of different research outputs of post-traumatic stress disorder and the diagnosis and statistical manual of mental disorder.
CHAPTER THREE: RESEARCH METHODS AND PROCEDURES

3.1. Research design

In order to address the objectives of this study, this research utilized descriptive survey specifically cross-sectional design. Since the cross-sectional survey design is allowed to measure the exposure and health outcomes simultaneously in a given population and in a given geographical area at a certain point of time. This is helpful in determining how many people are affected by a condition and whether the frequency of the occurrence varies across groups or population characteristics such as age and gender (Hemed, 2015).

Therefore, this research used the preexisting clinical data of the clients in The Center for Victims of Trauma –Ethiopia which is already collected for a counseling purpose. In approach wise the research was quantitative due to the nature of the data which were collected through close-ended questionnaire, checklists and scales.

3.2. Study sites

This study was conducted in Tigray regional state, Western Zone, Tselemt district at Mai Ayni and Adi Harush refugee camps where Eritrean refugees are accommodated. Center for Victim of trauma-Ethiopia is an US-based international non-governmental and non-profit organization which provides mental health service in Ethiopia to support the Eritrean refugees in Mai Ayni and Adi Harush refugee camps. The researcher has selected this study area due to the acquaintance to it and the nature of problems observed at the time of the second-year four-month internship program from September to January 2018.
Figure 1: Map of the study sites

Prepared by: Mr. Melaku Getachew (GIS and Remote Sensing Researcher at EEFRI)
3.3. **Participants of the study**

The participants of this study were all the help-seeking torture survivor clients at the Center for Victims of Trauma- Ethiopia and who obtained group or individual psychotherapy service. It included 516 (348 males and 168 females) clients registered in the clinical database of the center from 2013 when CVT-Ethiopia established its program to the Eritrean refugees in Mai Ayni and Adi Harush refugee camps up to end of 2018.

In this case, the researcher enacted to use the entire population as a census survey since the data from all CVT clients who completed consent for data use were available. This would substantially strengthen the outcome of the study.

The inclusion criteria were: (1) aged 18 or older; (2) both male and female; (3) refugees who are registered as CVT client based on the intake assessment and identified as a torture survivor by the center psychotherapist (4) who registered as Eritrean refugee in the Administration for Refugee and Returnee Affairs (ARRA) of Ethiopia.

3.4. **Measures and administration procedures**

In this study, the researcher used an existing clinical database developed by the Center for Victims of Trauma Ethiopia in Mai Ayni and Adi Harush refugee camps that provides mental health services to help-seeking torture survivors and created mental health data from all its clients. The instruments used for data collection were designed by the center’s psychologists and researchers for its program. The instruments included a comprehensive intake that comprises detailed torture assessment and mental health screening measures included for PTSD called Post-Traumatic Stress Diagnostic Scale (PD-S) and Behavioral and Functioning Problems Scale. All these measures were administered as part of a routine diagnostic assessment during the intake procedure to all clients applied for treatment.
A. Post-traumatic Stress Diagnostic Scale (PDS)

Post-traumatic Stress Diagnostic Scale (PDS) was originally developed and validated by Edna Foa to provide a brief but reliable self-report measure of post-traumatic stress disorder (PTSD) for use in both clinical and research settings (McCarthy, 2008). The scale is intended to screen for the presence of PTSD in clients who have identified themselves as victims of a traumatic event (McCarthy, 2008).

Post-Traumatic Stress Diagnostic Scale (PD-S) is a four-point scale (i.e. 0="not at all," 1="rarely,” 2="sometimes or 3="often") which contains 16 items representing the symptoms of PTSD experienced in the past 30 days based on DSM-IV.

The PDS a symptoms severity score which ranges from 0 to 48 and this is obtained by adding up the individual’s responses of items. The cut-offs for symptom severity rating are 0 no rating, 1–10 mild, 11–20 moderate, 21–35 moderate to severe and ≥36 severe (McCarthy, 2008).

According to McCarthy (2008) PDS has high face validity because items directly reflect the experience of PTSD with high internal consistency (Coefficient alpha of 0.92). Test-retest reliability was also highly satisfactory for a diagnosis of PTSD over a 2- to the 3-week period (kappa = 0.74). Test-retest using symptoms severity scores yielded a highly significant correlation (0.83). The analysis also revealed an 82% agreement between diagnosis using the PDS and the Structured Clinical Interview for DSM.

Ibrahim and Hassan (2017) had used this measure to assess post-traumatic stress disorder symptoms resulting from torture and other traumatic events among Syrian Kurdish Refugees and the internal consistency of the scale was (Cronbach’s α ≥ 0.88). Likewise, the actual internal consistency of the scale in the present study was (Cronbach’s α ≥ 0.88) for all participants. Therefore, these all implied the good reliability the measure that would be able to collect reliable data from the participant of the study.
B. Behavioral Functioning Problems Scale

Behavioral functioning problems scale has 10 items related to difficulties in behavioral functioning in daily life, such as difficulties in leaving the house, discussing new events, or doing domestic work with a four-point scale. This scale is internally developed by the CVT research department based on the most commonly reported or observed problems among clients in West Africa, Democratic Republic of Congo (DRC), and Jordan and the measure has been continually revised and refined to enhance reliability. And, the measure was demonstrated Cronbach Alpha $\alpha \geq 0.82$ for all participants. This indicated a good degree of reliability of a measure for collecting data for research.

C. Checklists for the torture events

The torture experiences of the participant were identified using a checklist consisting of 15 possible physical and psychological harms with open-ended options. As it stated in CVT’s group therapy manual, all these assessment instruments are reliable measures of common psychosocial indicators associated with war and torture. They have been found to be culturally acceptable in the various populations with which CVT has worked (Center for Victims of Torture, 2016).

Generally, the researcher enforced to use this existing clinical dataset which was already collected through these measures rather than gathering the new data due to the fact that: 1) the intake assessment encompasses all the relevant demographic information that the researcher intended to use 2) the measures were adopted and developed by experts from psychotherapy and psychometrics, and became refined through time 3) the data collection was conducted through face to face interview by the center Counselors and Psychosocial counselors who were familiar with the language of the client; in the healing center therapy room with in one or two sessions.
4 ) in some occasions female clients were interviewed by female Counselors or Psychosocial counselors especially in case of sexual and gender based violence ‘SGBV’ issues so that sensitive questions could be answered in a private manner 5) as a general assumption, the data collected for the clinical purpose is more valid and reliable than for conducting research since it demands great care and directly used for intervention strategies 6) the procedures of data collection met the ethical issues concerning clients’ protection and include informed consent for the use of the collected data in research and 7) the collected dataset is kept in the data base based on the assessment format by the monitoring and evaluation experts in the form of Statistical Package for Social Science( IBM SPSS software version 25).

3.5. **Data processing and analysis**

In this study, the researcher used quantitative data analysis techniques. It included descriptive statistics (percentage, frequency, mean, and standard deviation) for analyzing all demographic variables, torture events, the prevalence of behavioral functioning and PTSD symptom severity. The difference between groupings in PTSD among demographic variables were analyzed with the two-tailed independent sample t-test and one way ANOVA. Independent sample t-test was used to identify whether statistical significant mean difference in PTSD between male and female. Likewise, one way analysis of variance was used to investigate statistical significant mean difference in PTSD among age and marital status categories. In order to compute these statistical techniques the assumptions like independence collection of data, adequate sample size, homoscedasticity and homogeneity of variance were tested.
The researcher also computed simple linear regression to determine the relationship between PTSD symptom severity and behavioral functioning problems among help-seeking torture survivors. A P value of .05 was considered to be significant in the comparison of all results. All the statistical analyses were carried out by using the Statistical Package for the Social Sciences (SPSS) program version 25.

3.6. **Ethical consideration**

To make the study ethical, the researcher obtained cooperation letter from the College of Education and Behavioral Studies, School of Psychology, Addis Ababa University. Moreover, the researcher has taken an endorsement from the Center for Victims of Trauma Ethiopia by clarifying its purpose, methods, and objectives of the study and signed a data sharing agreement. The data sharing agreement has been issued between School of Psychology, Addis Ababa University and the Center for Victims of Torture. Then after, the research was conducted in accordance with the American Psychologist Association’s Ethical Code of conduct that ensures confidentiality and anonymity of the research participant.
Figure 2: Summary of the Research Methods

**Research Design and Methods**

**Research Design and Approach**
- Descriptive (Cross-sectional Survey)
- Quantitative Approach

**Types and Sources of Data**
- Quantitative data
- Secondary data (Clinical database of CVT-Ethiopia)

**Sampling**
- Population census (N=516)
- Inclusion criteria:
  - Age ≥ 18
  - Both male & female
  - Torture survivor client
  - Consented to data use

**Data Collection Measures**
- Check list (Demographic and Torture variables)
- Post-traumatic stress diagnosis scale (PTSD)
- Behavioral functioning problem scale (BFD)

**Data processing procedure**
Data were edited, coded, cleaned and computed using SPSS version 25

**Method of Data Analysis**
- Descriptive Analysis (frequency, percentage, mean and standard deviation)
- Inferential Analysis (independent sample T-test, One-way ANOVA, Pearson Correlation Coefficient)

Source: (Adopted from Creswell, 2003)
CHAPTER FOUR: RESULTS

This chapter attempted to analyze quantitative data so as to answer the basic research questions. The results of the present study are organized and presented in line with the major themes of these research questions.

4.1. Demographic information of the participants

Table 1: Participant’s demographic characteristics (N=516)

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>348</td>
<td>67.4</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>168</td>
<td>32.6</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>516</td>
<td>100.0</td>
</tr>
<tr>
<td>Age</td>
<td>Adolescent (12-18)</td>
<td>64</td>
<td>12.4</td>
</tr>
<tr>
<td></td>
<td>Early Adulthood (20-35)</td>
<td>335</td>
<td>64.9</td>
</tr>
<tr>
<td></td>
<td>Young Adulthood (35-50)</td>
<td>99</td>
<td>19.2</td>
</tr>
<tr>
<td></td>
<td>Matured Adulthood (50-80)</td>
<td>18</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>516</td>
<td>100.0</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>222</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>3</td>
<td>.6</td>
</tr>
<tr>
<td></td>
<td>Married (even if currently apart by circumstance)</td>
<td>213</td>
<td>41.3</td>
</tr>
<tr>
<td></td>
<td>Living together as a couple (but not married)</td>
<td>32</td>
<td>6.2</td>
</tr>
<tr>
<td></td>
<td>Divorced or separated (married but living apart by choice)</td>
<td>46</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>516</td>
<td>100.0</td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)
As illustrated in table 1, out of 516 participants 348(67.4%) were males and 168(32.6%) were females. With respect to age distribution, the majority of the participants were in early adulthood 335(64.9%) followed by young adulthood 99(19.2%), adolescent 64(12.4%), and Matured Adulthood 18(12.4%) with a mean of 30.08 and a standard deviation of 8.89. Relating to the marital status of the participants, most of them were single 222(43%) and married but currently apart by circumstance of forced migration 213(41.3%) and the remaining were divorced or separated (married but living apart by choice), living together as a couple but not married and widowed.
4.2. *Types of Tortures the Participants Experienced*

<table>
<thead>
<tr>
<th>Types Of Torture</th>
<th>Frequency</th>
<th>Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beating</td>
<td>406</td>
<td>78.7</td>
</tr>
<tr>
<td>Asphyxiation (choking, suffocation)</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>Deprivation (withholding basic necessities)</td>
<td>154</td>
<td>29.8</td>
</tr>
<tr>
<td>Forced to watch someone be tortured</td>
<td>64</td>
<td>12.4</td>
</tr>
<tr>
<td>Burn</td>
<td>13</td>
<td>2.5</td>
</tr>
<tr>
<td>Forced postures, stretching, or hanging</td>
<td>90</td>
<td>17.4</td>
</tr>
<tr>
<td>Sensory stress (noises, lights, etc.)</td>
<td>20</td>
<td>3.9</td>
</tr>
<tr>
<td>Torture through use of drugs (pharmacological torture)</td>
<td>20</td>
<td>3.9</td>
</tr>
<tr>
<td>Rape or sexual abuse</td>
<td>60</td>
<td>11.6</td>
</tr>
<tr>
<td>Electrical shock</td>
<td>13</td>
<td>2.5</td>
</tr>
<tr>
<td>Threats, humiliation, or other psychological torture</td>
<td>232</td>
<td>45</td>
</tr>
<tr>
<td>Wounding / maiming</td>
<td>68</td>
<td>13.2</td>
</tr>
<tr>
<td>Forced to kill / harm someone</td>
<td>9</td>
<td>1.7</td>
</tr>
<tr>
<td>Forced labor</td>
<td>65</td>
<td>12.6</td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)

As specified in table 2, among total torture survivors (N = 516), 406(78.7%) reported that they had been beaten, 232(45%) had been threatened, humiliated, psychologically tortured, or received a death threat. 90(17.4%) indicated that had suffered in forced postures, like stretching or hanging. 68(13%) had suffered in Wounding or maiming in different parts of their body. 64(12.4%) of them had been forced to watch someone being tortured and 60(11.6%) reported that they had been raped or sexually abused.
The other forms of torture that the participant experienced were asphyxiation (Choking, Suffocation), deprivation or withholding of basic necessities like food, water, light and toilet, sensory stress (Noises, Lights), tortured through use of Drugs (Pharmacological Torture), burn, electric shock and forced to kill or harm someone at 31(6%), 29(29.8%), 20(3.9%), 20(3.9%), 13(2.5%), 13(2.5%) respectively.

Moreover, 17(3.2%) of the participants reported additional tortured experience which was underground imprisonment, show food to him but they did not bring to him, tied with rob with 24 hours, tortured using insects and Stabbed gunshot in the open-ended questions.
4.3. The extent of post-traumatic stress disorder symptoms severity

Table 3: Item by item descriptive analysis PTSD symptom severity (N=516)

<table>
<thead>
<tr>
<th>Post-traumatic stress diagnosis scale</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Having repeating thoughts and memories about traumatic events when you do not want them? How much has each of these problems bothered you during the past two weeks?</td>
<td>2.42</td>
<td>0.797</td>
</tr>
<tr>
<td>2. Having repeating bad dreams or nightmares about the traumatic experience you have had? How much has each of these problems bothered you during the past two weeks?</td>
<td>2.02</td>
<td>1.012</td>
</tr>
<tr>
<td>3. Feeling like part of the trauma was happening again or that you are living the trauma again (sometimes called flashbacks)? How much has each of these problems bothered you during the past two weeks?</td>
<td>2.01</td>
<td>1.015</td>
</tr>
<tr>
<td>4. Feeling unhappy, nervous or upset by things that remind you of the traumatic event? How much has each of these problems bothered you during the past two weeks?</td>
<td>2.38</td>
<td>0.817</td>
</tr>
<tr>
<td>5. Having your body react to things that remind you of the traumatic event (like upset stomach, dizziness)?</td>
<td>2.11</td>
<td>0.907</td>
</tr>
<tr>
<td>6. Trying to avoid thoughts, feelings or conversations related to your traumatic event?</td>
<td>2.15</td>
<td>0.920</td>
</tr>
<tr>
<td>7. Trying to avoid activities, places or people that remind you of your traumatic experiences?</td>
<td>2.19</td>
<td>0.913</td>
</tr>
<tr>
<td>8. Not able to remember an important part of your traumatic experience, even when you try?</td>
<td>1.29</td>
<td>1.152</td>
</tr>
<tr>
<td>9. Feeling less interest in things that you used to enjoy?</td>
<td>2.13</td>
<td>1.003</td>
</tr>
<tr>
<td>10. Feeling emotionally distant from other people since your traumatic experience (feeling like you can’t talk or share feelings with other people)</td>
<td>2.10</td>
<td>0.997</td>
</tr>
<tr>
<td>11. Less able to feel happy since your traumatic experience?</td>
<td>2.43</td>
<td>0.825</td>
</tr>
<tr>
<td>12. Not thinking about or planning for the future as much as you did before your traumatic experience?</td>
<td>1.86</td>
<td>1.085</td>
</tr>
<tr>
<td>13. Being more irritable or angry than before your trauma experience (even if you keep it inside)?</td>
<td>2.36</td>
<td>0.859</td>
</tr>
<tr>
<td>14. Having difficulty concentrating or focusing on your thoughts?</td>
<td>2.02</td>
<td>1.012</td>
</tr>
<tr>
<td>15. Watching everything around you or feeling “extra alert” or “on guard” much of the time?</td>
<td>1.83</td>
<td>1.037</td>
</tr>
<tr>
<td>16. Being more “jumpy” to sounds or movements than before the trauma (“startling” easier than before)?</td>
<td>1.95</td>
<td>1.010</td>
</tr>
</tbody>
</table>

(Source: own survey data May, 2019)
As can be seen in table 4, the descriptive analysis (i.e. the mean and standard deviation) was computed to each of 16 Posttraumatic Stress Disorder Symptom items. The items were rated on a 4-point rating scale with the representation of 0: not at all, 1: rarely, 2: sometimes and 3: often distressed by the symptoms. After all, the mean score was established by adding up each rating then divided by the number of rating resulted in a mean of 1.5 as an empirical cut-off point to determine the severity of each symptom. Therefore, the finding of mean statistics depicted that except one PTSD symptom which is “not thinking about or planning for the future as much as they did as before your traumatic experiences” were above the theoretical mean of score 1.5 that directly indicated the presence posttraumatic stress disorder (PTSD) Symptoms.

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild (1-10)</td>
<td>14</td>
<td>2.7</td>
</tr>
<tr>
<td>Moderate (11-20)</td>
<td>24</td>
<td>4.7</td>
</tr>
<tr>
<td>Moderate to severe (21-35)</td>
<td>182</td>
<td>35.3</td>
</tr>
<tr>
<td>Sever (≥36)</td>
<td>296</td>
<td>57.4</td>
</tr>
<tr>
<td>Total</td>
<td>516</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)

As can be depicted from table 4, 296 (57.4%) of participants had reported the severe level of post-traumatic stress symptom, 182(35.3%) moderate to severe, 24(4.7%) and the rest 14(2.7%) mild level of PTSD symptoms in Post-traumatic diagnosis scale. This result confirmed that most of the respondent over 57.4% had suffered from the symptoms of post-traumatic stress disorder. These implied that each participant of this study has faced mild to severe symptoms of post-traumatic stress disorder.
4.4. The relationship between PTSD and demographic characteristics of the participant (i.e. gender, age, and marital status)

4.4.1. Gender difference in post-traumatic stress disorder symptom severity

Table 5: Independent Samples t-test result of Gender difference in PTSD

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>df</th>
<th>t-value</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>348</td>
<td>34.38</td>
<td>10.406</td>
<td>514</td>
<td>-4.451</td>
<td>.000</td>
</tr>
<tr>
<td>Woman</td>
<td>168</td>
<td>38.19</td>
<td>8.419</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note p* significant at .05 level (2-tailed)
(Source: own data survey May, 2019)

An independent samples t-test was conducted to compare post-traumatic stress disorder symptom severity for male and female respondents. As shown in table 5, results from an independent samples t-test revealed that there was a statistically significant difference on post-traumatic stress disorder symptom severity scores for males (M=34.38, SD=10.406), and females (M=38.19, SD=8.42); df (514)= -4.451, p≤0.05. So, females were reported more than males in post-traumatic stress disorder symptom severity.

Then the effect size was computed through Eta Squared. Eta squared = \( \frac{t^2}{t^2 + (N_1+N_2-2)} \) = \( \frac{(-4.435)^2}{(-4.435)^2 + (348+168-2)} \) = 0.037. Therefore, the result of Eta squared depicted that the magnitude of the difference in means was very small (Eta squared=0.037).
4.4.2. Age difference in post-traumatic stress disorder

Table 6: Descriptive summary result of Age difference in PTSD Symptom Severity

<table>
<thead>
<tr>
<th>PTSD symptom severity</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent</td>
<td>64</td>
<td>35.3</td>
<td>9.636</td>
<td>1.204</td>
<td>32.89</td>
<td>37.7</td>
<td>4</td>
</tr>
<tr>
<td>Early Adulthood</td>
<td>335</td>
<td>36.2</td>
<td>9.355</td>
<td>0.511</td>
<td>35.2</td>
<td>37.21</td>
<td>1</td>
</tr>
<tr>
<td>Young Adulthood</td>
<td>99</td>
<td>33.51</td>
<td>10.827</td>
<td>1.088</td>
<td>31.35</td>
<td>35.66</td>
<td>1</td>
</tr>
<tr>
<td>Matured Adulthood</td>
<td>18</td>
<td>33.67</td>
<td>10.997</td>
<td>2.592</td>
<td>28.2</td>
<td>39.14</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>516</td>
<td>35.48</td>
<td>9.779</td>
<td>0.43</td>
<td>34.64</td>
<td>36.33</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)

As presented in table 6, the majority of the participants were early adulthood followed by young adulthood, adolescent and matured adulthood.

Table 7: One way ANOVA summary result of Age difference in PTSD Symptom Severity

<table>
<thead>
<tr>
<th>Source: own data survey May, 2019</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>622.572</td>
<td>3</td>
<td>207.524</td>
<td>2.185</td>
<td>0.089</td>
</tr>
<tr>
<td>Within Groups</td>
<td>48624.304</td>
<td>512</td>
<td>94.969</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>49246.876</td>
<td>515</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)
As it is presented in table 6 and 7, a one-way between-group analysis of variance was conducted to explore the impact of age on the level of PTSD symptom severity as it measured by post-traumatic diagnosis scale. The participants of the study were divided into four groups according to their age (i.e. Adolescent, Early adulthood, Young adulthood and Matured adulthood). These revealed that there was no statistically significant difference at the p≤0.05 level in post-traumatic diagnosis scale for the four age groups \([F (3,512) =2.185, \text{Sig} =.089]\).

### 4.4.3. Marital status difference in post-traumatic stress disorder symptom severity

**Table 8: Descriptive summary result of the marital status difference in PTSD Symptom Severity**

<table>
<thead>
<tr>
<th>PTSD symptom severity</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Single</td>
<td>222</td>
<td>34.74</td>
<td>9.760</td>
<td>.655</td>
<td>33.45</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>38.00</td>
<td>11.136</td>
<td>6.429</td>
<td>10.34</td>
</tr>
<tr>
<td>Married (even if currently apart by circumstance)</td>
<td>213</td>
<td>36.30</td>
<td>9.794</td>
<td>.671</td>
<td>34.98</td>
</tr>
<tr>
<td>Living together as a couple (but not married)</td>
<td>32</td>
<td>37.53</td>
<td>8.497</td>
<td>1.502</td>
<td>34.47</td>
</tr>
<tr>
<td>Divorced or separated (married but living apart by choice)</td>
<td>46</td>
<td>33.70</td>
<td>10.341</td>
<td>1.525</td>
<td>30.62</td>
</tr>
<tr>
<td>Total</td>
<td>516</td>
<td>35.48</td>
<td>9.779</td>
<td>.430</td>
<td>34.64</td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)

**Table 9: One way ANOVA summary result of marital status difference in PTSD Symptom Severity**

<table>
<thead>
<tr>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>564.033</td>
<td>4</td>
<td>141.008</td>
<td>1.480</td>
</tr>
<tr>
<td>Within Groups</td>
<td>48682.843</td>
<td>511</td>
<td>95.270</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>49246.876</td>
<td>515</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)
As it depicted from table 8 and 9, a one-way between-group analysis of variance (ANOVA) was computed to analyze the influence of marital status on the level of PTSD symptom severity as it measured by post-traumatic diagnosis scale. The participants of the study were categorized into five groups according to their marital status (i.e. single, widowed, married (even if currently apart by circumstance), living together as a couple (but not married) and divorced or separated (married but living apart by choice). This revealed that there was no statistically significant difference at the p≤0.05 level in post-traumatic diagnosis scale for the five age groups [F (4,511) =1.4, Sig. =.207].
### 4.5. Behavioral functioning problems of torture survivors

Table 10: Descriptive summary result for Behavioral functioning problems of torture survivors through item by item analysis based on the response categories

<table>
<thead>
<tr>
<th>Items</th>
<th>Response categories</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty doing domestic work since your traumatic experiences?</td>
<td>Not at all</td>
<td>168</td>
<td>32.6</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>80</td>
<td>15.5</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>151</td>
<td>29.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>117</td>
<td>22.7</td>
</tr>
<tr>
<td>2. Difficulty leaving the house since your traumatic experiences?</td>
<td>Not at all</td>
<td>154</td>
<td>29.8</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>77</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>126</td>
<td>24.4</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>159</td>
<td>30.8</td>
</tr>
<tr>
<td>3. Difficulty engaging in income-generating activities since your traumatic experiences?</td>
<td>Not at all</td>
<td>202</td>
<td>39.1</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>80</td>
<td>15.5</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>118</td>
<td>22.9</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>116</td>
<td>22.5</td>
</tr>
<tr>
<td>4. Difficulty engaging in religious or spiritual activities since your traumatic experiences?</td>
<td>Not at all</td>
<td>235</td>
<td>45.5</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>81</td>
<td>15.7</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>104</td>
<td>20.2</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>96</td>
<td>18.6</td>
</tr>
<tr>
<td>5. Difficulty doing activities like playing games, sports, or dancing since your traumatic experiences?</td>
<td>Not at all</td>
<td>129</td>
<td>25.0</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>58</td>
<td>11.2</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>123</td>
<td>23.8</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>206</td>
<td>39.9</td>
</tr>
<tr>
<td>6. Difficulty enjoying entertainment (such as listening to the radio) since your traumatic experiences?</td>
<td>Not at all</td>
<td>163</td>
<td>31.6</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>66</td>
<td>12.8</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>155</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>132</td>
<td>25.6</td>
</tr>
<tr>
<td>7. Difficulty visiting friends or relatives since your traumatic experiences?</td>
<td>Not at all</td>
<td>127</td>
<td>24.6</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>58</td>
<td>11.2</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>137</td>
<td>26.6</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>194</td>
<td>37.6</td>
</tr>
<tr>
<td>8. Difficulty thinking about or discussing the future since your traumatic experiences?</td>
<td>Not at all</td>
<td>125</td>
<td>24.2</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>82</td>
<td>15.9</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>166</td>
<td>32.2</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>143</td>
<td>27.7</td>
</tr>
<tr>
<td>9. Difficulty thinking about going back to your country of origin (feeling fear or distress when thinking about returning in the current situation)?</td>
<td>Not at all</td>
<td>36</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>36</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>100</td>
<td>19.4</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>344</td>
<td>66.7</td>
</tr>
<tr>
<td>10. Difficulty discussing news, current events, or politics since your traumatic experiences?</td>
<td>Not at all</td>
<td>101</td>
<td>19.6</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>59</td>
<td>11.4</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>133</td>
<td>25.8</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>223</td>
<td>43.2</td>
</tr>
</tbody>
</table>

(Source: own data survey May, 2019)
In order to explore the behavioral functioning difficulties of the clients during the past two weeks, 10 items with a four-point scale were administered for the participants. They were rated each item to determine the extent of the problem the clients face in their daily routine by saying 1= not at all, 2= rarely, 3= some times and 4=often. As can be seen in table 10, majority of the participants around 444(86%) had reported difficulty in thinking about going back to their country of origin (feeling fear or distress when thinking about returning in the current situation). However, around 235(45%) participants had reported that less difficulty in engaging religious or spiritual activities since their traumatic experiences. So, engaging in religious or spiritual activities may help as a protective factor those who faced severe physical and psychological torture the clients experienced. This implied that the participant had behavioral functioning difficulties in their daily living as a result of their traumatic experience.
4.6. The relationship between Post-traumatic stress disorder and Behavioral functioning problems of torture survivors

Table 11: The relationship between Post-traumatic stress disorder and behavioral and functional difficulty through linear regression

<table>
<thead>
<tr>
<th>Model summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

ANOVA a

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>8906.485</td>
<td>1</td>
<td>8906.485</td>
<td>250.165</td>
</tr>
<tr>
<td>Residual</td>
<td>18299.66</td>
<td>514</td>
<td>35.602</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>27206.145</td>
<td>515</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coefficient a

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
</tr>
<tr>
<td>1. (Constant)</td>
<td>11.369</td>
<td>0.99</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>0.425</td>
<td>0.027</td>
</tr>
</tbody>
</table>

a Dependent Variable: Behavioral functioning difficulty

( Source: own data survey May, 2019)

As presented in table 11, a simple linear regression was calculated to predict behavioral functioning difficulty based on post-traumatic stress disorder. A significant regression equation was found (F (1,514) = 250.165, p<.000), with of 0.327. The participants’ predicted behavioral functioning difficulty is equal to 11.794 (11.369+0.425) PTSD in post-traumatic diagnosis scale when behavioral functioning difficulty measured in behavioral functioning scale. So, participant’s behavioral functioning difficulty increased 0.425 for each post traumatic diagnosis scale of PTSD. This indicated that post-traumatic stress disorder helps to explain 32.7 percent of the variance in respondents’ scores on the behavioral and functional difficulty in the scale.
CHAPTER FIVE: DISCUSSION

In this chapter, the results presented in the previous section are discussed. An attempt is made to discuss the major findings of the current study in line with previous research findings reviewed in the literatures. And, the discussion is presented based on the order of research objectives and major findings of the current study.

5.1. Types of Tortures the refugees’ encountered

The participants of this study have requested to answer the basic question “Have you ever been tortured?”; and all of them were confirmed and listed out the types of torture encountered in their life. The finding of the current study has revealed that the participants were suffering by more than one type of torture or forced to watch others being tortured in their country of origin and while crossing the border. Similar to this the International Society for Traumatic Stress Studies (n.d.) stated that refugees are typically exposed to multiple types of traumatic events in their countries of origin and during displacement. These events are often repeated, prolonged and interpersonal in nature, and have been demonstrated to have a deleterious effect on mental health.

In the present study, among 516 torture survivor respondents 406(78.7%) reported that they had been beaten, 232(45%) had been threatened, humiliated, psychologically tortured, or received a death threat. 90(17.4%) indicated that had suffered in forced postures, like stretching or hanging. 68(13%) had suffered in wounding or maiming in a different part of their body. 64(12.4%) of them had been forced to watch someone being tortured and 60(11.6%) reported that they had been raped or sexually abused.
The other forms of torture that the participant experienced were asphyxiation (Choking, Suffocation), deprivation or withholding of basic necessities like food, water, light and toilet, sensory stress (Noises, Lights), tortured through use of Drugs (Pharmacological Torture), burn, electric shock and forced to kill or harm someone at 31(6%), 29(29.8%), 20 (3.9%), 20 (3.9%), 13 (2.5%), 13 (2.5%) respectively. Moreover, 17(3.2%) of the participants reported additional torture experiences which were underground imprisonment, show food to them but they did not bring to them, tied with rob with 24 hours, tortured using insects and Stabbed gunshot. Similarly, a representative survey was conducted to assess refugee mental health in Ethiopia at Adi Harush and Mai Ayni refugee Camps by Golden (2017) explicitly revealed that after being offered a simple, brief definition of torture, a combined total of 40 percent of respondents reported that they had personally been tortured. This suggests that over 5,500 adults in these camps were likely to have experienced torture. Overall, 28 percent reported that someone in their family or in their household had been tortured. Finally, 60 percent speculated that they thought many people in their community had been tortured.

Likewise, according to Hondius, Willigen, and Kleijr (2000) the study conducted among Latin-American and Middle-Eastern Refugees revealed that most of the refugees knew friends or family members who were victims of violence (60-91%). Many reported having been imprisoned themselves, especially men (60%) in one study; and (86%) men and (77%) of women in another study. Being imprisoned, many suffered physical torture; the most frequently mentioned incidents were beating and kicking events among men (51-71%). Psychological forms of torture were also frequently mentioned. Threats of violence or being forced to witness torture were among the most reported incidents.
In agreement with this, potentially traumatic events commonly experienced by refugees and asylum-seekers in their home countries include interpersonal violence, sexual violence, life-threatening injuries, witnessing the murder of loved ones, and torture. People living in conflict-affected areas also report high levels of exposure to events such as injury, witnessing the deaths of others, terrorist attacks, and lack of food, water, shelter or medical care. As a function of persecution and conflict, refugees and asylum-seekers also often experience the death and/or disappearance of loved ones. While the extent of exposure to traumatic events may vary according to several factors including area/country of origin, characteristics of conflict and personal factors such as gender, age, ethnicity and sexual orientation, the dosage of exposure to traumatic events prior to displacement is commonly high amongst refugees and asylum-seekers (Asnaani, Jessica, Mina, Christine, Naser and Frank, 2018). These findings were also consistent with many other findings. A research conducted on Kurdish refugees to identify experiences of torture, participants reported that having been exposed to between 0 and 24 torture events (M = 4.23, SD = 5.21). Thirty-eight out of the 91 participants reported having experienced at least two events of torture; 38 (41.8%) of participants were exposed to rain or cold, 28 (30.8%) exposed to strong heat, sun, or light and 25 (27.5%) were deprived of food and water (Ibrahim & Hassan, 2017). A research done to examine the refugee mental health confirmed that among 179 screened at Roselawn Healtheast from May 2011-2013 had reported 27% and 51% of primary secondary torture respectively. The modalities of torture reported by survivors were forced labor, forced to be a soldier, forced to be a landmine sweep, beating, wounding, maiming or breaking bones, immobilization (being bound or tied up), degradation, threats, death threats, torture as witness and forced to bury body of family member who died from torture (Shannon & Letts, 2014).
Consistent with these all a research conducted entitled with factor structure of PTSD symptoms among west and central African refugees revealed that all participants reported at least one trauma experience related to political or ethnic violence. The most common experience involved physical assault (n=343, 85.8%). Other experiences included deprivation of food, water, or medical needs (n=114, 28.5%), sexual assault (n=111, 27.8%), being forced to witness the abuse of others (n=95, 23.8%), extended forced postures (n=51, 12.8%), degradation (e.g., forced nakedness in front of family, abuse with excrement; n=50, 12.5%), being burned (n=39, 9.8%), stress to senses (e.g., being bound; exposure to extreme heat; n=38, 9.5%), electric shock (n=25, 6.3%), pharmacological manipulation (n=10, 2.5%), asphyxiation (n=6, 1.5%), and amputation (n=3, 0.8%) (Rasmussen et al., 2007).

5.2. Post-traumatic stress disorder among torture survivor refugees

As can be illustrated in the result section, the descriptive analysis (i.e. the mean and standard deviation) was computed to each 16 Posttraumatic Stress Disorder symptom items. The mean score was established by adding up each rating then divided by the number of rating resulted in a mean of 1.5 as a theoretical cut-off point to determine the severity of each symptom. Therefore, finding of this statistics depicted that except one PTSD symptom which was “Not thinking about or planning for the future as much as I did before your traumatic experience” were above the mean score of 1.5 that indicated the presence posttraumatic stress disorder (PTSD).

Moreover, from the total 516 participants 296 (57.4%) of them had reported severe post-traumatic stress symptom, 182 (35.3%) moderate to severe, 24(4.7%) and the rest 14 (2.7%) mild level of PTSD symptoms in Post-traumatic diagnosis scale in reference to the clinical cut-off scores established. This result confirmed that most of the respondent over 57.4% had suffered from the symptoms of post-traumatic stress disorder.
This result was replicated previous findings of Ibrahim & Hassan (2017) that the prevalence of PTSD symptoms among Syrian Kurdish refugees in association with torture and other traumatic events were from the total sample, 38.46% reported PTSD symptoms in the clinical range using the 45-item total scale, and 35.16% met criteria on the first 16 symptom items of HTQ using established clinical cut-off scores. Similarly, findings of traumatic stress disorder (PTSD) are based on a published model were severe PTSD prevalence in population exposed to a high level of political terror and traumatic events was estimated at 12.4% (95%CI 8.5–16.7) and was 19.8% (95%CI 14.0–26.3) for severe depression. Across all six population (total population 1,236,600), the conflict could be associated with 123,200 (71,600–182,400) cases of severe PTSD and 228,100 (134,000–344,200) cases of severe depression; 50% of PTSD cases were estimated to co-occur with severe depression (Charlson et al., 2012).

5.3. PTSD and Demographic Variables (i.e. gender, age, and marital status)

5.3.1. Gender difference in post-traumatic stress disorder

An independent samples t-test was conducted to compare post-traumatic stress disorder symptom severity for male and female respondents. The results from an independent samples t-test that is two-tailed unequal variances revealed that there was a statistically significant difference on post-traumatic stress disorder symptom severity scores for males. So, females were reported more than males in post-traumatic stress disorder symptom severity with the effect size .037 computed through Eta Squared.

Consistent with this finding the higher prevalence of PTSD in women is a function of the gender difference in the conditional probability of PTSD. Women are approximately twice as likely as men to succumb to PTSD following traumatic events.
Even when cases with rape are excluded or when the event type is controlled, women have a higher rate of PTSD following traumatic experiences than do men (Breslau, 2002).

This confirmed that from the entire population, an estimated 6.8% of Americans had experience PTSD at some point in their lives. Women (9.7%) are more than two and a half times as likely as men (3.6%) to develop Post-traumatic stress disorder (National Center for Posttraumatic Stress Disorder, 2010). Moreover, a study conducted to identify traumatic events and symptoms of post-traumatic stress disorder amongst refugees in Sudan revealed that significantly higher numbers of refugee females suffer from symptoms of PTSD than their male counterparts (Karunakara et al., 2004).

It is also supported by the study conducted to determine the lifetime prevalence of trauma experiences and post-traumatic stress disorder insured that increased vulnerability in women when compared with men because gender made a significant contribution to predicting PTSD (Frans, Rimmo and Berg, 2005). More importantly, PTSD is more prevalent among females than among males across the lifespan, females in the general population experience PTSD for a longer duration than do males. At least some of the increased risk for PTSD in females appears to be attributable to a greater likelihood of exposure to traumatic events, such as rape, and other forms of interpersonal violence. Within populations exposed specifically to such stressors, gender differences in risk for PTSD are nonsignificant (American Psychiatric Association, 2013).

In contrast, the finding by Ibrahim and Hassan (2017) stated that gender differences in PTSD symptoms, the resulted from two-tailed $t$-tests (unequal variances) showed that there were no significant differences in PTSD symptoms between females and males.
5.3.2. Age difference in post-traumatic stress disorder

As it is presented in the result section, one-way between-group analysis of variance was conducted to explore the impact of age on the level of PTSD symptom severity as it measured by post-traumatic diagnosis scale. The participants of the study were divided into four groups according to their age (i.e. Adolescent, Early adulthood, Young adulthood and Matured adulthood). These revealed that there was no statistically significant difference at the \( p \leq 0.05 \) level in post-traumatic diagnosis scale for the four age groups.

This result was supported by a research finding by Ibrahim & Hassan (2017) they depicted that there was no statistically significant correlation between PTSD symptoms in age.

5.3.3. Marital status difference in post-traumatic stress disorder

A one-way analysis of variance (ANOVA) was computed to analyze the influence of marital status on the level of PTSD symptom severity as it measured by post-traumatic diagnosis scale. The participants of the study were categorized into five groups according to their marital status (i.e. single, widowed, married (even if currently apart by circumstance), living together as a couple (but not married) and divorced or separated (married but living apart by choice). These revealed that there was no statistically significant difference at the \( p \leq 0.05 \) level in post-traumatic diagnosis scale for the five age groups. Consistent with this finding, a study conducted by Gold et al. (2012) confirmed that there was no significant difference found between the PTSD and marital status of the participant as an independent variable.
5.4. Behavioral functioning problems of torture survivors

In the present study, majority of the participants around 444 (86%) had reported difficulty in thinking about going back to their country of origin (feeling fear or distress when thinking about returning in the current situation in their daily routine). This implied that the participants had behavioral functioning difficulties in their daily living after exposing traumatic experience. However, they had reported the smallest score in difficulty engaging in religious or spiritual activities since their traumatic experiences.

The results of the present study generally replicated findings from some previous studies. Diagnosis and statistical manual for mental disorder fifth edition revealed that PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical utilization. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains.

In community and veteran samples, PTSD is associated with poor social and family relationships, absenteeism from work, lower income, and lower educational and occupational success (American psychiatric association, 2013).

Moreover, similar to the present result, high-intensity arousal symptoms of PTSD produced sleep disturbance, irritability, angry outbursts, poor concentration, hypervigilant behavior and an exaggerated startle response. The syndrome is frequently complicated by alcohol abuse or dependence, and less frequently by other substance misuse disorders. There is a high rate of comorbid with depression. The combined effects of these psychopathologies on occupational function and interpersonal relationships can be devastating. Thus the syndrome not only affects the sufferer but also spouse, family, friends, and workmates (John & Sons, 1996).
5.5. The relationship between Post-traumatic stress disorder and Behavioral functioning problems of torture survivors

A simple linear regression was computed to determine the relationship between Post-traumatic stress disorder (as it measured by posttraumatic diagnosis scale) and behavioral and functional difficulty (as it is measured by behavioral functioning problem scale) of torture survivors. There was a moderate positive correlation between the two variables. Then, the coefficient of determination was computed through squaring the correlation gives 32.49 percent shared variance. This indicated that post-traumatic stress disorder helps to explain 32.49 percent of the variance in respondents’ scores on the behavioral and functional difficulty in the scale.

Similarly, as the National Center for PTSD (2010) symptoms of post-traumatic event lead to impairment of the person’s ability to function in social or family life, including occupational instability, marital problems and family problems. As described in the article, a path analysis conducted to make a model of suicidal behavior in PTSD. In the final model, two paths to suicidal behavior were identified. The first path was acting on suicidal behavior by exacerbating the severity of life impairment. Life impairment was directly associated with low levels of occupational impairment, which in turn was associated with greater social functioning impairment (Panagioti, Gooding, Dunn & Tarrier, 2011).
CHAPTER SIX: SUMMARY, CONCLUSION AND RECOMMENDATION

6.1. Summary
The major objective of this study was to examine post-traumatic stress disorder among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps. Accordingly, the study had tried to answer the following five basic research questions:

1) What are the types of torture among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps?

2) What is the extent of PTSD symptom severity among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps?

3) Is there a statistically significant difference in demographic variables (i.e. gender, age and marital status) in PTSD among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps?

4) To what extent help-seeking torture survivors of Eritrean refugees face behavioral functioning difficulties in their daily living?

5) Is there a relationship between PTSD and behavioral functioning problems of torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee camps?

In order to answer the basic research questions a cross-sectional survey design with quantitative approach were implemented. The participants of this study were 516 (348 males and 168 females) torture survivor Eritrean refugees, adolescent and adult clients which were identified from the clinical database of the Center for Victim of Trauma Ethiopia through population census.
The instruments used for data collection were designed by the center’s psychologists and researchers for its program. The measures were comprehensive intake that comprises detailed torture assessment and mental health screening measures included for PTSD called Post-Traumatic Stress Diagnostic Scale (PD-S), Behavioral and Functioning Problems Scale and checklists. Descriptive statistics (frequencies, percent, means, and standard deviations) were used for analyzing all demographic variables, types of torture, PTSD symptom severity and behavioral functioning difficulties. The difference between groups were analyzed with the two-tailed independent sample t-test and one-way ANOVA. The relationship between PTSD symptom severity and behavioral functioning difficulties was tested with linear regression. A P value of .05 was considered to be significant in the comparison of results.

The results of the present study revealed that: the participants were exposed to more than one types of torture and the majority of the respondents reported that 406(78.7%) they had been beaten and 232(45%) psychologically tortured. Regarding the severity of posttraumatic stress disorder, from the total 516 participants, 478(92.7%) had moderate to severe symptoms of post-traumatic stress disorder. There was a statistically significant difference in post-traumatic stress disorder symptom severity in gender in which female suffered more than male. However, there were no statistically significant differences in post-traumatic stress disorder symptom severity among the age and marital status categories. Majority of the participants had behavioral functioning problems in their daily living as a result of their torture experiences especially thinking about going back to their country of origin (feeling fear or distress when thinking about returning in the current situation). There was a moderate positive correlation between Post-traumatic stress disorder and behavioral and functional difficulty among help-seeking torture survivors of Eritrean refugees. And, post-traumatic stress disorder helps to explain 32.49 percent of the variance in respondents’ scores on the behavioral and functional difficulty in the scales.
6.2. Conclusion

This study was conducted to examine post-traumatic stress disorder among help-seeking torture survivors of Eritrean refugees at Mai Ayni and Adi Harush refugee campus. In order to realize this purpose, five specific objectives were established. Therefore, in light of these objectives of the study and discussion of the results made above, the researcher draws the following conclusions.

- The participants of the present study were encountered more than one type of torture or forced to watch others being tortured in their country of origin or while crossing the border. The majority of the respondent 406(78.7%) and 232(45%) had reported that they had been beaten and threatened, humiliated, psychologically tortured, or received a death threat respectively.

- Regarding the severity of posttraumatic stress disorder (PTSD), the respondents had experienced PTSD in each symptom. And, from the total 516 participants, 478(92.7%) had reported severe to moderate symptoms of post-traumatic stress disorder with reference to the clinical cut-off. So, these directly indicated that torture survivors of Eritrean refugees had suffered and exposed to post-traumatic stress disorder in a very high degree of severity.

- There was a statistically significant difference in post-traumatic stress disorder symptom severity in gender in which females had reported more than males among torture survivor Eritrean refugees.

- With respect to age and marital status, there were no statistically significant differences in post-traumatic stress disorder symptom severity among torture survivor Eritrean refugees.
• Majority of the participants had behavioral functioning problems in their daily living as a result of their torture experience especially thinking about going back to their country of origin (feeling fear or distress when thinking about returning in the current situation).

• There was a moderate positive correlation between Post-traumatic stress disorder and behavioral and functional difficulty among help-seeking torture survivors of Eritrean refugees. And, post-traumatic stress disorder helps to explain 32.49 percent of the variance in respondents’ scores on the behavioral and functional difficulty in the scales.

• Generally, the results of this study supported findings from the literature about PTSD symptoms, torture, and other war-related trauma in the refugee setting. The findings of the study have possible applications for local and international governments, human right and mental health organizations, especially for those who provide psychosocial support programs for Eritrean refugees.
6.3. **Recommendations**

Eritrean refugees in Ethiopia had experienced torture events and had reported moderate to severe level of symptoms of PTSD and behavioral functioning difficulty in their daily living. Therefore, the researcher would like to recommend the following points for the respective stake holders:

A. **Implication for National and International Organizations**

- The national and international organizations such as ARRA-Ethiopia and UNHCR should advocate acts against human rights abuses and the implementation of international treaties prohibiting the use of torture by taking the mental health impact of torture into account. They should aware of the mental health impact of torture and should protect the citizens from such a brutal act of inhumane treatment.

- The policy makers of national and international organizations should encourage the mental health providers to ensure refugees and conflict-affected societies, especially for the torture survivors. So, mental health and psychosocial support (MHPSS) programs should be facilitated to bring positive mental health outcomes amongst refugees via enhancing the capacity of the individual for resilience and strengthening family and community supports.

B. **Implication for Mental health service providers**

- Since female torture survivor refugees were more vulnerable to PTSD, the mental health providers should give special emphasis to them. For instance: motivating the female torture survivor clients to use psychotherapy service through creating comfortable helping relationship.
According to the present study as well as the National Center for PTSD (2010) PTSD can be treated with psychotherapy (“talk” therapy) and medications such as antidepressants. Early treatment is important and may help reduce long-term symptoms. Unfortunately, many people do not know that they have PTSD or do not seek treatment. Therefore, the mental health service workers for torture survivor refugees should provide the treatment either psychotherapy or medical as soon as possible to mitigate the long-lasting impact of the disorder to meet their intended objectives.

The mental health providers and victims of torture survivor should be aware of the resilience factors that may reduce the risk of PTSD include: seeking out support from other people, such as friends and family, finding a support group after a traumatic event, try to spend time with other people and confide in a trusted friend or relative, learning to feel good about one’s own actions in the face of danger, having a coping strategy, or a way of getting through the bad event and learning from it, and being able to act and respond effectively despite feeling fear.

C. Implication for Researchers

Finally, since this research was conducted based on cross-sectional data at a point of time, it is recommended to fellow researchers to carry out longitudinal type with other equivalent measures to examine the duration of PTSD symptoms that is the course of the disorder on the torture survivor refugees or in another similar setting. Moreover, it is also recommended using qualitative methods to describe the experience of torture survivors in detail.
REFERENCES


International Society for Traumatic Stress studies. (n.d.). *Trauma and Mental Health in Forcibly Displaced Populations An International Society for.*


APPENDIX A: THE INSTRUMENT OF THE COLLECTED DATA (ENGLISH VERSION)

<table>
<thead>
<tr>
<th>ADMINISTRATIVE BOX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of pre-screening:</td>
</tr>
<tr>
<td>___________________</td>
</tr>
<tr>
<td>□ Completed consent?</td>
</tr>
<tr>
<td>□ Consent to data use?</td>
</tr>
<tr>
<td>Initials: ____________</td>
</tr>
</tbody>
</table>

| CLIENT’S ID: | ________________ |

**PSC at Intake: First Name:** Last Name:
| ___________________ | ___________________ |

**Trainer at Intake: First Name:** Last Name:
| ___________________ | ___________________ |

**C.S. at Intake:** First Name: Last Name:
| ___________________ | ___________________ |

**First Intake Session Date:** ________________  
**Treatment Location:** ________________

dd/mm/yyyy

1. **Client’s Name:**
First Name: _____________________________ Grandfather Initial: ________________

2. **Gender:**
☐ Man ☐ Woman

ASK THE CLIENT QUESTIONS DIRECTLY, USING THE BOLD WORDS WRITTEN ON THE FORM. YOU CAN USE ADDITIONAL PROMPTS IF NEEDED. DO NOT READ THE NOTES UNDER THE QUESTIONS. DO NOT READ THE ANSWER OPTIONS UNLESS NOTED.

3. **How did you learn about CVT?**
Check all that apply. If selecting “From another NGO or agency” or “Other,” fill in the blank.

☐ From a family member or friend  ☐ From another NGO or agency:
| ___________________ |

☐ From a CVT staff member
| ___________________ |

☐ From a former or current CVT client  ☐ Other:
| ___________________ |

☐ From a CVT event
| ___________________ |
What is the main reason you have come to CVT?

**READ TO CLIENT:**
Today I would like to ask you questions about your life and your experiences. I’ll ask you about where you come from, your current situation, your relationships, your health, your past experiences, and problems you’re facing. This conversation will help me get to know you and understand you. There are no right answers or wrong answers to these questions. If I ask you any question that you don’t want to answer or if you want to take a break, just tell me so. I want you to be comfortable throughout this discussion.

First, I’ll ask for some basic information about you.

**DEMOGRAPHICS INFORMATION**

4. What is your home country?
   ○ Eritrea       ○ Ethiopia       ○ Other: __________

5. Where do you live now?
   ○ Mai Ayni       ○ Adi Harush       ○ Other: __________

6. How old are you? __________ years

7. What language/s do you speak?
   *Check all that apply.*
   ☐ Tigrigna       ☐ Kunama       ☐ Arabic       ☐ Other: __________
   ☐ Saho       ☐ Amharic       ☐ Other: __________
   ☐ Tigre       ☐ English
8. What is your religion?
*If the client is Muslim, do NOT ask specifically about sect. Check the appropriate boxes ONLY if the client specifically mentions their sect through the course of their history; otherwise, select “Not able to determine.”*

- ☐ Muslim –
- ☐ Sunni
- ☐ Shi’a
- ☐ Not able to determine
- ☐ Sabian
- ☐ Catholic
- ☐ Orthodox Christian
- ☐ Protestant or Anglican
- ☐ Pentecostal or born again
- ☐ Christian – other or no denomination
- ☐ Jewish
- ☐ Indigenous, traditional, or folk religion
- ☐ No religion
- ☐ Other: _____________________

9. What is your primary ethnicity?
*Select only one.*

- ☐ Tigrigna
- ☐ Tigre
- ☐ Tigrigna
- ☐ Other: ____
- ☐ Saho
- ☐ Kunama

10. Do you currently attend an educational program or institution?

- ☐ Yes
- ☐ No

11a. Have you and your family been able to access schools or other education that you have wanted in your current community?

- ☐ Yes
- ☐ No

11b. If no: Why not?
*Check all that apply.*

- ☐ Lack of funds
- ☐ No education available
- ☐ School is too far away
- ☐ Lack of documents/IDs
- ☐ Bullying
- ☐ Legally unable to register
- ☐ Discrimination
- ☐ Other: ______________

12. Have you completed…
*Select “Yes” or “No” for each level*

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary or elementary education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical, vocational, or trade school?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University (bachelor’s)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-graduate (masters or doctorate)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13. Altogether, how many years of education do you have?
Write the number of whole years of formal education, rounding down (if the client says 1.5 years, write 1). Write 0 for no formal education.

______________ years

ECONOMICS

READ TO CLIENT:
The next questions are about your work, income, and how you support yourself or your family.

14a. What is your main work or activity right now?
Select only one. Do not read the response options to the client.

- Employed (working at a job)
- Self-employed (work that could include own business, farming, etc)
- Student
- Retired or pensioner
- Military
- Unemployed and looking for work
- Cannot work due to permanent disability
- Cannot work due to legal status
- None of the above (includes staying at home by choice to take care of children or household)

14b. If client is working (employed or self-employed): In what area do you primarily work?
Write the client’s response below and then select one option.

- Farming
- Fishing, livestock, forestry
- Industry (manufacturing finished goods)
- Commerce (buying or selling goods and services)
- Construction
- Education
- Services (not making products but providing time, knowledge, or skills)
- Public sector (government or politics)
- Other: ______________________

15. In what area did you primarily work before leaving home?
Write the client’s response below and then select one option.

- Did not work (includes students)
- Farming
- Fishing, livestock, forestry
- Industry (manufacturing finished goods)
- Commerce (buying or selling goods and services)
- Construction
- Education
- Services (not making products but providing time, knowledge, or skills)
- Public sector (government or politics)
- Military
- Other: ______________________
16. Do you currently have money for basic necessities? Do you never, rarely, frequently or always have money for things like food or clothing?
   ○ Never ○ Frequently
   ○ Rarely ○ Always

17. Does your family have money to send the children to school? Do you never, rarely, frequently or always have money required for school?
   ○ Never ○ Always ○ Not
   ○ Rarely Frequently applicable

18. On an average day, how many meals do you eat?
   ○ Less than 1 ○ 1 meal ○ 2 meals ○ 3+ meals

19. In the past week, have you eaten...
   Select “Yes” or “No” for each question.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green vegetables?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20a. Do you currently have shelter?
   ○ Yes ○ No

20b. If yes: Do you think it’s safe and comfortable enough for you?
   ○ Yes ○ No

21a. How often do you receive help from other service providers or NGOs?
   ○ Never ○ Occasionally ○ Regularly (at least once a month)
   ○ Rarely or only in emergencies

21b. If client ever receives help: What kind of help have you received from other NGOs or service providers?
   Check all that apply.
   □ Financial/cash
   □ Medical
   □ Food
   □ Other: _______________________
   □ Shelter or clothing
   □ Resettlement/family tracing
   □ Education support/scholarships
   □ Legal/registration
   □ Livelihood/vocational/income-generating
   □ Psychosocial
## Relationships

**Read to Client:**
My next questions are about your relationships, such as the people you live with, people you can go to for help, and your family members.

22. Are you married?
- ○ Single
- ○ Living together as a couple (but not married)
- ○ Married (even if currently apart by circumstance)
- ○ Divorced or separated (married but living apart by choice)
- ○ Widowed

23a. How many people live in your household right now, not including yourself? (How many people do you share meals with most days?)
*Write 0 if the client lives alone. Do not count the client.*

______ people

23b. If the client does not live alone: **Who do you currently live with?**
*Check all that apply.*

- □ Mother
- □ Father
- □ Sibling/s
- □ Spouse/partner (husband/wife)
- □ Child/children
- □ Friend/s
- □ Co-wife/co-wives
- □ Other/s:

_____________________

24. How many children do you have?
*Write 0 if the client has no children.*

___________ children

25a. Do you have people to go to for help or support? This refers to both financial and non-financial support.
- ○ Yes (6+ people)
- ○ Yes (2-5 people)
- ○ Yes (1 person)
- ○ No

26b. If yes: **Do any of these people live near you?**
- ○ Yes (6+ people)
- ○ Yes (2-5 people)
- ○ Yes (1 person)
- ○ No

26c. If yes: **Is this financial or non-financial support?**
*Check all that apply.*

- □ Financial
- □ Non-financial
26a. Do people come to you for help or support? This refers to both financial and non-financial support.
   ○ Yes (6+ people) ○ Yes (2-5 people) ○ Yes (1 person) ○ No

26b. If yes: Who comes to you for help or support?
   Check all that apply.
   □ Family □ Yes (6+ people)
   □ Yes (2-5 people)
   □ Yes (1 person) □ Community members
   □ Yes (1 person) □ Friends
   □ Others: ______________

26c. If yes: Is this financial or non-financial support?
   Check all that apply.
   □ Financial □ Non-financial

27. Do disagreements at home often involve hitting, beating, kicking, or other physical attacks?
   DO NOT read response options to client.
   ○ Yes, client is victim ○ Yes, client is causing violence ○ No

28a. Have you ever been separated from your family (due to the conflict or persecution)?
   ○ Yes ○ No

28b. If client has been separated from family: What was the longest period of time you were separated from your family?
   If client and her/his family were separated for less than one month, write 0.
   _____months

28c. If client has been separated from family: Are you separated from your family now?
   ○ Yes ○ No

28d. If client is currently separated from family: Who are you separated from?
   Check all that apply.
   □ Mother □ Grandparents
   □ Father □ Aunts/uncles, cousins, nephews/nieces
   □ Sibling/s □ Other relatives:
   □ Spouse/partner (husband/wife)
   □ Child/children
   □ Co-wife/co-wives

29a. Do you have any family member who is currently missing?
   ○ Yes ○ No
29b. If client has a family member who is missing: Which family member(s)?
Check all that apply.
- Mother
- Father
- Sibling/s
- Spouse/partner (husband/wife)
- Child/children
- Co-wife/co-wives
- Grandparents
- Aunts/uncles, cousins, nephews/nieces
- Other relatives: ______________

**PHYSICAL HEALTH**

**READ TO CLIENT:**
My next questions are about your health.

30. How would you rate your physical health overall: very poor, poor, fair, good, or very good?
- Very Poor
- Poor
- Fair
- Good
- Very Good

31a. Do you have any medical or health problems that cause trouble with your daily functioning?
- Yes
- No

31b. If client has medical or health problems: What kinds of health or medical problems do you have?
Check all that apply. If the client mentions pain, discomfort, or wounds, please select “pain, discomfort, or wounds,” and also select at least one sub-response of where this pain is.
- Pain, discomfort, or wounds:
- Overall (whole body)
- Head (headache)
- Back, neck, spine
- Chest, abdomen
- Arms, hands, legs, or feet
- Other: ______________
- Disease or infection
- Gastro-intestinal or digestive
- Eyes, ears, nose, throat, mouth, skin
- Bones, muscles, joints, mobility
- Respiratory (breathing)
- Cardiovascular (heart, blood, veins)
- Brain and nerves (neurological & psychological)
- Reproductive or urinary
- Endocrine (energy, nutrition, glands)
- Other: ______________

32. Are you currently taking any medications for your health?
- Yes
- No

33. Do you drink alcohol? If so, how often?
- Never (less than monthly)
- Occasionally
- Monthly
- Weekly (some each week)
- Daily
34. Do you use any drugs for non-medical reasons? If so, how often?

*This question is referring to non-prescribed “street drugs.”*

- O Never (less than monthly)
- O Occasionally (less than once a week)
- O Monthly (some each week)
- O Weekly (some each week)
- O Daily

35. Have you or a family member ever been concerned about your alcohol or drug use?

- O Yes
- O No

**Notes:**

(***optional***)

---

**KNOWLEDGE AND ATTITUDES**

**READ TO CLIENT:**

Now I’m going to read some statements that you might agree with or disagree with. We are interested in knowing your opinion in general. We are not asking about your specific experiences. For each one, please tell me if you: strongly disagree, disagree, agree, or strongly agree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>36a. To deal with trauma, it helps to think or talk about what happened.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>36b. Mental health problems are not shameful or a sign of weakness or failure.</td>
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<tr>
<td>36c. It is always against rights if a person is beaten by someone in authority to intimidate them.</td>
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<tr>
<td>36d. It is good to talk to my family or friends about my mental health.</td>
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<tr>
<td>36e. I know and use healthy strategies to cope with negative thoughts or feelings about what happened to me.</td>
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<td>36f. It is always against rights if a person is beaten by someone in authority to get a confession.</td>
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</table>

**DISCUSS KNOWLEDGE AND ATTITUDE QUESTIONS WITH CLIENT:**

Is there anything from the previous questions that you would like to discuss more?
READ TO CLIENT:
The next questions are about your experiences leaving your home because of war, conflict, or persecution. I want to understand what caused you to leave and how you came to be here now.

37a. What year were you first forced to leave your home (because of conflict or persecution)?
If needed, assist the client to make the best estimate possible.

_________ (yyyy)
☐ Check here if the client has not left home due to conflict or persecution

37b. If the client has been forced to leave home: For how long altogether have you been away from your home?
If needed, assist the client to make the best estimate possible.

______months

37c. If the client has been forced to leave home: Why did you leave your home the first time you were forced to leave?
Do not read the answer options. Listen to the client and check all boxes that apply.

☐ Generalized violence/fear
☐ Economic reasons related to the conflict
☐ Family reunification
☐ Directly threatened/targeted (such as arrest or specific fear of persecution or harm)
☐ Family threatened/targeted (such as arrest or specific fear of persecution or harm)
☐ Other: ______________________

37d. If the client or family was threatened/targeted: What do you think were the reasons that you and/or your family were threatened or targeted?
Do not read the answer options. Listen to the client and then check all boxes that apply.

☐ Political opinions
☐ Family associations
☐ Religion
☐ Age
☐ Sexual orientation
☐ Other:

________________________
38a. How many times have you lived in a refugee camp or an IDP camp? Write 0 if the client has never lived in a camp.
______times

38b. If the client has lived in a camp: For how long altogether have you lived in a refugee camp or an IDP camp?
______months

39. What month and year did you arrive in your current community? If needed, assist the client to make the best estimate possible.
____________________________ mm/yyyy

40. What problems did you face while traveling to your current community? Allow the client to tell their story and check off each experience they mention. Do not read response options to the client. If the client describes a problem that does not fit any of the responses, select “problems other than those listed above.” If the client describes having no problems, select “no problems” only.

☐ Psychological problems (such as anxiety, grief, or loneliness)
☐ Health or physical challenges
☐ Property loss (such as robbery, destruction of property)
☐ Lack of food, water, shelter, or necessary money
☐ Harsh conditions (such as length of journey, weather difficulties, difficulty finding transport)
☐ Legal (such as lack of or problems with documentation or identification, problems at borders)
☐ Apprehended (such as abducted, arrested, detained, captured, sold/trafficked, kidnapped)
☐ Physical attacks (such as getting beaten, shot, bombed, caught in clashes)
☐ Separation from family or friends (such as being lost)
☐ Family/friends attacked or killed (includes rape and torture)
☐ Torture
☐ Rape or sexual abuse
☐ Witness (first-hand observation of traumatic situations)
☐ Problems other than those listed above
☐ No problems

Notes:
____________________________________________________________________
____________________________________________________________________
___________________
_____________________________________________
TRAUMATIC EXPERIENCES

READ TO CLIENT:
In this next section, I am going to ask you about some violent or scary things that sometimes happen to people. These are times where someone may have been hurt very badly or killed, or were in a situation where they could have been. Some people have had these experiences, and some people have not. Please be honest in answering if these experiences have happened to you, if they have happened to a member of your family, or if you have not experienced these things.

Remember that if you don’t want to answer any question, we can skip it.

41a. Have you ever been knocked unconscious?
   ○ Yes ○ No

41b. If yes: How many times?
   If needed, assist the client to make the best estimate possible.
   ______ times

41c. If yes: What caused you to become unconscious?
   Check all boxes that apply.
   □ Direct injury to the head (such as an attack/beating, vehicle accident, falling, bomb blast)
   □ Lack of oxygen to the brain (such as loss of blood, suffocation, drowning, strangulation)
   □ Very strong emotional reactions (such as from bad news, fear, anxiety, witnessing trauma)
   □ Other reasons (such as hunger, fatigue, other kinds of sickness)
   □ Client doesn’t know or can’t remember

42a. Have you ever been captured, detained, or held against your will?
   ○ Yes ○ No

42b. If client has been captured or held: How many times have you been held captive or detained?
   ______ times
**42c. If client has been captured or held:** What was the longest period of time you were held captive or detained?

_____ days

**42d. If client has been captured or held:** Who held you against your will?

*Do not read the answer options. Listen to the client and check all boxes that apply.*

- [ ] Military
- [ ] Police
- [ ] Security forces
- [ ] Paramilitary (non-governmental acting for government)
- [ ] Non-governmental armed groups (including opposition forces, organized criminal groups, or others that control territory)
- [ ] Other: ________________
- [ ] Unaffiliated individuals
- [ ] Unknown
- [ ] Client does not want to say

**43a. Have you ever been tortured?**

- [ ] Yes
- [ ] No

**43b. Has someone from the government or other organized authority or group intentionally hurt you?**

- [ ] Yes
- [ ] No

**43c. If “yes” to 43a or 43b: How many times did this happen?**

_____ times

**43d. If “yes” to 43a or 43b: What kind of experiences were you subjected to?**

*Do not read the answer options. Listen to the client and check all boxes that apply.*

- [ ] Beating
- [ ] Asphyxiation (choking, suffocation, etc.)
- [ ] Deprivation (withholding necessities)
- [ ] Forced to watch someone be tortured
- [ ] Burns
- [ ] Forced postures, stretching, or hanging
- [ ] Sensory stress (noises, lights, etc.)
- [ ] Torture through use of drugs (pharmacological torture)
- [ ] Rape or sexual abuse
- [ ] Electrical shock
- [ ] Threats, humiliation, or other psychological
- [ ] Wounding / maiming
- [ ] Forced to kill / harm someone
- [ ] Client does not want to say
- [ ] Other: ________________
43e. If “yes” to 43a or 43b: Why do you think you were harmed? (Do you think there was a reason, or something the perpetrator hoped to gain or accomplish?)
Do not read the answer options. Listen to the client and check all boxes that apply.

☐ To extract information
☐ To punish
☐ To force cooperation (of self or others)
☐ Unknown
☐ Other: ___________________________

43f. If “yes” to 43a or 43b: Why do you think you were targeted? (Why do you think you were specifically singled out?)
Do not read the answer options. Listen to the client and check all boxes that apply.

☐ Political opinions
☐ Family associations
☐ Religion
☐ Age
☐ Sexual orientation
☐ Other: ___________________________

☐ Governmental affiliation
☐ Gender
☐ Occupation
☐ Unknown
☐ Other: ___________________________

43g. If “yes” to 43a or 43b: Who did this to you?
Do not read the answer options. Listen to the client and check all boxes that apply.

☐ Military
☐ Police
☐ Security forces
☐ Paramilitary (non-governmental acting for government)
☐ Non-governmental armed groups (including opposition forces, organized criminal groups, or others that control territory)
☐ Unaffiliated individuals
☐ Unknown
☐ Client does not want to say
☐ Other: ___________________________

43h. If “yes” to 43a or 43b: In which zone (or country) did this take place?
Check all that apply.

In Eritrea:
☐ Maekel/Central
☐ Anseba
☐ Gash-Barka (including Sawa)
☐ Southern
☐ Northern Red Sea
☐ Southern Red Sea
☐ Client named a specific place in Eritrea, but does not know which region it is: ___________________________

☐ In another country: ___________________________

☐ Unknown
☐ Client does not want to say
44. Have you ever experienced rape or other forms of sexual assault?
*If the client described sexual assault as part of their torture, do not ask this question.*
☐ Yes ☐ No

45a. Have any of your family members been captured or held against their will?
☐ Yes ☐ Not to my knowledge

45b. *If client’s family members have been captured: Who was captured or held against their will?*
*Check all that apply.*
☐ Mother ☐ Spouse/partner ☐ Client does not want to say
☐ Father ☐ (husband/wife)
☐ Sibling/s ☐ Child/children ☐ Other relatives:
☐ Co-wife/co-wives

45c. *If client’s family members have been captured: Who held them against their will?*
*Do not read the answer options. Listen to the client and check all boxes that apply.*
☐ Military ☐ Non-governmental
☐ Police ☐ armed groups (including opposition forces, organized criminal
goovernmental acting groups, or others that control territory)
☐ Paramilitary (non-governmental acting for government) ☐ Unaffiliated
☐ Unknown ☐ Other:
☐ Client does not want to say
☐ Other: ☐ Other:

46a. Have any of your family members been tortured?
☐ Yes ☐ Not to my knowledge

46b. Has someone from the government or other organized authority or group intentionally hurt a member of your family?
☐ Yes ☐ Not to my knowledge

46c. *If “yes to 46a or 46b: Who did this happen to?*
*Check all that apply.*
☐ Mother ☐ Spouse/partner ☐ Co-wife/co-wives
☐ Father ☐ (husband/wife)
☐ Sibling/s ☐ Child/children ☐ Other relatives:
☐ Other: ☐ Other:
46d. If “yes to 46a or 46b: What kind of experiences were they subjected to?
Do not read the answer options. Listen to the client and check all boxes that apply.

- Beating
- Asphyxiation (choking, suffocation, etc.)
- Deprivation (withholding necessities)
- Forced to watch someone be tortured
- Burns
- Forced postures, stretching, or hanging
- Sensory stress (noises, lights, etc.)
- Torture through use of drugs (pharmacological torture)
- Rape or sexual abuse
- Electrical shock
- Threats, humiliation, or other psychological
- Wounding / maiming
- Forced to kill / harm someone
- Unknown
- Client does not want to say
- Other: ________________

46e. If “yes to 46a or 46b: Why do you think they were harmed? (Do you think there was a reason, or something the perpetrator hoped to gain or accomplish?)
Do not read the answer options. Listen to the client and check all boxes that apply.

- To extract information
- To punish
- To force cooperation (of self or others)
- Client does not want to say
- Other: ________________

46f. If “yes to 46a or 46b: Why do you think they were targeted? (Why do you think they were specifically singled out?)
Do not read the answer options. Listen to the client and check all boxes that apply.

- Political opinions
- Family associations
- Religion
- Age
- Sexual orientation
- Race or ethnicity
- Government affiliation
- Gender
- Occupation
- Unknown
- Client does not want to say
- Other: ________________

46g. If “yes to 46a or 46b: Who did this to them?
Do not read the answer options. Listen to the client and check all boxes that apply.

- Military
- Police
- Security forces
- Paramilitary (non-governmental acting for government)
- Non-governmental armed groups (including opposition forces, organized criminal groups, or others that control territory)
- Rashaida
- Other: ________________
- Unaffiliated individuals
- Unknown
- Client does not want to say
- Other: ________________
46h. If “yes to 46a or 46b: In which zone (or country) did this take place?

In Eritrea: □ In another country: _________________________
□ Maekel/Central □ Unknown
□ Anseba □ Client does not want to say
□ Gash-Barka (including Sawa)
□ Southern
□ Northern Red Sea
□ Southern Red Sea
□ Client named a specific place in Eritrea, but does not know which region it is:
_____________________

47a. Have any of your family members been killed due to the conflict or persecution?
○ Yes ○ Not to my knowledge

47b. If client’s family members have been killed: Who was killed? Who was killed?
Check all that apply.
□ Mother □ Child/children □ . Other relatives:
□ Father □ Co-wife/co-wives
□ Sibling/s □ Grandparents
□ Spouse/partner □ Uncles/aunts, cousins, nieces/nephews
(husband/wife)

Notes:
____________________________________________________________________
(optional)
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
PROBLEM RATING SCALES

READ TO CLIENT:
This is the last section. I am going to ask you how often you experience certain problems or symptoms. You can use this picture of cups to help you. The more full cups mean that you experience these problems more regularly. Please think about how much these symptoms have bothered you during the past two weeks.

Not at All Rarely Sometimes Often

How much have each of these problems bothered you during the past two weeks?

<table>
<thead>
<tr>
<th>POST-TRAUMATIC STRESS SYMPTOMS</th>
<th>Not at All</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Having repeating thoughts and memories about traumatic events when you do not want them?</td>
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<tr>
<td>2 Having repeating bad dreams or nightmares about the traumatic experience you have had?</td>
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<tr>
<td>3 Feeling like part of the trauma was happening again or that you are living the trauma again (sometimes called “flashbacks”)?</td>
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<tr>
<td>4 Feeling unhappy, nervous, or upset by things that remind you of the traumatic event?</td>
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<tr>
<td>5 Having your body react to things that remind you of the traumatic event (like upset stomach, dizziness)?</td>
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<tr>
<td>6 Trying to avoid thoughts, feelings, or conversations related to your traumatic event?</td>
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<tr>
<td>7 Trying to avoid activities, places, or people that remind you of your traumatic experiences?</td>
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<tr>
<td>8 Not able to remember an important part of your traumatic experience, even when you try?</td>
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<tr>
<td>9 Feeling less interest in things that you used to enjoy?</td>
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<td>Feeling emotionally distant from other people since your traumatic experience (feeling like you can’t talk or share feelings with other people)?</td>
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<tr>
<td>11</td>
<td>Less able to feel happy since your traumatic experience?</td>
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<tr>
<td>12</td>
<td>Not thinking about or planning for the future as much as you did before your traumatic experience?</td>
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<td>13</td>
<td>Being more irritable or angry than before your trauma experience (even if you keep it inside)?</td>
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<tr>
<td>14</td>
<td>Having difficulty concentrating or focusing on your thoughts?</td>
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<tr>
<td>15</td>
<td>Watching everything around you or feeling “extra alert” or “on guard” much of the time?</td>
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<td>16</td>
<td>Being more “jumpy” to sounds or movements than before the trauma (“startling” easier than before)?</td>
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How much have each of these problems bothered you during the past two weeks?

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DATA USE AGREEMENT BETWEEN

The Center for Victims of Torture (Holder)

and

Addis Ababa University, School of Psychology

This Data Use Agreement is made and entered into on April 15, 2019 by and between The Center for Victims of Torture, hereafter “Holder” and Addis Ababa University, School of Psychology, hereafter “Recipient.”

1. This agreement sets forth the terms and conditions pursuant to which Holder will disclose certain protected health information, hereafter “PHI” in the form of a Limited Data Set to the Recipient.

2. Terms used, but not otherwise defined, in this Agreement shall have the meaning given the terms in the HIPAA Regulations at 45 CFR Part 160-164.

3. Permitted Uses and Disclosures

3.1 Except as otherwise specified herein, Recipient may make all uses and disclosures of the Limited Data Set necessary to conduct the research described herein:

The dataset may be used by Recipient for the completion of requirements for a MA thesis by Amare Worku Assefa. The student’s thesis will explore the relationship between torture, PTSD symptoms, behavioral functioning difficulties, and
3.2 The data remain the property of CVT. Any unauthorized reproduction or sharing of the data without CVT authorization is strictly prohibited. The Recipient will not release nor permit others to use or release the data to any other person without the written authorization from CVT, unless for purposes of conducting the research as described above.

4. Recipient Responsibilities

4.1 Recipient will not use or disclose the Limited Data Set for any purpose other than permitted by this Agreement pertaining to the Research Project or as required by law;

4.2 Recipient will use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Limited Data Set other than as provided for by this Agreement;

4.3 Recipient will report to the Holder any use or disclosure of the Limited Data Set not provided for by this Agreement of which the Recipient becomes aware within 10 days of becoming aware of such use or disclosure;

4.4 Recipient will ensure that any agent, including a subcontractor, to whom it provides the Limited Data Set, agrees to the same restrictions and conditions that apply through this Agreement to the Recipient with respect to the Limited Data Set;

4.5 Recipient will not identify the information contained in the Limited Data Set; and

4.6 Recipient will not contact the individuals who are the subject of the PHI contained in the Limited Data Set.

5. Termination

5.1 The terms of this Agreement shall be effective when signed by both parties and shall continue until terminated by one or both parties. Unless notice to terminate is given, the period of agreement shall extend until 31 December 2019. Upon termination, the dataset must be destroyed by Recipient and/or returned to Holder.

5.2 Upon the Holder’s knowledge of a material breach of this Agreement by the Recipient, the Holder shall provide an opportunity for Recipient to cure the breach or end the violation. If efforts to cure the breach or end the violation are not successful within the reasonable time period specified by the Holder, the Holder shall discontinue disclosure of PHI to the Recipient and report the problem to its designee. The Holder shall immediately discontinue disclosure of the Limited Data Set to the Recipient if the Holder determines cure of the breach is not possible.

6.1 Recipient and Holder understand and agree that individuals who are the subject of Protected Health Information are not intended to be third party beneficiaries of this Agreement.

6.2 This Agreement shall not be assigned by Recipient without the prior written consent of the Holder.

6.3 Each party agrees that it will be responsible for its own acts and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other party or the results thereof.

IN WITNESS WHEREOF, the parties hereto execute this agreement as follows:

<table>
<thead>
<tr>
<th>Date: 15/04/2019</th>
<th>The Center for Victims of Torture (CVT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By: Craig Higson-Smith</td>
</tr>
<tr>
<td></td>
<td>Director of Research</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date: 15/04/2019</th>
<th>Addis Ababa University, School of Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By: Moges Ayele (PhD)</td>
</tr>
<tr>
<td></td>
<td>Assistant Professor of Psychology</td>
</tr>
</tbody>
</table>