

ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES, SCHOOL OF MEDICINE

DEPARTMENT OF PSYCHIATRY, CLINICAL PSYCHOLOGY PROGRAM

OPTIMISM, RESILIENCE, SOCIAL SUPPORT, AND HARDINESS AS PROTECTIVE FACTORS IN COPING WITH PSYCHOLOGICAL DISTRESS AMONG GENDER BASED VIOLENCE (GBV) SURVIVORS AT AWSAD, ETHIOPIA

BY: NITSUH KIBREWORK (CPY-2)

A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS MASTER'S DEGREE IN CLINICAL PSYCHOLOGY

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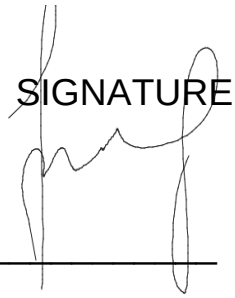
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Acronyms

GBV (Gender-based Violence)

IPV (Intimate Partner Violence)

PTSD (Post-Traumatic Stress Disorder)

AWSAD (Association for Women's Sanctuary and Development)

WHO (World Health Organization)

Acknowledgment

First and foremost, I would like to express my deepest gratitude to God, whose guidance, and strength have sustained me throughout my academic journey.

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Abstract

Background: Gender-based violence (GBV) is a pervasive global and Ethiopian public health concern, disproportionately affecting women and girls and resulting in severe psychological consequences, including Depression, Anxiety, and Post-traumatic stress disorder (PTSD). While much research focuses on prevalence and risk factors, limited attention has been given to protective psychological resources that may help survivors cope with these distresses. Optimism, resilience, social support, and hardiness are conceptualized as key resources that shape survivors' coping experiences.

Objective: To explore how optimism, resilience, social support, and hardiness influence coping with psychological distress among female GBV survivors residing at the Association for Women's Sanctuary and Development (AWSAD) shelter in Addis Ababa, Ethiopia.

Methods: This study employed a qualitative descriptive design to explore the experiences of GBV survivors based on a pre-determined framework of protective factors. Purposive sampling was used to recruit nine female participants aged 18 to 35 years who were residing at the AWSAD shelter. Interviews were audio-recorded, transcribed verbatim in Amharic, and subsequently translated into English. Data analysis was conducted using deductive thematic analysis with Open Code software, guided by the study's conceptual framework of psychological distress, optimism, resilience, social support, hardiness, and interplay role of protective factors as predetermined themes.

Results: Psychological distress was severe: eight of nine participants reported suicidal ideation, and all described intrusive symptoms, sleep disturbances, and anger dysregulation. Social support primarily institutional rather than familial was the most critical protective factor. Only three participants had family support; counseling was identified as the single most helpful factor. Optimism was recoverable for seven participants but not all. Resilience developed through two pathways: drawing on past hardship or developing strength without prior adversity. Hardiness manifested as

decisive action and commitment to children. Faith was cited by eight participants as a foundational source of strength intersecting with all protective factors.

Conclusion: Protective factors, particularly institutional social support, faith, and commitment to children, facilitate coping among GBV survivors, but recovery is neither linear nor uniform. The absence of family support highlights the critical role of shelter-based services. Findings support trauma-informed, survivor-centered interventions.

Keywords: Gender-based violence, psychological distress, optimism, resilience, social support, hardiness, coping, qualitative research, descriptive design, AWSAD.

1. Introduction

1.1. Back ground of the Study

Gender-based violence (GBV) is a major global public health and human rights concern that affects millions of women worldwide. The World Health Organization defines GBV as any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats, coercion, or deprivation of liberty (1). Globally, nearly one in three women has experienced physical or sexual violence in her lifetime (1). Such violence has far-reaching emotional and psychological consequences, including depression, anxiety, trauma-related symptoms, emotional distress, and impaired social functioning (2, 3).

In this study, psychological distress refers to the emotional and psychological difficulties that may develop following GBV, including fear, sadness, anxiety, emotional instability, and trauma-related reactions. These reactions commonly arise after exposure to sexual assault, physical violence, emotional abuse, or other forms of interpersonal trauma. According to the American Psychiatric Association (2022), traumatic experiences can lead to intrusive memories, avoidance, heightened arousal, and negative emotional states. Research similarly shows that survivors of interpersonal and gender-based violence experience higher levels of emotional distress, depressive symptoms, and trauma-related experiences compared to those without such histories (4, 5, 6).

Findings from sub-Saharan Africa further demonstrate the psychological toll of GBV. A recent systematic review reported that sexual and physical GBV in the region is strongly associated with psychological distress, including emotional trauma, anxiety, depression, and even suicidality (3). A scoping review on sexual violence in sub-Saharan Africa also highlighted the frequent occurrence of trauma-related emotional disturbances among survivors (7). Such evidence confirms that the psychological consequences of GBV are both severe and widespread.

In Ethiopia, GBV remains highly prevalent. Emotional intimate partner violence alone affects 53% of women, indicating chronic exposure to psychological and emotional

abuse (8). A national systematic review that included nearly 24,000 women found that more than half had experienced at least one form of GBV in their lifetime (9). Such persistent violence contributes to significant psychological distress, often interfering with daily functioning, emotional stability, and overall well-being. Despite these profound effects, most Ethiopian studies have focused on prevalence, risk factors, or clinical outcomes, with limited attention given to survivors' subjective experiences or the psychological strengths that support healing.

Although the psychological consequences of GBV can be severe, not all survivors experience distress in the same way. Research shows that certain psychological and social resources help individuals navigate and cope with trauma. Protective factors such as optimism, resilience, social support, and hardiness have been found to buffer the emotional impact of violence and promote positive adaptation. Social support, in particular, contributes to enhanced resilience and reduced emotional distress (10, 11), while optimism and hardiness have been linked to more adaptive coping, meaning-making, and improved emotional adjustment following traumatic experiences (12, 13). However, despite these findings, little is known about how these protective factors operate among GBV survivors in Ethiopia, especially those living in shelters.

The Association for Women's Sanctuary and Development (AWSAD) provides safe housing, rehabilitation, counselling, and psychosocial support to women and girls who have survived GBV. Understanding how survivors at AWSAD experience optimism, resilience, social support, and hardiness and how these factors influence their coping with psychological distress is essential for strengthening trauma-informed services and improving psychosocial care. Given the limited qualitative evidence in the Ethiopian context, a phenomenological approach is necessary to explore the lived experiences and personal meanings survivors attach to their emotional and psychological responses.

Therefore, this study explored how protective psychological factors shape coping with psychological distress among GBV survivors at AWSAD aiming to generate insights that can inform culturally relevant and survivor-centered intervention strategies.

1.2. Statement of the problem

Gender-based violence (GBV) remains a pervasive public health and human rights challenge worldwide, with survivors frequently experiencing different psychological distress, including depression, anxiety, post-traumatic stress, and emotional dysregulation (1, 2). In Ethiopia, studies show that more than half of women experience some form of GBV in their lifetime, with emotional and intimate partner violence being particularly prevalent (8, 9). These experiences often result in significant trauma and hinder survivors' capacity to function and thrive in daily life.

Despite the high prevalence and profound psychological consequences of GBV, not all survivors develop chronic distress or post-traumatic symptoms. Research indicates that certain psychological and social resources, such as optimism, resilience, social support, and hardiness, may serve as protective factors that buffer against the negative impact of trauma and enhance coping (10, 12, 13). However, evidence on how these protective factors operate among GBV survivors in Ethiopia is scarce. In particular, little is known about the lived experiences of women residing in shelters such as the Association for Women's Sanctuary and Development (AWSAD), where survivors receive psychosocial support and rehabilitation.

This gap in knowledge limits the ability of practitioners and policymakers to design culturally sensitive, survivor-centered interventions that leverage existing psychological strengths. Without a clear understanding of how protective factors like optimism, resilience, social support, and hardiness influence survivors' coping strategies, trauma-informed care may not fully address the psychological needs of women recovering from GBV. Therefore, there is a critical need to explore these protective factors and their role in mitigating post-traumatic stress symptoms among GBV survivors in Ethiopia.

1.3. Rationale of the Study

Gender-based violence (GBV) continues to be a major public health and human rights concern, with profound consequences for survivors' psychological well-being. In

Ethiopia, the high prevalence of emotional and other forms of intimate partner violence reflects the severe and chronic nature of psychological distress many women experience. However, despite the significant burden of GBV-related mental health problems, research in Ethiopia has primarily focused on prevalence and risk factors, leaving important gaps in understanding how survivors cope and recover. Ethiopia's GBV response system remains critically underdeveloped, with most interventions focusing on immediate physical safety and legal aid rather than long-term psychological recovery.

Protective psychological factors such as optimism, resilience, social support, and hardiness have been shown in international studies to buffer the effects of trauma and reduce psychological distress. Yet, such protective factors have received little empirical attention within the Ethiopian context, and no study has examined these variables together as an integrated framework for trauma recovery. This gap is particularly relevant for women residing in shelters, who often face severe and repeated forms of violence.

The Association for Women's Sanctuary and Development (AWSAD) plays a critical role in supporting GBV survivors through shelter, counselling, and rehabilitation services. Understanding the psychological resources that contribute to better coping among AWSAD residents is essential for informing trauma-informed care, enhancing psychosocial interventions, and improving survivor outcomes. This study is therefore timely and necessary, as it shifts the focus from documenting harm to identifying strengths that promote healing. By examining optimism, resilience, social support, and hardiness as protective factors against psychological distress, this research contributes valuable evidence to guide mental health practitioners and shelter programs working with GBV survivors in Ethiopia.

2. Literature Review

2.1. Introduction

Gender-based violence (GBV) is widely recognized as a severe public health, psychological, and human rights issue, affecting millions of women globally, and disproportionately impacting women in low- and middle-income countries. According to the World Health Organization (2021), nearly one in three women worldwide experience either physical or sexual violence during their lifetime (1). In African countries, including Ethiopia, the prevalence of intimate partner violence (IPV) is particularly high, with many nations reporting rates above 30% (14). Beyond its prevalence, GBV is strongly associated with adverse psychological outcomes; including depression, anxiety, emotional distress, and post-traumatic stress disorder (PTSD) (2, 3).

In Ethiopia, emotional IPV, a form often overlooked due to its invisible nature is notably high at 53% (8). Research consistently shows that chronic exposure to emotional abuse has profound impacts on mental health, placing survivors at high risk for long-term psychological distress. Despite this evidence, most Ethiopian studies focus on prevalence and risk factors rather than understanding the protective factors that may buffer against psychological harm.

Psychological strengths such as optimism, resilience, social support, and hardiness have been shown to mitigate psychological distress in various populations (10, 11). However, there is limited evidence on how these protective factors function among Ethiopian GBV survivors, especially shelter-based women receiving rehabilitation services. This chapter reviews existing literature on GBV, psychological distress, and the key protective factors relevant to this study.

2.2. Prevalence of GBV

Gender-based violence (GBV) is a widespread public health and human rights issue affecting women globally. In the United States, nearly half of women report experiencing psychological aggression and over 40% report physical violence in their lifetimes.

Among female victims, almost 87% experience at least one negative impact related to intimate partner violence (IPV), including post-traumatic stress symptoms, fear, and emotional harm. Early exposure to IPV, either personally or through witnessing violence in the household, increases the risk of future victimization and adverse mental health outcomes. Certain racial and ethnic minority groups are disproportionately affected, highlighting the need for culturally sensitive prevention and support strategies (15,16).

Studies show that the prevalence of intimate partner violence (IPV) varies widely across countries, with African nations experiencing particularly high rates. According to a survey conducted in low-income and middle-income countries from 2000 to 2021 2022 more than half of the African countries included in the study reported that over 30% of women experienced some form of IPV, including physical, sexual, or psychological violence. Many of these countries are classified as low- and middle-income countries (LMICs), where structural inequalities, economic hardship, and limited access to protection and support services increase women's vulnerability to violence (14). This highlights the importance of examining the experiences and coping strategies of survivors in African contexts such as Ethiopia.

In Sub-Saharan Africa, GBV remains highly prevalent, encompassing physical, sexual, and emotional forms of violence, including both IPV and non-IPV cases. Emotional IPV is the most common type of violence, with Eastern Africa, including Ethiopia, being among the most affected regions (8). Evidence from Nigeria shows that among 710 GBV survivors in Enugu, 89.9% were female, with more than half (56.8%) experiencing sexual violence. Younger individuals under 19 years were 23 times more likely to experience sexual violence than those aged 40–59, highlighting the vulnerability of young women (17).

In Ethiopia, GBV prevalence is also high. A cross-sectional study among 1,199 female high school students in eastern Ethiopia found that more than half (55%) had experienced some form of GBV in their lifetime, with affected students frequently reporting self-blame (35.7%) and anxiety (23.3%) (18). Among female students at Wolkite University, the overall prevalence of GBV was 46.2%, with physical and sexual

violence reported at 56.1% and 47.0%, respectively. Factors associated with higher risk included being in the second year of study or having a lower educational level, being married or cohabiting, having a father with no formal education, alcohol use, and limited ability to discuss family issues openly (19).

A systematic review of 19 studies involving 23,787 Ethiopian women reported a pooled prevalence of GBV of 51.34% (95% CI: 44.48–58.19), confirming that more than half of women experience some form of violence in their lifetime (9). Emotional IPV in Ethiopia reaches 53%, while physical IPV is lower at 5%, suggesting that women are more frequently subjected to ongoing psychological abuse (8).

2.3. Psychological Distress among GBV Survivors

Gender-based violence (GBV) remains a critical public health and human rights issue, with severe and long-lasting psychological consequences for survivors. In Ethiopia, emotional intimate partner violence alone affects more than half of women (53%), reflecting a pattern of chronic and sustained trauma exposure that places survivors at heightened risk for serious mental health outcomes (8). This widespread exposure to violence has significant implications for psychological well-being.

For the purpose of this study, Psychological distress is defined as the emotional and psychological difficulties that may develop following GBV, including fear, sadness, anxiety, emotional instability, and trauma-related reactions.. Among women exposed to GBV, distress frequently develops as a direct response to ongoing fear, threats, or repeated trauma.

In Africa, GBV similarly contributes to a wide range of mental health issues. A systematic scoping review of sexual gender-based violence in Sub-Saharan Africa found that survivors commonly experience post-traumatic stress disorder (PTSD), depression, anxiety, suicidal ideation, and general psychological trauma (7). A meta-analysis reported that sexual violence survivors were significantly more likely to experience depression (69%) and PTSD (29%) compared to women without such experiences (3). Sexual violence during pregnancy, in particular, strongly increased the

risk of developing PTSD (OR 3.64, 95% CI: 1.34–9.83) and depression (OR 3.50, 95% CI: 2.43–5.04), highlighting heightened vulnerability during this period (3).

In Ethiopia, the psychological impact of GBV is equally concerning. A systematic review and meta-analysis reported a pooled prevalence of PTSD of 39.28% among trauma-exposed individuals. Factors associated with higher risk included: poor social support, female sex, previous mental illness, and witnessing trauma (20). Emotional IPV, which affects over half of Ethiopian women, has been linked to anxiety, depression, and PTSD. The similarity between lifetime and past-year prevalence indicates sustained exposure, which may exacerbate mental health consequences (8).

Evidence from sub-Saharan Africa demonstrates that women who experience sexual or intimate partner violence are significantly more likely to develop PTSD, depression, anxiety, and other forms of psychological distress. A recent systematic review found that PTSD affected nearly one-third of sexual-violence survivors, and mental health burdens were consistently higher among GBV survivors than among women without such experiences (3). Survivors often experience symptoms across multiple domains. For example, Bellot Valenzuela found that IPV survivors commonly display intrusive memories, avoidance behaviors, negative mood states, and hyperarousal hallmarks of trauma-related distress (21.) Similarly, Woldie et al. reported high rates of depression and PTSD among African survivors of sexual violence, highlighting that the psychological impact of GBV is multi-dimensional and can significantly disrupt daily life and functioning (3).

In Ethiopia, the nature and prevalence of emotional violence further exacerbate distress among women. Chronic exposure to emotional IPV, often characterized by humiliation, threats, insults, and controlling behaviors, increases vulnerability to long-term distress, particularly when combined with social stigma, economic dependence, fear of retaliation, and limited institutional support (8). Among adolescent girls, distress is particularly pronounced; a study of high school students in eastern Ethiopia revealed that over one-third of GBV survivors reported self-blame, while nearly a quarter

experienced anxiety (18). Such findings underscore the deep emotional toll of GBV across age groups and highlight the sustained nature of psychological suffering.

2.4. Protective Factors against Psychological Distress

While gender-based violence often leads to significant psychological distress, research shows that not all survivors experience the same level of emotional suffering. Certain psychological and social resources can serve as protective factors, helping survivors cope with and reduce their distress.

2.4.1. Optimism

Optimism has been linked to positive psychological functioning (self-efficacy, self-esteem) and with a positive effect on PTSD symptoms following tragic events (22). Optimism is an individual difference variable that reflects the extent to which people hold generalized favorable expectancies for their future (12). Optimistic individuals tend to cope more effectively with stress and maintain better psychological well-being. In the context of trauma or gender-based violence, optimism may enable survivors to perceive challenges as manageable, sustain hope for recovery, and engage in adaptive behaviors that promote positive mental health outcome.

Anderson et al. found that among survivors of conflict-related sexual violence in Bosnia and Herzegovina, higher optimism was associated with greater posttraumatic growth (PTG). Most participants (92.3%) showed clinically significant PTSD symptoms, while the average PTG score was 58.94 (SD = 23.01). Optimism, along with approach-oriented coping strategies like positive reinterpretation and planning, predicted higher PTG, whereas avoidance strategies such as behavioral disengagement and substance use predicted lower PTG (23). These results highlight optimism as a protective factor that fosters adaptive coping and psychological growth following trauma.

Monahan (2008) examined 427 women in California, USA, recruited from rape crisis centers, women's health centers, and university students. Results showed a significant negative relationship between optimism and PTSD symptoms ($r = –.50$, $p < .01$), with

optimism explaining 22.6% of the variance in PTSD severity (24).These findings suggest that higher optimism serves as a protective factor in reducing psychological distress.

2.4.2. Resilience

Resilience can be described as the ability of a dynamic system to effectively adjust and cope with challenges or disruptions that may endanger its functioning, stability, or growth. (25)

Empirical evidence demonstrates the tangible impact of GBV on this capacity. A study conducted among South African adolescent girls and young women (AGYW) used a cross-sectional household survey of 4,399 participants aged 15–24 years and measured resilience using the 10-item Connor-Davidson Resilience Scale (CD-RISC 10). The findings indicated that exposure to physical and sexual intimate partner violence, as well as forced sex or rape, was associated with significantly lower resilience scores. This demonstrates that experiences of GBV can actively undermine an individual's innate capacity to adapt to adversity (26).

However, the same study also identified protective factors that were positively associated with higher resilience among survivors. Specifically, adherence to more equitable gender norms and receiving social support from a significant person were linked to higher resilience scores. These findings suggest that resilience is not merely a static trait but can be strengthened through social, relational, and individual factors (26). This underscores the importance of interventions that promote gender equity and social connectedness to mitigate the negative effects of GBV and foster resilience. (26).

2.4.3. Social support

Social support has been consistently identified as a primary protective factor in the recovery from psychological distress among abused women (27). It can buffer against

stress in several ways, including enhancing self-esteem, shaping perceptions of stressful events, and increasing knowledge of coping strategies (28).

A large U.S. population-based study by Platt, Keyes, and Koenen examined whether the size and diversity of one's social network or the perceived quality of social support was more protective against PTSD (29). The findings showed that social-network role diversity engagement across varied social groups such as family, work, community, or religious organizations was more strongly protective than the perceived strength of support. Individuals with low social-role diversity had significantly higher odds of current PTSD, even if they reported high perceived support, whereas those with diverse networks did not show elevated risk even when perceived support was low. This suggests that the structural aspects of social connections may play a pivotal role in buffering against psychological distress, highlighting the importance of interventions that promote engagement in varied social networks.

While social support is widely considered protective against psychological distress, its effect may be limited in certain high-risk populations. For instance, Pinto et al. examined a risk-sample of adolescents exposed to trauma and adversity and found that 26.2% met criteria for probable PTSD (30).Their statistical model explained 64% of the variance in PTSD symptoms; however, social support was not a significant protective factor after adjusting for other covariates. These findings suggest that interventions focusing solely on enhancing social support may be insufficient to mitigate Psychological distress among adolescents who have experienced severe or multiple forms of childhood adversity.

Among refugees and internally displaced women in Africa, lack of social protection increases vulnerability to gender-based violence. Without supportive networks, access to social assistance, or legal and law enforcement resources, these women are more susceptible to exploitation and abuse (31).

In Ethiopia, adolescents exposed to abuse and violence rely heavily on informal social support from family, peers, and teachers to cope and build resilience. However, these support networks are often uneven, limited, or misaligned with formal protection

systems due to gender norms, cultural practices, and lack of access to resources. This limited or inadequate social support represents a significant risk factor for the development of mental health problems among adolescents experiencing abuse and violence. Strengthening both informal networks and formal interventions is therefore crucial to mitigate psychological distress in this population (32).

2.4.4 Hardiness

Hardiness is a personality trait that influences how individuals respond to stressful and traumatic experiences. Originally conceptualized by Kobasa (1979) and further developed by Maddi (2004), hardiness is described as a form of existential courage that allows people to turn stressful circumstances into opportunities for growth rather than decline. It is composed of three interrelated attitudes, often referred to as the "3Cs": commitment (remaining engaged and involved in life even under stress), control (the belief that one can influence outcomes rather than feeling powerless), and challenge (viewing stressors as opportunities to learn and develop rather than threats). (13).

A study of 429 South African first responders found that higher hardiness, particularly control and challenge, reduced the impact of psychological distress including PTSD on burnout, whereas commitment alone was not protective (34).

Hardiness is associated with greater post-traumatic growth (PTG) and well-being among severely wounded servicemen and their spouses. Individuals high in hardiness demonstrate strong commitment, perceive life as meaningful, and approach obstacles as challenges, enabling them to interpret difficulties positively, recover from injuries, and utilize social support effectively (35)."

However, limited research has examined hardiness specifically among survivors of gender-based violence in low-income settings such as Ethiopia. Most existing hardiness research has focused on military personnel, first responders, and general trauma populations.

2.4.5 The interplay role of Optimism, resilience, social support and hardiness

According to Carver, Scheier, and Segerstrom (2010) review, optimism plays an important role in facilitating social interactions and enhancing social support. Optimistic individuals are more likely to engage with others, maintain broader social networks, and participate actively in social activities. They tend to be perceived more positively by others, which fosters stronger and more supportive social relationships. In contrast, pessimistic individuals are more likely to withdraw from social interactions, limiting the social support available to them. These findings suggest that optimism serves as a personal resource that promotes social engagement and strengthens social connections (12).

Machisa et al. also reported that social support plays a critical role in fostering resilience among women survivors of intimate partner violence in Gauteng, South Africa. In their study, women who perceived strong community support and accessible resources were more likely to exhibit psychological resilience, while factors such as recent severe IPV, negative responses to disclosure, and binge drinking were associated with lower resilience. This evidence emphasizes the protective interplay between social support and resilience in mitigating the mental health impact of gender-based violence. (10)

A study conducted in china also examined the relationship between perceived social support and PTSD symptoms among 2,751 medical staff in Hubei Province, China, two years after a public health emergency. The study found that higher social support was associated with lower PTSD symptoms, both directly and indirectly through resilience and positive coping. Resilience and coping together mediated 17% of the total effect, highlighting a chain of protective factors that buffer trauma. While the sample involved medical staff rather than GBV survivors, these findings suggest that enhancing social support and fostering resilience and positive coping may be important strategies for reducing PTSD in other trauma-exposed populations (11).

Resilience depends not only on individual capacity but also on the surrounding social environment, including relationships within families, communities, and organizations

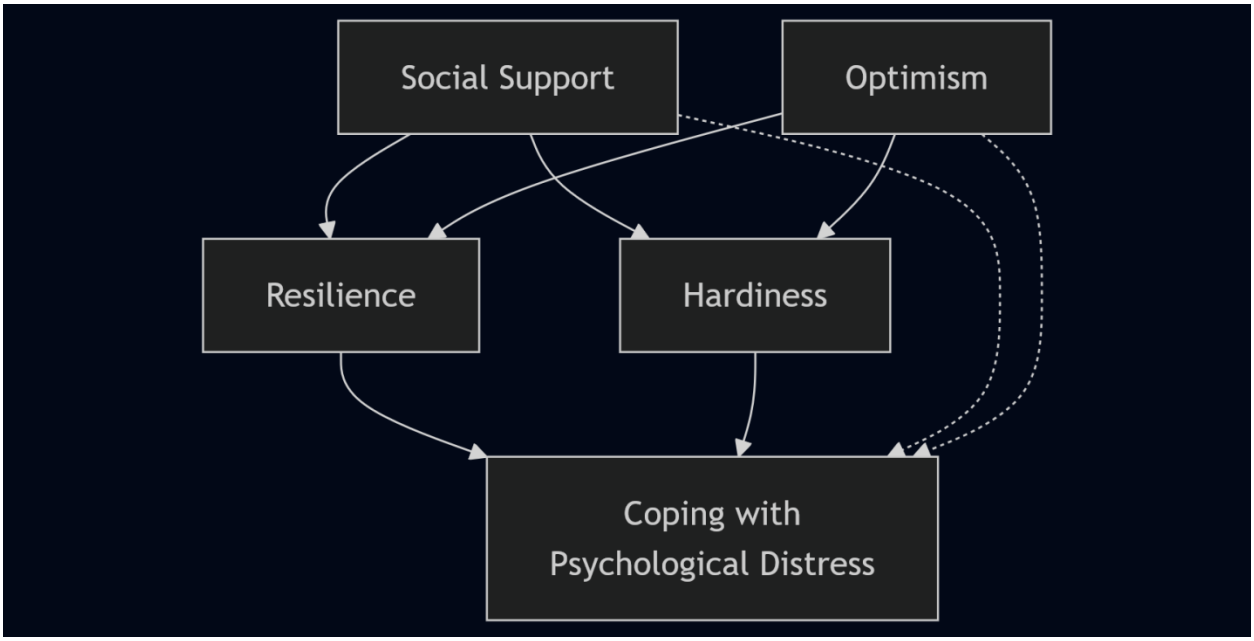
(36). Higher levels of caregiver support and caregiver education significantly predicted resilience in adolescents with a history of sexual abuse. Warm relationships with caregivers and increased time spent with them were also positively associated with resilience in this population (37).

According to Maddi (2013), Hardiness does not develop in isolation; rather, it is shaped and reinforced through supportive relationships. The presence of parents, mentors, or significant others plays a crucial role in fostering hardiness by encouraging individuals to practice adaptive coping strategies, engage in supportive social interactions, and maintain beneficial self-care. Through such guidance, individuals not only acquire practical skills but also internalize the motivation and courage necessary to face adversity. In this way, social support becomes a foundation for cultivating hardy attitudes, enabling individuals to approach stressful experiences with greater resilience and perseverance.(13)

Maddi (2005) and Bonanno (2004) suggest that hardiness serves as a key pathway to resilience under stress. Resilience is generally understood as maintaining health and performance despite challenging circumstances.(38) Maddi (2013) further emphasizes that resilience is not only about surviving adversity but also about thriving, as stressful experiences can enhance well-being and performance through learning and application.(13)

2.5. Conceptual Framework

This study is guided by a conceptual framework that illustrates the hypothesized relationships between the key protective factors: optimism, resilience, social support, and hardiness, and the process of coping with psychological distress among GBV survivors. The framework, presented below, is synthesized from the existing literature and serves as a map to guide the exploration of survivors' lived experiences.



The model proposes that:

1. Social Support and Optimism serve as foundational resources that help build internal strengths
2. Resilience and Hardiness function as core psychological capacities that directly facilitate coping
3. All four factors may work together in a dynamic interplay to influence how survivors manage psychological distress

2.6. Research Questions

1. How do GBV survivors experience and make meaning of psychological distress in the aftermath of violence
2. How do survivors describe the role of internal strengths such as optimism and resilience in their journey of survival and coping?
3. How is social support experienced by GBV survivors, and how does it shape their coping with psychological distress?
4. How do GBV survivors experience personal hardiness in enduring and responding to psychological distress?

2.7. General Objective

To explore how optimism, resilience, social support, and hardiness influence coping with psychological distress among gender-based violence survivors at AWSAD.

2.7.1. Specific Objectives

1. To explore the lived experiences of GBV survivors regarding psychological distress and coping in the aftermath of violence.
2. To understand how GBV survivors experience and interpret optimism and resilience as internal strengths in their coping process.
3. To explore how GBV survivors experience social support and the meanings they attach to it in coping with psychological distress.
4. To investigate how personal hardiness is experienced by GBV survivors in enduring and responding to psychological distress.

3. Methodologies

3.1. Study Design

This study employed a qualitative descriptive design to explore and understand the lived experiences of gender-based violence (GBV) survivors regarding how optimism, resilience, social support, and hardiness shape their coping with psychological distress. Qualitative descriptive design was appropriate for this study as it allows for a more flexible approach that can be guided by existing theoretical frameworks while remaining grounded in participants' own words. This design was well-suited to the present study because the research questions were informed by a pre-existing conceptual framework of protective factors, and the analysis employed a deductive thematic approach using predetermined themes derived from the literature.

3.2. Study setting

The study was conducting at AWSAD which is a non-governmental organization formed in 2003, and provides a transitional women's only shelter, psychological counselling, legal aid and other services to help clients recover from trauma for women and girls who are survivors of Gender Based Violence in Ethiopia. AWSAD currently has various branches in several cities in Ethiopia, including Addis Ababa, Hawassa, and Adama.

3.3. Study Period

The study was conducted from February to May 2026.

3.4. Study Population

The participant of this study were female and women survivors of GBV who were currently residing in AWSAD shelter, which is found in Equatorial Guinea Street, Akaki Kality Sub-city, Woreda 08, and Addis Ababa**.** These participants were GBV survivors who experienced (Intimate partner violence, sexual assault, physical or emotional abuse) and are receiving support services such as psychosocial counselling, legal aid, and shelters.

3.5. Sample size determination

This study used purposive sampling to recruit participants who can provide rich, detailed information about their experiences of coping with psychological distress. Eligible participants were first identified by shelter counselors based on the inclusion criteria provided by the researcher (age 18+, GBV experience at least three months prior, current psychological distress, emotional stability to participate). The counselors provided potential participants with information about the study and asked for their permission to be contacted by the researcher. The researcher then met with each interested participant, re-explained the study purpose and procedures, confirmed eligibility, and obtained informed consent.

Data Saturation was defined using the **a** priori thematic saturation model (39). As described by Saunders and colleagues, a priori thematic saturation refers to "the extent to which pre-determined codes or themes are adequately represented in the data rather like the idea of the categories being sufficiently replete with instances, or 'examples', of data" (39). Data collection continued until sufficient depth and repetition were obtained across the predefined categories. By the ninth interview, participants were providing recurring accounts, and no substantially new insights emerged. Therefore, data collection was concluded after nine participants.

3.6. Eligibility

3.6.1 Inclusion criteria

Participants were women:

Aged 18 years or older

Had left their home due to experiencing GBV and are currently residing at the AWSAD shelter.

Had experienced GBV at least three months prior to participation allowing time for stabilization and reflection on their coping experiences, and were able to give written consent form.

- This timeframe is supported by meta-analytic evidence indicating that the majority of PTSD recovery occurs within the first three months post-trauma, after which the rate of recovery slows and survivors enter a more stable phase of psychological adjustment (41).

Self-report experiencing psychological distress related to the GBV.

Deemed by the shelter counselor as having sufficient emotional stability to understand the study information, provide informed consent, and participate in an interview without immediate risk of psychological harm.

3.6.2 Exclusion criteria

Women with language barriers, and were unable to give consent.

3.7. Data collection and analysis

Data for this study were collected through semi structured interview question developed based on the predetermined themes and designed to explore GBV survivors' experiences of psychological distress and the role played by optimism, resilience, social support, and hardiness in shaping their coping processes. The interviews were conducted face-to-face in a private counselling room within the AWSAD shelter to ensure confidentiality and emotional safety. Each interview lasted approximately 30 to 50 minutes and was conducted in Amharic and audio-recorded to ensure accuracy during transcription and translated back to English.

Data were analyzed using deductive thematic analysis guided by the study's conceptual framework. A deductive approach was appropriate because the study had predetermined protective factors derived from existing literature.

3.8. Data quality assurance

To ensure the quality of this study, the researcher used open-ended and non-directive questions during the interviews, which were conducted in a neutral and minimally

disruptive environment to reduce interruptions. The collected data were transcribed verbatim, translated, and coded promptly to minimize potential bias. Additionally, the emerging themes from pre-existing theory and findings were discussed with the research supervisors to enhance the credibility and trustworthiness of the study.

To further strengthen trustworthiness, the coded data based on the predetermined themes were reviewed by one academic person who provided external scrutiny of the analysis.

3.9. Ethical consideration

Ethical clearance was obtained from the Department of Psychiatry, College of Health Sciences, Addis Ababa University. Informed written consent was obtained from all participants after explanation of the study's purpose, procedures, and their right to withdraw at any time. Data confidentiality and anonymity were ensured. Before data collection, all participants were given detailed information about the study. After explaining all the purposes, risks, benefits, confidentiality of the information, and voluntary nature of the participation, both verbal and written informed consent was obtained from all subjects before the study.

4. Findings

4.1. Demographic background

The study included nine participants who were selected based on their experiences related to Gender Based violence. All participants were female and their age range is between18 – 35. All of the participants had experienced varying forms of Gender Based Violence, including Interpersonal violence, Physical abuse, and sexual violence and are currently residing in the AWSAD shelter.

Several participants had children, with caregiving responsibilities being a central aspect of their lived experience. Educational backgrounds ranged from no formal education to primary and secondary level schooling.

The participants selected for this study have experienced GBV at least three months prior to participation, and experienced any form of psychological distress related to the GBV, and deemed by shelter staff counsellors as emotionally stable enough to reflect on their coping experience

Participant	Age	Education	Type of GBV	Children
1	22	G-9	Sexual	2
2	29	G-8	Physical	1
3	22	G-11	Psychological	1
4	22	G-12	Psychological	1
5	26	Diploma	Physical and psychological	1
6	20	G-8	Psychological	1
7	35	5th year university (dropped out)	Sexual	No
8	19	G-8	Physical and psychological	1
9	18	No formal education	Sexual	1

Table: 1. Demographic background of participants

4.2. Experiencing Psychological distress in response to Gender Based Violence

All participants reported experiencing different forms of psychological distress in response to Gender Based Violence. However, the severity and manifestation of distress differed across participants. They reported intense emotional suffering, hopelessness, fear, shame, suicidal ideation, anger, and emotional instability.

For many participants, psychological distress did not emerge only from the experience of Gender Based Violent itself, but also from the long-term consequences that followed, including homelessness, rejection, poverty, lack of support, and the burden of raising children alone. Participants response showed that the impact of gender-based violence extended beyond immediate physical or sexual harm but deeply affected their hope, emotional wellbeing, and ability to cope with daily life.

4.2.1. Hopelessness and Suicidal Ideation

One of the strongest experiences described by participants was hopelessness and emotional exhaustion. Eight of nine participants explained that after the abuse they reached a point where life no longer felt meaningful or manageable and developed thoughts of ending their own lives. Some participants also reported attempts.

Participant 1 described how she refrained from suicide only because of her children:

"I refrained from killing myself. I often felt the urge to kill myself. I refrained from doing so because I thought these children had no one else."

Participant 3 reported active attempts to end her life during pregnancy:

"I dissolved some lemon and salt in water and drank it, thinking it would terminate the pregnancy. At that time, because of the distress I was experiencing, I felt that my inner self was deeply damaged."

She later described preparing to kill herself after giving birth:

"I thought about killing myself many times. At that time, I could not find anything to use. If I had, I would have seriously harmed myself."

Participant 9 described the most severe case. She is the youngest participant (18 years old) and reported intense experiences including rape by her employer, homelessness, and giving birth to her daughter alone in a rented room without any assistance. She described feeling deeply ashamed:

"I was very afraid of people. Giving birth alone in a room made me feel deeply ashamed of myself."

She explained that after giving birth to her daughter, and experienced difficult periods, she experienced hopelessness and thoughts of killing both herself and her child:

"I thought about ending my life many times. I made attempts to do so. I even thought, 'Why should I give this child to the government? I should kill her instead.'"

"I had prepared a plan, thinking that I would kill my child and then kill myself."

Only Participant 4 reported no suicidal thoughts. Her distress was milder, and she maintained hope throughout her pregnancy and after giving birth.

These findings suggest that hopelessness and suicidal ideation were common experiences among participants following GBV. Most participants described feeling overwhelmed by their circumstances and losing hope for the future, which contributed to thoughts of ending their lives. The severity of these experiences varied, ranging from suicidal thoughts to active suicide attempts and plans. Participants who reported more severe abuse, social isolation, and life challenges appeared to experience more intense hopelessness and suicidal ideation. In contrast, Participant 4 maintained hope despite her difficulties and did not report suicidal thoughts.

4.2.2. Behavioral Changes: Anger, Irritability, and Losing Control

Beyond suicidal ideation, five participants reported behavioral and emotional changes including being easily irritable, quick to anger, and unable to control their reactions toward others.

Participant 3 described how her previous self had disappeared entirely:

"My behavior is no longer the same as it was before. My mind feels completely poisoned. My current behavior and my previous behavior are nothing alike."

She explained that even though she could control her emotions, her behavior had changed beyond her control:

"I can control my emotions very well, but my behavior has changed a lot. Even when people talk, I hate the sound of human voices. I cannot get along with the children in the shelter at all."

Participant 5 described how the exhaustion of caring for her child made her snap at others:

"When he exhausts me so much, and other people ask me to help with work or something, I snap at them. I become irritable with them. That is what has exhausted me."

Participant 9 described the most severe behavioral changes. She reported fighting with other residents daily, screaming at staff, and being unable to control her anger:

"Even while I was here, I used to do many things that were wrong. I caused a lot of disruptions. Whenever people talked to me, even when they were saying good things, I became very angry. Everything seemed bad to me."

"I used to fight with the other residents very often. I got angry very easily. We fought almost every day. When my thoughts clashed with others', I became very angry."

"Everything was difficult for me. When I looked back on the life I had been through, everything felt difficult. I could not get along with people at all. Even when my child cried, I would hit her and say, 'Why are you crying?' Everything made me angry."

These findings indicate that psychological distress was associated with noticeable behavioral changes among participants. Common changes included irritability, social withdrawal, difficulty getting along with others, and increased anger. The severity of these changes varied across participants, with some reporting withdrawal from social interactions, while others described frequent conflicts and aggressive behaviors. Overall, the findings suggest that distress affected participants' ability to regulate their emotions and maintain positive interpersonal relationships.

4.2.3. Crying and Emotional Sensitivity

In addition to behavioral changes, participants described profound emotional suffering. Crying was nearly universal and often uncontrollable.

Participant 1 explained how she had become someone who cries constantly:

"I have become someone who cries very easily. Because I was deeply hurt, I now cry very often."

Participant 3 described hiding away to cry alone:

"I used to hide away and cry all the time. I cried a lot and worried those around me. I would hide myself and cry alone."

She also described how even the counselor's questions would make her break down:

"When she asked me, 'How has the postpartum period been for you?' it made me very sad. I felt much worse than I had before."

Participant 4 described spending her nights crying:

"At night, even a small worry would make me cry, and I would wake up with swollen eyes."

Participant 7 stated simply:

"I cried a lot. Sometimes, I would cry for no apparent reason."

These findings indicate that crying was a common emotional response among participants and reflected the depth of their psychological distress. Participants described frequent and sometimes uncontrollable crying, often occurring in isolation or in response to reminders of their experiences. The findings suggest that emotional sensitivity and persistent sadness were significant features of their distress, affecting their daily functioning and emotional well-being.

4.2.4. Intrusive Symptoms, Nightmares, and Sleep Disturbances

Many participants also experienced intrusive symptoms and nightmares.

Participant 1 described:

"Traumatic and painful memories, nightmares... the things that happened to me would replay repeatedly in my dreams."

Participant 3 described feeling like something was possessing her:

"Sometimes I wake up at night and go outside and walk around. It feels as if something is holding me tightly, like a nightmare. I find myself in another world."

Participant 7 explained how unwanted thoughts would come:

"What happened to me used to come back repeatedly in my dreams. Sometimes unwanted thoughts would come over me, and it felt like something beyond my control."

Sleep disturbances accompanied these intrusive symptoms. Participant 3 stated:

"I do not sleep. I stay awake throughout the night in the darkness, consumed by these thoughts. I have never been able to sleep properly."

Participant 9 described waking up and leaving her bed without knowing it:

"I even get up at night and go outside. I think I am sleeping in my bed, but somehow I get up and leave without realizing it. I scream a lot."

These findings suggest that intrusive memories, nightmares, and sleep disturbances were common among participants. Many described repeatedly reliving distressing experiences through dreams and unwanted thoughts, while others reported severe sleep difficulties and nighttime disturbances. The findings indicate that the effects of GBV persisted beyond the traumatic events themselves, continuing to affect participants' thoughts, sleep, and overall psychological well-being.

4.2.5. Anxiety, Numbness, and loss of trust

Beyond specific symptoms, participants described a general sense of being anxious, damaged, or unable to trust other people.

Participant 1 stated:

"Psychologically, I have been deeply hurt. I have stopped trusting people. It does not go away completely; it is something very difficult."

Participant 2 described how her morale was affected:

"First, it affects your morale. It is very hard and has many impacts. Nothing good comes from it."

Participant 3 explained her emotional state:

"My mind feels poisoned. I am constantly overthinking and distressed. My inner self has become very numb. I have come to accept myself as if my way of thinking is not right."

Participant 8 described her distress and anxiety:

"It was very difficult. I was in great distress. Because I was also hurt, I experienced a lot of anxiety and worried constantly. I even became physically sick."

These findings suggest that participants experienced a general sense of psychological damage characterized by anxiety, emotional numbness, and loss of trust in others. Many described persistent worry and difficulty recovering emotionally, indicating long-term effects on their mental well-being. The findings highlight how GBV contributed to reduced trust, ongoing distress, and a weakened sense of psychological stability.

4.3. Social Support as a Protective and Turning Point Factor

Social support was the most critical turning point for participants in this study. Before receiving support, most participants could not imagine recovering. After receiving support, they began to heal.

Most survivors highlighted the significant role of counseling support they received in the shelter. The participants spoke about how this support served as a starting point in their recovery from the psychological distress that followed Gender Based Violence.

Participant 8 stated:

"Yes, the organization I am in now has helped me a lot, thank God, in many ways. From mental trauma, overthinking, and anxiety, it has relieved me a lot. It has also taught me many things."

Participants described that, beyond experiencing trauma, what made things more complicated was the lack of family support in the aftermath. Few participants (3 out of 9) reported receiving support from a family member. However, only one participant highlighted the primary role of support from her mother. She said:

"First and foremost, it is my mother who stood by my side."

Six out of nine participants reported that their families either did not know about their situation, were unable to help, or had abandoned them. For these participants, the shelter and counseling services became their primary source of support.

Participant 2 explained that her family never helped her:

"My family has never helped me. No friend or family helped me. Even when I was being beaten, people just stood and watched. No one helped me."

For some participants, family was not only absent but also perceived as unsafe. Returning to family meant facing punishment, shame, or rejection. As a result, some chose to hide their situations entirely rather than risk further harm.

Participant 3 also reported having no family support. She explained:

"I cannot go to my family like this. My family is very strict; they would make me lose my life. None of my family knows that I am like this or where I am."

Some participants did not have rejecting families but rather families who simply did not know about their situation. The shame associated with their experiences prevented them from reaching out.

Participant 8 also reported no family support:

"Nobody in my family knows. I haven't told my friends either. Nobody knows where I am."

She described how Women and Children Affairs and the shelter supported her:

"First, Women and Children Affairs helped me in many ways. They covered all the hospital expenses. Secondly, AWSAD accepted me freely and provided me with many services. What helped me most is AWSAD."

Participant 9 had the most extreme case of family absence. She had been without family since the age of six:

"I left home when I was six years old. I grew up in someone's house. I didn't know anyone. I have no one."

These findings suggest that social support played a crucial protective role in participants' recovery and was described as a major turning point after GBV experiences. While most participants initially experienced isolation and lack of support, engagement with shelter services and counseling contributed to reduced distress and improved coping. The absence of family support, and in some cases fear or rejection from family members, intensified participants' vulnerability and limited their recovery options. Overall, institutional support from the shelter emerged as the primary source of emotional and practical assistance for most participants.

4.3.1. Practical Support: Safety, Survival, and Stability

After getting into the AWSAD shelter, participants described the shelter as a turning point and a source of hope for their recovery journey. All participants reported receiving holistic and practical service from the shelter staff. They described the shelter as the first place they felt safe and secure after leaving an abusive situation. It provided access to basic needs including food, clothing, beds, and sanitary products.

For participants who had been living on the streets or in unsafe situations, this practical support was critical.

Participant 3 described how the shelter staff helped her when she was unable to care for herself:

"They made me stand. I could not stand when I came. They made me eat and drink and helped me to become functional again. A family would not have received me like this."

She also described how the staff did not only meet her basic needs but cared for her like family something she had never experienced before.

Participant 3 further explained:

"They help a lot. There are nurses and psychological counselors; they work hard in their respective fields. To tell the truth, they do not just do it because it is their job, but with a sisterly attitude, thinking, 'what if she were my sister, my mother, my child, or my friend?' They work as if their own family member were in need."

Participant 3 also described how the shelter comprehensively met her daily needs:

"Since I entered this shelter, the support has been consistent and the same for everyone. There is bedroom service, food breakfast, lunch, and dinner shower, laundry, everything you need at home is provided here. They give soap every week, laundry soap separately, and bar soap separately."

Other participants described how the shelter removed the constant burden of worrying about basic needs. This relief created mental space for healing.

Participant 6 explained:

"If I were outside, I would need many things like house rent, groceries, soap. Since I came here, I do not pay for these. Everything is covered. This has been a great help to me."

She also described how the support was comprehensive and dignified, making participants feel cared for and respected:

"Since I entered here, everything including soap, toiletries, food, blankets, clothes, beds is provided for us. We are living well."

For some participants, practical support extended beyond basic needs and included transportation, food for their children, and legal assistance.

Participant 5 described:

"Here, they also help with transport, supplies, milk for the child, and food."

Beyond material support, the shelter's assistance helped restore participants' trust in people. For Participant 5, who had developed strong negative feelings toward others, the support changed her outlook:

"Their support was very important. I had started to hate people. Being alone, I used to think, 'to which world shall I go?' But they supported me financially and emotionally, encouraging me to be strong. They made me feel that I would not be left alone."

The shelter also provided training and skill development, giving participants hope for their future after leaving.

Participant 7 described:

"They arrange various training opportunities. Recently, I was sent to another place for design training. That gave me hope. Now I know what I can do when I leave here."

Participant 8 similarly stated:

"I attend various trainings. They also provide money for house rent and basic needs when we leave, so we do not fall back into the same situation. It gives me strength and hope that I will be able to work after leaving."

She also emphasized that simply having shelter was the most important support:

"For me, all the help is important. But more than food and other support, simply having this shelter is the most important thing."

Other participants noted that staff also helped them identify their needs and goals by asking what they wanted.

Participant 1 explained:

"They ask me what I want. If there is something I need or can do, they help me to achieve it."

Participant 2 described legal and institutional support:

"For about two months, they supported me through legal processes and court follow-ups. They also registered me for training. I am now waiting with hope that I may get work through the institution."

Across all these accounts, the shelter's practical support was not just about meeting basic needs. It was about treating and guiding participants in every aspect of their recovery journey.

4.3.2. Counseling: The Core of Psychological Recovery

While participants were grateful for basic needs and additional services, they consistently identified counseling as the most important factor in their psychological recovery. Counseling helped them understand themselves, regain hope, control their emotions, and rebuild their identity.

Many participants highlighted that the most beneficial support and the starting point of their recovery was the strength they found from the counseling support through shelter counselors.

Participant 3, who had experienced severe distress including suicidal thoughts, said:

"What helped me the most are the counselors. They helped me return to myself more than I expected. What I consider the most important support from this organization is the counseling. The counselor has a very important place in my life."

She also described how the counselor's patience and non-judgmental listening made a difference. Unlike others who might have responded to her anger with punishment, the counselor waited calmly and then offered guidance.

"Even when I speak loudly or shout, she waits until I finish. Then she gives me advice. She tells me, the reason you are like this is because of this, but after this, you will be like this."

Participant 1 also clearly stated that counseling was what benefited her most:

"What helped me most is counseling. The counselors know your history in detail. They go deeply into your situation because they are there to support your psychological well-being, and they provide care in a way that is comfortable for you. I think counseling benefited me the most."

Participant 5 described how counselors gave her hope by speaking about her future:

"What gives me hope is when they tell me, 'Be strong, we will give you training, we will support your child.' Those words give me great hope."

Participant 6 explained that counseling helped her calm down and think clearly:

"Counseling and the support I received here helped calm me down. Our counselors advise us, saying, 'If this happens, it means this; if that happens, it means that.' From this, I became stronger."

Participant 7 described how counseling helped her understand her behavior and reactions:

"They provided me with psychotherapy and counseling. The advice I received here helped me understand everything about my behavior and what I should do. It has benefited me a lot."

Participant 8 described how counselors helped her feel capable and strong:

"There are people who give us counseling and support. When we feel down, they lift us up, advise us, and share different stories. They remind us of our strengths and help us recognize them. This gives me strength."

Participant 9, who had severe behavioral difficulties including fighting with other residents and aggression toward her child, explained that counseling helped her regulate her anger and behavior:

"What helped me was counseling. It helped me return to my previous healthy behavior and develop a better outlook toward people. They advise me every day. Now I have hope for the future, and my behavior has improved."

She contrasted the shelter with counseling (AWSAD) to a previous shelter without counseling (Mother Teresa):

"There, there was no counseling or advice. We were just living there. They only knew I was fighting, but they did not understand why I was fighting. It was just living without support. But here, they listen to us. We receive counseling, and even when I get angry, they treat me well."

Overall, these findings indicate that counseling was the most central component of psychological recovery among participants. A comparison of participants' experiences across different settings further highlights its importance, as those who lacked counseling services described receiving only basic support without emotional understanding or guidance. This contrast shows that while practical assistance was helpful, counseling was the key factor that enabled psychological healing and recovery after GBV.

4.3.3. The Power of Peers and Strangers: Learning from Others and Unexpected Help

Beyond formal support from shelter staff and counselors, participants drew significant strength from other survivors living in the shelter. Meeting women who had experienced similar trauma helped participants feel less alone, learn from others, gain perspective on their own situation, and find hope for their own recovery. Some participants also received unexpected help from strangers during their most difficult moments.

Unexpected Help from Strangers

Some participants also received help from strangers during their most difficult moments. These unexpected acts of kindness were deeply meaningful and contributed to their recovery.

Participant 8 described how a woman she did not know advised her during her pregnancy:

"There was a woman who lived there renting. Her husband had left her, and she used to advise me. She would tell me, 'Take heart, it will pass; I have been through this.' From her, I learned strength."

Participant 9 described the most striking example of unexpected help. After giving birth on the road and staying at a police station, a woman who worked in a hair salon helped her:

"She placed a canvas over me so the rain would not hit me. She brought me food and said, 'Stay here with me until they find an organization for you.' I am very grateful to her; I can never repay her kindness."

Participant 9 also explained how the help she received from strangers contributed to her strength and her ability to give back to others:

"People who help me like this are helping me become stronger and build a better life in the future. It also makes me feel that I can be kind to others and treat people well in return."

Learning from Other Survivors and Gaining Perspective

Many participants described how meeting other women who had gone through similar experiences helped them realize they were not alone. A recurring theme was comparing their situations to others who had suffered more severe experiences, which helped them feel stronger, more grateful, and more capable of recovery.

Participant 1 explained how sharing problems with other survivors helped her gain perspective:

"When you meet others and share your problems and challenges, you realize that there are situations worse than yours. This makes you stronger and more grateful. I think sharing experiences is helpful."

Participant 2 described how seeing women who had suffered more severe abuse helped her feel stronger:

"It helped me a lot because there are women who have suffered more than I have. When I see them and hear their stories, I feel that my situation is not the worst. It makes me strong and grateful."

Participant 5 described how seeing other women helped her realize she was not alone:

"When I see all the women here, I realize I was not the only one who was hurt. I tell myself there are others worse off than me, and I become strong and thankful."

She also described how living with people from different backgrounds taught her tolerance and resilience:

"Getting to know different people here has taught me how to live with others. I have learned tolerance and understanding of different behaviors, languages, and backgrounds."

Participant 8 explained how seeing long-term survivors gave her strength:

"When I first came here, I felt like I was the only one who was hurt. But seeing other women who have recovered and become strong gives me hope and strength."

She also described mutual encouragement among residents:

"There are people here who encourage you and tell you to take heart. I gain strength from such support."

Participant 8 further explained:

"Getting to know others has helped me a lot. If I were alone, I might overthink and struggle more. But here, I realize I am not alone, and I also learn from others and share my experiences."

Participant 7 described her feelings about some shelter activities:

"We cook our own food here, and I do not feel comfortable with that. Activities like chopping wood and baking injera do not really suit me. I just want to improve myself."

Overall, these findings suggest that peer support and informal interactions within the shelter played an important role in participants' psychological recovery. Sharing experiences with other survivors helped participants reduce feelings of isolation, gain perspective on their own suffering, and develop a sense of strength and gratitude. In addition, unexpected acts of kindness from strangers contributed to emotional support and reinforced feelings of hope and humanity. Together, these experiences highlight that both peer connection and informal social support were significant protective factors alongside formal counseling and institutional care.

4.4. How Optimism Helped Survivors Cope

While all participants experienced significant psychological distress, many also described how optimism helped them cope. Optimism, in this study, refers to participants' expectations that their future could improve and their belief that they could survive and rebuild their lives. However, the presence and trajectory of optimism varied considerably across participants. Some never lost hope. Others lost hope completely but later regained it through counseling, shelter, faith, or their children.

Most participants in this study experienced a transition from hopelessness to restored hope. Participant 1 described her initial state:

"I didn't think things would pass... I didn't even think about the future."

After receiving counseling and shelter support, she reported:

"After I get counseled... I start to think about the future." Similarly, Participant 6 stated***:***

I did not even think about tomorrow; even thinking about today was very hard for me."
"Now, I am in a better place. Having found a shelter, I feel that my life has improved."

Participant 3 remained in a state of future-blindness despite receiving institutional support:

"I don't know, I have no thought of any kind regarding that. You cannot think about the future when you have nothing."

4.4.1 The Arc of Hope: Losing, Finding, or Never Regaining Optimism

For most participants, optimism was not present immediately after the abuse. Instead, hope was something that returned gradually after receiving support. However, the timing and extent of this return varied.

Several participants described moving from complete hopelessness to restored hope after entering the shelter and receiving counseling.

Participant 1 explained how she initially could not think about the future at all:

"I didn't think things would pass. I didn't even think about the future."

But after receiving counseling, she described a shift:

"After I got counseled... it is after that I start to think about the future."

She later stated with confidence:

"I will live a very good life... I will be a strong worker."

Similarly, Participant 2 described her past hopelessness:

"At that time, I never thought about hope or the future. I never thought about any hope."

After coming to the shelter and receiving support, her outlook changed:

"Now, when I think about my tomorrow, I see good things—that I can work and raise my child properly. I have realized this after coming here."

Participant 7 also described her shift from hopelessness to hope:

"At that time, I didn't think about the future. I didn't think people would accept me either."

But later she stated:

"Right now, I think that I will do work, that I will change. I have great hope for the future. I want to finish my education and get a good job."

Participant 8 describes the same experience of shifting from losing hope to restoring after shelter counselling support.

"While I was outside, before I entered here, life was very difficult for me. How am I going to live? I had reached a point where I had lost hope."

She later described:

"But when I entered here, with the advice and support I received, I started to hope again. I began to believe that I can live and do many things without giving up.

Participant 9 described the most dramatic transformation. She explained her past hopelessness:

"I had lost hope. I didn't have the thought that I could endure this life and raise my child."

Later, after receiving counseling and support, she stated:

"When I listen to the advice given to me and try to apply it, I now have hoped to live in the future."

One participant, Participant 3, stood apart from the others. Despite receiving shelter and counseling, she remained in a state of hopelessness throughout her time at the shelter.

She explained:

"I don't know, I have no thought of any kind regarding that. You cannot think about the future when you have nothing. Sitting in someone else's hands with empty hands, how can I think about my tomorrow?"

"I do not know; I have no thoughts about that. You cannot think about the future when you have nothing. Staying at someone else's place, how can I think about tomorrow when I have nothing?"

When asked if she had felt hopeful in the past month, she responded:

"No."

Her case shows that for some survivors, even when institutional support is available, hope may not return.

Overall, these findings show that optimism was largely shaped by access to support, with most participants regaining hope after counseling and shelter services, although this recovery was not universal.

4.4.2 Where Hope Came From: Children, Faith, and Believing in Oneself

Participants who regained or maintained hope identified specific sources that sustained them. The most commonly reported sources were children, faith, and belief in their own abilities.

Children as a Source of Hope

For many participants, their children were the primary reason they continued to hope and plan for the future.

Participant 2 explained how her child gave her hope:

"When I see my child, I feel that I can live and that I must live for him. My child is the reason I continue."

She described her hopes for the future:

"I hope that I can go out and work, that I can put him in daycare and do my own work."

Participant 4 stated simply that her daughter was her only hope:

"It is my daughter. There is nothing else. She is my hope. I tell myself, 'Now I have her.' I will strive for her."

Participant 6 also described how her child gave her hope:

"When my child grows up a little, I will go out and work. Through the support I received, I have calmed down and gained strength."

Participant 8 explained that her child was her primary strength:

"When I see my child, I become strong. My child is my primary strength to me. It is in my child that I hope, because I think this child will grow up and do many things for me."

Faith as a Source of Hope

Faith was another powerful source of hope for many participants. Eight of nine participants mentioned God or prayer as a reason they did not give up.

Participant 1 stated:

"The first thing that gives me a hope is prayer"

Participant 2 explained:

"I pray often. It calms me in many ways. When I sleep after praying, it feel hope."

Participant 5 described how prayer encouraged her:

"It is prayer that encourages me—my God. My Creator is the one who gives me hope."

Participant 7 stated her hope was in God alone:

"My hope is in God alone. Because unless God helps you, you will remain right there forever, meaning as a damaged person."

Participant 8 also credited her faith:

"I believe that there is a better day. When things get tough on me, I pray to the God. I think of it as Gods test."

Participant 9 described how faith gave her the strength to continue:

"What helps me is prayer. I always hear from God that I will pass through this and live a good life in the future. I hope in God."

The only participant who did not mention faith as a source of hope was Participant 4, whose hope came exclusively from her daughter.

Believing in Oneself as a Source of Hope

Several participants also described how believing in their own abilities gave them hope for the future.

Participant 2 described her self-confidence:

"Believing that I can work and change my life on my own gives me hope."

Participant 7 described how reading a book helped restore her self-belief:

"I read a book. It made me hopeful and helped me not break down. I was able to see what I can do."

Participant 9 expressed strong self-belief:

"I convince myself that I can handle it. Better than the life I passed through will come, but worse will not come. Even if it comes, I can handle it."

Overall, this theme shows that survivors' hope was mainly shaped by three key sources: their children, faith, and belief in their own abilities. Children served as a strong motivation to survive and rebuild life, while faith provided emotional comfort, strength, and meaning during difficult times. In addition, self-belief helped participants regain confidence and develop a sense of control over their future. Together, these sources highlight that optimism among survivors was deeply connected to personal relationships, spirituality, and internal strength.

4.5. Resilience as Internal Strength and Recovery

Resilience was a critical protective factor that helped participants to cope with psychological distress following GBV. However, participants did not all become resilient in the same way. Some gain strength from past hardships they had already survived. Others developed resilience despite having no prior experience with adversity. Across both ways, participants described common internal resources that kept them going: endurance, inner strength, and faith. Many also found meaning in their suffering, gain purpose from their children, and learned that speaking out about their problems could be a source of strength.

4.5.1. Two Ways to Be Strong: Using Past Pain or Finding Strength without It

Participants followed two distinct pathways to resilience. Some drew on past hardships they had already survived, using those experiences as proof that they could survive again. Others developed resilience despite having no prior experience with significant adversity.

Resilience through Past Hardship

Several participants explicitly stated that surviving difficult experiences in the past gave them strength to face their current situation.

Participant 1 explained how previous challenges helped her build strength:

"Those challenges helped me build strength. Problems make you build strength. Since those problems helped me build some strength, this is just another challenge. It gave me the strength to think, 'this is something I can build strength from.'"

She also described how knowing she had survived before gave her confidence for the future:

"Even if a bigger problem than my past ones comes, I will withstand it. I am certain that whatever challenge comes into my life, I will endure it and pass through it."

Participant 3 drew on her extensive past hardships:

"I have been through so much pain. I had another life before this, and I suffered a lot in that life too. I have gone through very difficult years, and now I am at a better level."

She added:

"This trouble itself teaches many things. Trials teach you not to despise work. Suffering teaches many things."

Participant 4 said:

"My mother raised me without a father. Thinking of her, I told myself I must also be like her and raise my daughter. That gave me strength."

She also explained:

"Because I went through all those problems and I know my background, I told myself, 'this is not more than that,' and I must pass through this too."

Participant 5 said:

"This trouble itself teaches many things. Suffering teaches you not to despise work. It can also push you to prove others wrong by becoming strong."

Participant 7 explained:

"I learned many things from my past life, especially patience and strength. I went through a very difficult time. Now I no longer blame anyone. I have accepted whatever comes."

Participant 9 said:

"A better life than what I went through will come, but worse will not come. Even if it comes, I can handle it. I have convinced myself that I can handle it."

She also said:

"I went through many bitter days. I was almost killed. It was from the mouth of danger that my Creator rescued me and brought me here."

Resilience without Past Hardship

Not all participants had past hardships to draw on. Three participants (2, 6, & 8) explicitly stated that they had never faced significant adversity before the GBV they experienced. Despite this, they still developed resilience.

Participant 2 stated clearly:

"I was happy before. I had never experienced anything like this before. This is the hardest thing for me."

Despite having no past hardship to draw on, she developed resilience through endurance and faith, stating:

"I helped myself. The biggest thing is that I survived. By being strong and enduring my pain, I recovered myself."

Participant 6 also reported no prior hardship:

"No, there wasn't. I have never faced something hard like this before."

Yet she developed resilience through self-calming:

"By calming myself, I reached here. I try to think positively and focus on working for the future."

Participant 8 similarly reported no past hardship:

"There is no such kind of thing. I have never faced something this severe before."

Despite this, she developed resilience through her child and faith:

"When I see my child, I become strong. My child is my primary strength to me. It is in my child that I hope, because I think this child will grow up and do many things for me."

Overall, these findings suggest that resilience developed in two ways: through past hardships or through coping without prior adversity. In both cases, resilience was strengthened by internal resources such as endurance, self-belief, and acceptance, showing that resilience is a dynamic process shaped by both past experiences and current coping.

4.5.2. What Kept survivors Going Inside: Endurance, Inner Strength, and Faith

Across both ways, participants described common internal resources that helped them endure. The most frequently reported were endurance (persisting despite difficulty), inner strength (a perceived internal capacity), and prayer and belief in God.

Endurance

Many participants described enduring their circumstances simply because they had no other option. This was not passive suffering but an active choice to keep going.

Participant 2 explained that having no choice forced her to endure:

"When I think about it, there was simply no option. If there were someone by my side, you would say 'they will carry it for me.' But when you realize there is no one for you, you simply have no choice. Unless you struggle through life, you cannot pass."

Participant 3 described her endurance:

"I struggled on my own. If you don't stand up for yourself, no one will stand up for you."

"Suing alone has made me rely on myself. In the future too, no matter what offends me, I no longer think 'who is by my side.' I realized that I can do it by myself."

Participant 6 described how she strengthened herself through endurance:

"My capacity is my way of thinking—leaving everything behind and strengthening myself by saying 'I will work and grow like this, it is nothing, it is just one child.'"

Participant 7 also explained how she endured alone:

"I said I would not go with anyone, and I slept on the street for 15 days. I didn't want anyone to be with me. I have friends; I could have gone to them, but I decided I don't want anyone. I made that decision."

She also reflected on her strength:

"I have seen how strong I am. I overcame it alone without anyone being by my side."

Participant 8 described guiding herself through endurance:

"No one was near me. I was guiding myself by myself."

Participant 9 explained that she had always endured since childhood:

"I was making an effort to raise myself. I didn't grow up with family. No one was near me. I was guiding myself by myself."

Overall, endurance emerged as a survival strategy shaped mainly by necessity and lack of support. Participants described continuing through difficulties by relying on themselves when no external help was available. This shows that endurance was not passive suffering, but an active coping response that enabled survivors to persist through severe adversity.

Inner Strength

Several participants explicitly identified their own inner strength as the most important factor in their recovery.

Participant 1 stated:

"It is my own strength. Because anyone can come and tell you any anything, but if you don't have strength inside you, it is hard to build it again. I think it is my own strength."

She also advised other women:

"Any woman should be able to listen to herself. Because she has her own strength that she doesn't know. Any kind of problem will be overcome."

Participant 2 similarly said:

"Even before coming here, it was by my own strength that I passed through difficult things and came here. Even reaching here, I escaped from death, and it was again my own strength that kept my life from being lost."

Participant 5 described how she became stronger:

"Compared to before, I am now becoming stronger. Here, I have recovered very much. I have understood that I can do everything by myself."

Participant 7 described her inner strength:

"My ability to think positively is what gives me hope. I have decided. Even before, for something I believed in, I did not step back."

She also reflected on her recovery:

"Now, thank God, I have calmed down very much. When I sleep and wake up, I feel good. My ability to think positively is what gives me hope."

Participant 9 stated:

"I think of myself as strong. My own strength helped me a lot. Having withstood many things and passed through them, and today holding my daughter, becoming a strong person, reaching here today makes me very happy."

She also described how she had endured from a young age:

"Even when that man was struggling with me like that, he was a grown man, but I escaped from his hands too. I paid a heavy price to raise myself. After I grew up, another pressure was created, and I endured that too. Reaching today, I don't even know how I managed it."

Based on the participants' response, inner strength was described as a key internal resource that helped participants survive and recover from GBV. Participants viewed strength as something within themselves that enabled them to overcome past and current challenges. This suggests that resilience was closely linked to self-belief and the recognition of personal capacity to endure and rebuild life.

Faith as a Source of Strength

For many participants, faith was deeply intertwined with their inner strength. Eight of nine participants described prayer and belief in God as sources of calm, hope, and endurance.

Participant 1 explained:

"When I pray, I always receive an answer in some way. Being able to pray a lot also helps me accept people's ideas."

Participant 2 described how prayer calmed her:

"I pray often. It calms me in many ways. When I sleep after praying, it gives me hope. The next day, I hear something like 'be strong.' There is nothing to calm me; it is only prayer."

Participant 3 explained that faith was what strengthened her:

"My faith has helped me a lot. I believe in my faith. It has strengthened me until now. Through my faith, I have reached this stage. Truly, my Lady Virgin Mary is the one who helps me quickly; she thinks of me very much."

She described how prayer gave her strength:

"When I pray, I always get help from God. Prayer is the number one thing. It helps me a lot. God helps you from above. He helps you to be strong through His power and blessing."

Participant 5 stated:

"It is through prayer. I went to holy water. That is what helped me."

Participant 6 explained:

"I rely on God. If I say to Him, 'Oh my God, make this succeed for me,' then God does it for me. Through my prayer and His kindness, everything becomes easier for me."

Participant 7 described faith as her foundation:

"I read spiritual materials. I believe that God helped me. It is only believing in God. The things that make me live hopefully are mostly spiritual things."

She also described how church helped her:

"Spending time at church has benefited me very much. When you go and listen, a certain power enters inside you. I sit in the Orthodox spiritual compound in the morning and listen. It gives you its own power. Holding onto faith until the end is very fundamental for me."

She described how prayer gave her strength in difficult moments:

"When I feel like this, I read spiritual materials about strength and thanksgiving. I read these things and my mind gets renewed."

Participant 8 explained:

"When I get anxious or when trouble happens, I pray to God. I pray, I cry, but I calm down. After I pray, I think calmly. It gives me strength. Prayer is the number one thing."

She also described how faith sustained her when she was alone:

"When I was pregnant and close to giving birth, there was no one by my side. Only the icon of St. Michael was with me. Through prayer to the Creator, I gave birth without anxiety. God helped me when no one was by my side."

Participant 9 described faith as what gave her strength to endure:

"What helps me is prayer. I always believe that God will help me pass through this and live a good life in the future. The one who gave me the power to be strong is the Creator. I think this strength is given to me by God."

She also explained that faith and counseling worked together:

"I believe this strength is given to me by God. In addition, the advice they give me and the examples they share also give me strength to live a better life in the future and to rise after falling."

She concluded:

"I was not strong either, but the one who gave me the power to be strong is the Creator. The one who gave me the strength to pass through all of this is God."

The only participant who did not mention faith as a source of strength was Participant 4**,** whose strength came exclusively from her daughter and her mother's example.

Overall, the findings show that faith was a key internal source of strength for most participants. Prayer and belief in God helped them manage emotional distress, regain calmness, and endure difficult experiences. Faith also provided meaning and reassurance during periods of isolation and crisis, showing that spiritual belief played a central role in sustaining psychological resilience alongside other internal coping resources.

4.5.3. Finding Meaning and Moving Forward: Children, Purpose, and Speaking Out

Beyond internal resources, participants also found resilience through meaning-making which is reframing their suffering as purposeful thing, and their children as a reason to keep living.

Several participants described viewing their suffering as having purpose or meaning.

Participant 1 explained her meaning-making process:

"I think that whatever happens in my life, it is for the best. Therefore, I think that way of thinking has helped me pass through things easily."

Participant 4 similarly stated:

"I thought to myself that 'it is for the best.'"

Participant 5 described how trouble taught her not to despise any kind of work:

"Situations teach you not to despise work. People who think like 'you will be nothing,' to show them by being a hero, I think not despising work is useful."

Participant 7 described moving into a place of acceptance:

"I have passed through a time that can be called hard. Now, I am on the acceptance part. I have that thing to accept everything that happened. I want to go in the right path. Thinking this way makes me hopeful."

Participant 9 described meaning-making as:

"I think everything is for good. If this thing I thought of today does not work out, I think tomorrow God will change it in another way and fix it for me. Even if a bad thing comes, I think it is for good."

She also described how her suffering refined her like gold:

"In light of the life I passed through, I think that I will be a strong person, like a person who is refined like gold. I am not an ordinary person. I am not an ordinary thing."

Meaning-making was an important resilience process among participants. By reframing their suffering as purposeful or as part of a larger plan, participants were able to reduce distress and maintain hope. This cognitive reframing helped them accept past experiences and move forward with a more positive outlook.

Children as Purpose and Motivation

For many participants, their children were the primary reason to bounce back.

Participant 1 explained that her children prevented her from killing herself:

"I refrained from killing myself... I feel the urge to kill myself very much. I refrain from killing myself with the thought that these children have no one."

Participant 2 stated:

"It is my child. The one who makes me feel that I can live, that I must live for him, is my child."

Participant 3 explained:

"I have become a mother now. From now on, I have no other choice. I can't throw her out. I must be like my aunt. Let me try to strengthen myself, let me be a person, and let me make my child a person."

Participant 4 stated simply:

"It is my daughter. There is nothing else. She becomes my hope. I say to myself, 'Now I have her.' It is for her that I will strive."

Participant 6 explained:

"What made me not lose hope is this child being born. Thinking 'even if I gave birth, my child is a grace.'"

Participant 8 described her child as her primary strength:

"When I see my child, I become strong. My child is my primary strength to me. It is in my child that I hope, because I think this child will grow up and do many things for me."

Participant 9 explained that she lives for her child:

"After this, I want to live for my child. As long as she has come to this earth, I live for her. To make her happy and to bring out what she is capable of, I want to make her live the life she wants. Because I make an effort for her, because I live for her, I have hope."

Overall, children emerged as the strongest source of purpose and motivation for participants. Many survivors reported that their children gave them a reason to survive, recover, and plan for the future. This indicates that motherhood played a central role in strengthening resilience and sustaining hope after GBV experiences.

4.6. How Hardiness Helped Survivors Cope

In this study, participants demonstrated hardiness in three primary ways: taking control through decisive action and self-regulation, staying committed through children and faith, and viewing struggle as a challenge that could be overcome.

4.6.1. Taking Charge: Decisiveness, Self-Control, and Action

Many participants described actively taking control of their situations through decisive action and self-regulation. They made conscious decisions to leave abusive situations, controlled their emotions and behaviors, and took steps to change their circumstances.

Decisiveness: Making the Choice to Leave

Making a conscious decision to leave an abusive situation was described by several participants as a turning point. They reported overcoming fear, shame, and uncertainty gave them a sense of agency they had lost during the abuse.

Participant 1 explained how she became a person of decision:

"I have become a person of decision. Going and telling a person about your problems is not easy by itself. Before you speak, there is a fear that ' people would exclude me.' Being able to decide is what helped me."

For Participant 7, deciding to leave was the biggest thing she did. She described it as the single most important action she took in her recovery journey.

"….being able to decide and leave it and get out is the biggest thing, I think. I decided and came out. I will not go back to the past life again."

She also advised other women to do the same. She described:

“They should not just sit there, but make a decision and leave.”

Participant 9 also described making the decision to leave an unsafe situation. Even as a young woman with no family support, she found the courage to say no and walk away.

She said: *"I told her, 'I want to go out, I don't want to live here.' I decided and came out."* Participants demonstrated the control component of hardiness by actively taking responsibility for their situations and making decisive choices to leave abusive environments. Despite fear and uncertainty, they showed a belief in their ability to influence outcomes through their own actions.

Self-Control: Managing Emotions and Behavior

Beyond deciding to leave, participants also described actively controlling their emotions and behaviors to prevent those feelings from harming themselves or others.

Participant 1 explained how she controlled her reactions for the sake of her children:

"I feel the urge to kill myself very much. I control it so that their feelings don't get disturbed. I refrain from killing myself with the thought that these children have no one."

Participant 2 described how she used prayer and positive thinking to calm herself. She did not wait for her emotions to change she took action to change them.

"I control myself as much as possible. When something happens, I go out and go to church. There I calm myself, telling myself it will pass, and with hope, I return."

Participant 3 described how she learned to control her suicidal thoughts. She recognized that these thoughts were temporary and that if she survived the moment, she could survive the next one.

"When the devil makes you think bad things, like when you think about killing yourself, if you do not act on it in that moment, as long as your soul is in your body, you will keep

thinking. I say, 'O Creator, please return me to myself; tomorrow is another day.' You control yourself and pass through that moment somehow."

Participant 4 described how she tried to manage herself by focusing on the future. Even when things were hard, she reminded herself that she had hope.

Participant 4 described how she tried to manage herself:

"Since I do not let things affect me that much, I try to manage myself—to control myself no matter what, to believe that I will pass through everything, and to have hope for the future."

Participant 6 described how she conquered herself to reach the shelter:

"I was thinking very much about harming myself. I conquered myself and here I came. If I hadn't conquered it while outside, I wouldn't even have been able to reach here. I have conquered it myself. I said 'I must compose myself and stay,' and I managed to enter here."

Participant 7 described how she pushed away negative thoughts by reminding herself of her own strength. She chose not to connect every negative comment to her assault history**.**

"I convince myself that a person can say a lot of things to me. If a person who doesn't know my history says something to me, I shouldn't relate it with my history and become depressed. I think of myself as a very heroic woman. I push away the negative things."

She also described how she took control by visiting her family, something she had been afraid to do. The action itself proved to her that she was capable.

"I decided to go and visit my family in person. I went, I visited them, and I came back. That in itself is a big thing. Everything that I said will never happen, that I can never do, I have seen now that I can do it all."

Participant 8 described how she tried to control things even when life was difficult. Her hope that she could do things even small things kept her going.

"There were many things I tried to do. I hoped that I can do many things. That I can live, without giving up hope, I can live."

Participant 9 described how her behavior changed through self-control. Even she was surprised by her own transformation from someone who could not control her anger to someone who could.

"Compared to the life back then, now after this, my behavior has become better for me. Even I, when I think about it, my change surprises me. From being so bad, from where I had lost hope, now I have changed."

This reflects the *control* dimension of hardiness, where the participant actively regulates her emotions and thoughts instead of being overwhelmed by distress. By deliberately managing her reactions and maintaining hope, she demonstrates a sense of personal agency and the belief that she can influence how she responds to difficult situations.

Taking Action: Doing Something to Change the Situation

Beyond controlling emotions, participants described taking concrete actions to change their circumstances. These actions ranged from legal action to simply showing up each day.

Participant 2 described how she took legal action against her abuser by her own self.

"I was confronting him face-to-face. When there was an appointment, I would go alone and confront him. I finished my case."

Participant 5 described how she sued her husband alone. This action taught her that she could rely on herself.

Participant 5 described how she sued her husband alone:

"Suing him alone has made me rely on myself. In the future too, no matter what offends me, the thought of 'who is by my side?' does not come to me. I have realized that I can do it by myself."

Participant 9 described how she took action to keep her child. Despite pressure to give her daughter to the government, she refused.

"I didn't want to give my child to the government. I said I will not give her to them. I will raise her myself."

This reflects the control dimension of hardiness, where the participant gains confidence through direct action. By handling the legal process alone, she develops self-reliance and a stronger belief in her ability to manage future challenges independently.

4.6.2. Staying Committed: Children and Faith as Anchors

For many participants, commitment to their children and to their faith provided the strength to keep going when they wanted to give up. These anchors gave them a reason to live and a reason to persevere.

Commitment to Children

Participants repeatedly described how their children gave them a reason to stay alive and keep fighting.

Participant 1 explained that her children prevented her from killing herself:

"I refrained killing myself... I feel the urge to kill myself very much. I refrain from killing myself with the thought that these children have no one. I control it so that their feelings don't get disturbed."

She also described how caring for her children helped her forget her own pain. Focusing on their needs gave her a break from her own suffering.

She described how caring for her children helped her forget her pain:

"I focus on his growth. Him eating food, when I wash him, feed him, breastfeed him — leaving all my own things aside, that I must live for him — at that moment, I leave everything behind."

Participant 2 stated clearly that her child was the reason she could live. Without him, she might have given up.

"The only thing that makes me feel that I should live, that I must live for him, is my child. When I see my child sleeping, I realize that he needs me. I must live for him. I must get through these things."

Participant 3 explained how becoming a mother gave a reason to be strong and keep going.

"I have become a mother now. From now on, I have no other choice. I can't throw her out. I must be like my aunt. Let me try to strengthen myself, let me be a person, and let me make my child a person."

She also described how her child helped her return to herself. When she was lost in anger and despair, thinking about her daughter brought her back.

"When I think about what I would do if something happened while I'm holding this infant, for her sake it became like a sacrifice, and I returned to myself."

Participant 4 stated simply that nothing was too hard when it came to her daughter.

"No matter how hard it is, no matter what, I won't hold back from doing anything for the sake of my daughter."

Participant 9 described the heavy price she paid to raise her child. She did not want to give her child away, even when people told her she should.

"This is the price of motherhood. I have sacrificed many things to raise her. To bring her to where she is today — one year and five months old — I have paid a very heavy price. I thought about giving her to the government, but then I change my mind and ask myself, 'What if I raise her myself?' I must raise her."

She explained that she lives for her child:

"After this, I want to live for my child. As long as she has come to this earth, I live for her. To make her happy and to bring out what she is capable of, I want to make her live the life she wants. Because I make an effort for her, because I live for her, I have hope."

For all participants who had children, motherhood served as a powerful anchor of commitment. Children provided a reason to live when personal hope was absent and a reason to endure when suffering was hard. This finding aligns with the commitment component of hardiness, where remaining engaged in life despite stress becomes a pathway from despair to perseverance.

Commitment through Faith

For many participants, faith provided another anchor for commitment. They described relying on God to give them strength and to guide their lives**.**

Participant 1 explained:

"It is God; no one else can help me, first. It is God who gave me these children too. He gave them to me for a reason. Even now, I am alive for a reason. It is God who does everything."

Participant 2 described how faith helped her continue even when she did not understand why things were happening.

"I said, Well, God, do as you will. I continued life. I am still continuing."

Participant 3 described how faith helped her control suicidal thoughts. She prayed to God to return her to herself when she felt lost.

"At that moment, I say 'O God, please return me to myself; tomorrow is another day.' I shouldn't do something to myself and regret it before my God. You have done so much for me. I shouldn't make you sad."

Participant 6 described how faith helped her continue. She prayed to God to return her to herself when she felt out of control.

"I wouldn't kill myself. I say 'O God Creator, return me to myself; tomorrow is another day.'"

Faith reinforced participants' commitment to life. When their own will to live faded, their belief in God kept them going. Praying to be "returned to myself" reflects an active choice to stay engaged in life despite despair the essence of commitment as a component of hardiness.

4.6.3. Seeing Struggle as Strength: Challenge Orientation

Many participants viewed their struggles not as punishments or reasons to give up, but as challenges that could be overcome. This "challenge orientation" helped them reframe adversity as something that could make them stronger.

Adversity as a Challenge to Be Overcome

Participants described viewing their difficulties as temporary problems that they could survive.

Participant 1 explained:

"A challenge greater than the pasts challenges could come into my life. Because I am certain in myself that whatever kind of challenge comes into my life, I will withstand and overcome it."

She reflected on how passing through hard times gave her confidence:

“When I think about the hard times I have passed, I know that problems are temporary. Thinking about that helps me. Even if a greater problem comes, I believe it will pass."

Participant 3 described how she learned that everything passes:

"There is nothing that does not pass; everything passes. God has brought me through everything, and I have reached this stage after passing through all that suffering."

She also reflected on how her past struggles taught her:

"I have learned that something worse than this could happen. Therefore, I must be strong and pass through it. It has become a lesson for me."

Participant 4 explained how she convinced herself that her current struggles were not worse than what she had already survived. This comparison gave her confidence.

"Since I passed through all those problems and know how I grew up, I convinced myself and said, 'This is not worse than that. I must pass through this too.' facing problems in childhood can be strength for the future. I have convinced myself that there may be problems or there may not be."

Participant 5 described how she developed a challenge orientation:

"There is certain heroism within me. Being able to explain my situation helped me understand myself. Feeling that I can rely on myself, that I can do everything by myself benefited me. If another problem comes in the future, I know that I can endure it by myself."

Participant 6 explained that her struggles taught her to protect herself. She learned from her pain, and that learning made her stronger.

She explained:

"What happened to me teaches me many things. It makes me protect myself, to work while protecting myself. I think I must live by controlling myself and protecting myself so that this kind of abuse does not happen again. Even if it does happen, I have already passed through it once."

Participant 7 reflected on how her challenges showed her own strength:

"If I were not strong, I would not have reached here. I have seen how strong I am. I overcame it alone without anyone by my side."

She also described how she now views future challenges differently. Instead of fearing them, she believes she can adapt and find another way.

"Now if something happens to me, giving up hope does not come to my mind. Instead, I will live by a plan. If one plan fails, it's no problem. I will just bring another idea and live it."

Participant 8 described what her struggles taught her:

"I am strong. If a human being makes a mistake once, they should learn from it for the second time. This pushes me to learn, from now on, to depend on myself and stand with strength. I have learned that."

Participant 9 described report a bold challenge orientation:

"I have passed through this life. After this, I feel that if anything happens, I can handle it because I am a strong person. In a person's life, there is trial. No matter what happens, in light of the life I have passed through, I think that I will be a strong person, like gold that is refined. I am not an ordinary person. I am not an ordinary thing."

This challenge orientation reflects the third component of hardiness. Survivors reframed adversity as temporary, survivable, and even strengthening. Past hardships became evidence of their capability, and future challenges were approached with confidence rather than fear. This transformation represents a core psychological recovery.

4. 7. The Interplay of Protective Factors in the Recovery Process

The previous themes have shown how optimism, resilience, social support, and hardiness each helped survivors cope with psychological distress. But in real life, these things did not work alone. They worked together, each one helping the others. This theme shows how they worked together to help survivors recover.

Many participants described receiving social support before they began to report renewed hope for the future. Several participants explained that counseling, training opportunities, encouragement from staff, and the availability of basic necessities helped them begin thinking about life beyond their current circumstances.

Participant 5 stated:

"What gives me hope is when they tell me, 'Be strong. We will give you training. We will treat your child.' When they tell me they will train me in many things, that gives me even more hope."

Similarly, Participant 7 described how participation in training opportunities influenced the way she viewed her future:

It helped me to have hope. I thought my life was ruined, but after coming here, I do not just sit and think about what I have lost. Now, when I leave here, I know what kind of work I can do."

Participants also described gaining encouragement from observing and interacting with other women who had experienced similar situations. Seeing others recover from difficult experiences appeared to provide reassurance that recovery was possible.

Participant 8 explained:

"What gave me hope was being with other women. There was a woman renting a room nearby. Her husband had left her, and she used to advise me. She was raising two children by herself. She told me, 'Take heart. This will pass. I passed through this and even built a house.' It was from her that I learned strength."

Several participants further described how hope for the future was accompanied by efforts to endure challenges and continue moving forward. They spoke about working toward future goals, caring for their children, participating in training, pursuing legal action, and trying to rebuild their lives despite ongoing difficulties.

Participant 1 stated:

"I will live a very good life. I will be a strong worker."

Participant 2 similarly explained:

"I don't stop hoping. I just think about the future with hope, 'what can I work at?' I can change by working."

Participant 9 also described confidence in her ability to continue despite future difficulties:

"A feeling comes over me and says, 'I can do it.' I have passed through that difficult life and reached this stage. Whatever life comes after this, I know I can handle it."

Participants frequently described becoming more confident in their abilities after successfully overcoming previous challenges. Experiences such as pursuing legal action, caring for children independently, or managing difficult situations appeared to contribute to a greater sense of self-reliance.

Participant 2 stated:

"When I think about it, there was simply no other option. Unless I struggle through life, I cannot survive."

Participant 5 similarly explained:

"Suing alone now has made me very much rely on myself. I realized that I can do anything by myself."

Across participants' narratives, social support, optimism, resilience, and hardiness often appeared together rather than as separate experiences. Participants described receiving support from counselors, shelter staff, peers, family members, and strangers; maintaining hope for a better future; enduring significant hardships; and taking active steps to improve their situations. Together, these experiences formed important aspects of their recovery process following gender-based violence.

5. Discussion

This study explored how optimism, resilience, social support, and hardiness influence coping with psychological distress among nine GBV survivors at AWSAD shelter in Addis Ababa.

The finding revealed that many participants reported different forms of psychological distress following experiencing Gender-Based-Violence. Eight of nine participants reported suicidal ideation confirms that psychological distress following GBV is severe and pervasive. This aligns with Woldie et al. (2025), who found that sexual violence survivors in sub-Saharan Africa have significantly higher rates of depression (69%) and PTSD (29%) than women without such experiences. The current study adds qualitative depth to these statistics, revealing that suicidal thoughts are not abstract but concrete: participants described specific plans and, in one case, thoughts of killing her child.

Importantly, participants' distress was not caused solely by the GBV incident itself. It was worsened by secondary adversities: homelessness, family rejection, poverty, legal delays, and raising children alone. This finding supports the concept of cumulative trauma (Masten, 2014), where multiple adversities produce greater psychological harm than a single event. For Participant 9, giving birth alone in a rented room without assistance compounded her distress beyond the original assault. This means that interventions cannot focus only on the GBV incident; they must also address the social and material context in which survivors live.

The most important finding of this study is that institutional social support. No family support was the critical protective factor for most participants. Only three of nine had any family support. For the remaining six, families were absent, unaware, or actively unsafe. This contradicts much of the existing literature, which typically assumes family and informal networks are primary sources of support (Carlson et al., 2002; Zimet et al., 1988).

This finding likely reflects the intense stigma surrounding GBV, particularly sexual violence and pregnancy outside marriage. Several participants explicitly stated they

could not tell their families because families would punish or reject them. This means that assuming family support is available may be a dangerous assumption in practice. Shelters must be prepared to be the primary, and sometimes only, source of support.

Counseling was identified as the single most helpful factor by five participants. Participant 3 stated: *"What helped me the most were the counsellors. They made me return to myself."* Participant 9 directly compared AWSAD (which has counseling) to Mother Teresa shelter (which does not): *"Over there, counseling — there is no such thing. We just live. But in this house, they listen to a person."* This comparison provides strong evidence that basic shelter provision (food, beds, safety) is insufficient without psychosocial support.

In a low income country like Ethiopia for the participants of this study**,** practical support also mattered. Participants reported that having food, soap, transport, and childcare provisions removed the burden of daily survival and created mental space for healing.

Peer support from other survivors was another important source of strength. Participants gained hope by seeing others who had survived and were recovering. Some used downward social comparison comparing themselves to those worse off to feel stronger. While not typically emphasized in trauma literature, this finding suggests that shelter environments should facilitate structured peer support opportunities.

Consistent with Carver, Scheier, and Segerstrom (2010), who define optimism as favorable expectations for the future, this study found that optimism was not a fixed trait but could be restored. Seven of nine participants moved from future-blindness to restored hope through counseling, faith, and their children. Participant 1 stated: *"I didn't think things would pass. I didn't even think about the next [future]. After I get counseled... I start to think about the next [future]."*

This finding aligns with Anderson et al. (2019), who found that higher optimism predicted post-traumatic growth among conflict-related sexual violence survivors. The current study extends this by demonstrating that optimism can be cultivated through

institutional support. Hope is not something survivors have or do not have; it can be taught, supported, and restored.

However, one participant (Participant 3) remained persistently hopeless despite receiving the same services. She stated: *"I don't know, I don't think about that at all. You cannot think about the future when you have nothing."* This finding is significant because it demonstrates the limits of current interventions. Not all survivors respond to standard support. Possible explanations include the severity and duration of her past trauma (she had extensive prior adversities), the absence of any social anchor (no family, and her relationship with her child was still developing, and may requiring more intensive treatment. This finding supports the need for stepped care models where non-responders receive more intensive or specialized interventions.

The primary sources of restored hope were children, faith, and belief in oneself. Children provided purpose and a reason to live. Faith provided a framework for meaning-making and a source of strength beyond oneself. Self-belief grew as survivors took action and saw results.

This study identified two distinct pathways to resilience, a finding that extends existing literature. The first pathway involved drawing on past hardship as evidence of survivorship. Participants who had survived previous adversities used those experiences as proof they could survive again. Participant 1 stated: *"Those challenges helped me build strength. By the way, problems make you stronger."* This aligns with the concept of stress inoculation or steeling effects (Rutter, 2012; Seery, 2011), where moderate adversity can enhance subsequent resilience.

The second pathway involved developing resilience without prior adversity. Three participants explicitly stated they had never faced significant hardship before the GBV they experienced. Despite this, they still developed resilience. Participant 2 stated: *"I recovered by myself. I treated myself... Being strong on my own and enduring my pain, I recovered*. This finding challenges the assumption that resilience requires prior practice with hardship. Instead, it supports Masten's (2014) conceptualization of resilience as

"ordinary magic" that can emerge from basic human adaptive systems even without prior adversity.

Across both pathways, common resilience resources included endurance (persisting because there was no other choice), inner strength (a perceived internal capacity), and faith. Endurance was not passive suffering but an active, agentic choice to continue. Participant 2 explained: *"When you realize there is no one for you, you simply have no choice. Unless you struggle through life, you cannot pass."*

Participants demonstrated all three components of hardiness as conceptualized by Kobasa (1979) and Maddi (2013). **Control** appeared as decisive action (making the conscious choice to leave abusive situations) and self-regulation (actively managing suicidal thoughts and anger). Participant 7 stated: *"The main thing is my getting out of that life. My being able to decide and leave it and get out is the biggest thing."* Participant 3 described controlling suicidal thoughts: *"If you don't kill yourself in that moment... you control yourself and pass through that hour somehow."*

Commitment appeared through unwavering dedication to children and faith. Participant 1 stated: *"I refrain from killing myself with the thought that these children have no one."* Participant 3, after becoming a mother, stated: *"I have become a mother now. From now on, I have no other choice. I can't throw her out. Let me try to strengthen myself."*

Challenge appeared as viewing struggle as strength. Participants reframed adversity as a teacher, as evidence of their capability, and as a refining fire. Participant 9 stated: *"In light of the life I passed through, I think that I will be a strong person, like a person who is refined like gold. I am not an ordinary person."* This finding aligns with Bartone and Bowles (2021), who found that hardiness, predicts post-traumatic growth among severely wounded individuals.

One of the most important findings is that protective factors did not operate in isolation. They worked together in a clear sequence. Participants' responses suggest that Social support came first**.** Before participants could be optimistic or resilient, they needed

someone else to believe in them. Counselors and the shelter provided safety, listening, and practical help.

Social support then enabled optimism. Hope was not something participants found within themselves. It was given to them through counseling, training, and encouragement. Optimism then enabled resilience**.** Hope for a better future gave participants a reason to endure present suffering. Social support also enabled hardiness. Safety and support created the conditions for participants to take decisive action.

Resilience and hardiness reinforced each othe**r.** Endurance led to action, and action led to greater endurance. Optimism and hardiness reinforced each other**.** Hope motivated action, and action proved that hope was justified. Together, they created an upward spiral toward recovery.

Endurance was the foundation and faith was the thread that held everything together. For eight of nine participants, faith provided hope, strength, commitment, and a source of support beyond themselves. It was available when nothing else was, and it interacted with every other protective factor. This finding suggests that trauma interventions of GBV survivors in shelter settings in Ethiopia should integrate, not ignore, survivors' spiritual coping.

The findings largely support this framework but require two modifications.

First, the framework positioned social support and optimism as foundational, but the findings suggest that social support is primary and optimism follows from support rather than preceding it.

Second, the framework did not explicitly include faith as a protective factor. Given that most participants identified faith as central to their coping, the framework should be revised to include faith as a meta-factor that strengthens all four existing factors.

6. Conclusion

This study provides important insights into how optimism, resilience, social support, and hardiness influence coping with psychological distress among nine GBV survivors at AWSAD shelter in Addis Ababa.

The findings show that psychological distress among survivors is severe. Eight of nine participants reported suicidal ideation. All experienced crying, sleep disturbances, and emotional sensitivity. Five reported anger dysregulation. This distress was worsened by homelessness, family rejection, and poverty.

The findings also show that institutional social support particularly counseling was the most critical protective factor. Only three of nine participants had any family support. Counseling was identified as the single most helpful factor by five participants. Practical support such as food, shelter, and transport created the foundation for recovery.

Optimism was recoverable for most but not all. Seven of nine participants regained hope through counseling, faith, and their children. However, one participant remained persistently hopeless despite receiving full services. Resilience followed two pathways: some drew strength from past hardships, while others developed resilience without prior adversity. Hardiness appeared as control, commitment, and challenge. Survivors took decisive action, controlled their emotions, committed to their children and faith, and viewed their struggles as making them stronger.

Faith was central. Eight of nine participants cited faith as a source of hope, strength, and endurance. Protective factors did not work alone. Social support enabled optimism, which enabled resilience, with hardiness emerging as survivors took action. Endurance, the choice to keep going when there was no other option was the foundation of everything.

The results show that GBV survivors need more than just safety and basic needs. They need counseling, peer support, faith-inclusive care, and stepped support for those who

do not respond to standard services. The absence of family support for most participants means shelters must be prepared to be the primary source of support.

This study contributes to the limited qualitative literature on protective psychological factors among GBV survivors in shelter settings. While the findings are specific to nine women in one Addis Ababa shelter, they highlight the importance of survivor-centered and strength-based approaches to recovery within similar shelter contexts.

7. Limitations

The sample was limited to nine participants from a single shelter in Addis Ababa.

The original study design intended to recruit participants from two sites to enhance sample diversity. However, due to difficulties identifying GBV survivors at Tikur Anbessa Specialized Hospital within the research deadline, data were collected from AWSAD shelter only. Findings may not apply to survivors in rural areas, other shelters, or survivors who never reach shelter services.

As a female clinical psychology trainee, my identity may have helped participants feel safe and understood, but my clinical background may also have shaped my assumptions, expectations, and interpretation of survivors' experiences.

All participants were recruited with the assistance of shelter counselors, which may have introduced selection bias. Counselors may have preferentially referred survivors who were coping well or held positive views of the shelter. The fact that only one survivor expressed a negative experience of the shelter may also indicate this bias.

Interviews were conducted in Amharic and translated to English. Some cultural meaning and nuance may have been lost despite back-translation of a subset.

The researcher was the primary coder. However, to enhance trustworthiness, the coded data were reviewed by one academic person. While this is not equivalent to having a second independent coder, it provided external scrutiny and reduced the risk of individual bias.

The shelter environment may have influenced participants' perspectives because all participants were currently receiving support services

8. Recommendations

- Health institutions should provide regular training for mental health professionals working with GBV survivors on how to assess and restore hope, as seven of nine survivors regained hope through counseling.
- Provide ongoing supervision and peer support groups to help clinicians manage emotional challenges when working with GBV survivors, including managing countertransference to anger and suicidal ideation.
- Assign specific clinicians or teams to work continuously with GBV survivors in shelter and hospital settings to build trust and continuity of care.
- Raise awareness about GBV and its psychological consequences among healthcare providers and the general public to reduce stigma and encourage survivors to seek help.
- Ensure all GBV shelters have access to qualified mental health professionals, as counseling was identified as the single most helpful factor by five survivors.
- Provide practical support (food, shelter, soap, transport, and childcare) alongside psychological services, as meeting basic needs was the foundation of recovery.
- Integrate faith-based coping into treatment when appropriate, as eight of nine survivors relied on faith as a source of hope and strength.
- Develop stepped care protocols for survivors who remain persistently hopeless despite standard services, as one participant did not regain hope.
- Establish referral pathways and collaboration between hospital psychiatry OPDs (such as Black Lion) and GBV shelters to ensure survivors receive coordinated care.
- Conduct further research on the experiences of GBV survivors in other settings, as this study could only include shelter-based survivors due to time constraints.

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Appendix

Annex I

My name is Nitsuh Kibrework, and I am a second-year clinical psychology trainee at Addis Ababa University. I am conducting research to explore and understand how optimism, resilience, social support, and hardiness influence coping with psychological distress among survivors of gender-based violence (GBV) at AWSAD shelter and Tikur Anbessa Specialized Hospital**.**

The interview has two parts:

1. Background information about yourself.
2. Questions about your experiences of Gender-based Violence and how protective factors (optimism, resilience, social support, and hardiness) have shaped your coping.

Confidentiality

All information you provide will be strictly confidential. Your name and identity will not be shared. Instead, a unique code will be used in all documentation. Audio recordings and collected data will be securely stored and used solely for academic purposes.

Right to Withdrawal

Participation in this study is completely voluntary. The interview will last approximately 45–60 minutes and will be audio recorded. You have the right to refuse participation or to withdraw at any time without penalty. You may also skip any questions you feel uncomfortable answering.

Potential Risks and Benefits

This study may not offer direct personal benefits; however, your participation will contribute to a better understanding of coping mechanisms among GBV survivors. No significant risks are anticipated, but some questions may bring up difficult memories and

cause discomfort. If you feel uncomfortable at any point, you have the right to take a break, skip questions, or stop the interview entirely

If you have any questions or would like additional information about this study, please contact:

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Annex II

Informed Consent Form

I have read and understood the information provided about this research study exploring how optimism, resilience, social support, and hardiness influence coping with psychological distress among GBV survivors. I understand that participation is voluntary and that I may withdraw at any time without penalty. I have been informed that the interview will be audio recorded and that the researcher will take measures to protect my privacy. I understand the purpose, procedures, risks, and benefits of this study.

By signing below, I voluntarily consent to participate in this research study.

Participant Signature: _____
Date: _____

Annex III

Section 1: Background

1. Age?
2. Could you tell me a little bit about yourself? What was your life like before you came here?
3. How did you come to this place?

Section 2: Experiences related to Psychological distress

4. After the incident [assault/abuse], what specific changes in your emotions, thoughts, or behavior have you noticed?
5. What has your life been like since the incident [assault/abuse]?
6. Are there any behavioral or emotional changes that you are currently struggling with or finding particularly difficult? If so, what are they?

Section 3: Optimism

7. During the times you consider difficult, what thoughts used to come to your mind when you thought about your future? What about now?
8. What kind of things give you hope?
9. Was there a time during the past week or month where you felt hopeful, or felt that things might improve a little? Please tell me more about that.
    - **Probe:** What is it that makes you feel things will get better?

Section 4: Resilience

10. When things become very difficult, what helps you to keep going without giving up?
11. Is there a particular strength or capacity that has helped you recover from the incident [assault/abuse]? If so, what is it?
12. Where did this power or strength come from?
13. Throughout this entire process, what does your internal strength look like that encourages you to move forward?
14. Are there specific beliefs, values, or practices (e.g., prayer, personal mindset) that help you?

    Probe: What is the "one thing" that helped you stand back up during the times you felt most hopeless?

Section 5: Social Support

15. Has there been anyone by your side or supporting you since these events? (Family, friends, people at this institution where you receive assistance, etc.)
16. Is there any support you received from family, friends, people in your community, or from this institution? If so, what is it?
17. In what ways has this support been helpful for your recovery or in overcoming the challenges you face? How important was it?

18. Since you came seeking help, what kind of support have you received? How did it help you to meet other women who have had similar experiences?

    Probe: Which of the support services you received was the most beneficial to you? Why?

Section 6: Hardiness

19. On days you consider difficult, have you ever felt that you had the capacity to manage things? Could you tell me a little about that?
20. Despite the ongoing challenges since the incident [assault/abuse], what has helped you to keep moving forward with life without giving up?
21. Prior to the incident, have you ever faced and overcome a major difficulty in your life? Knowing that you overcame it, does it help you now? In what ways does it help you?

Section 7: Closing

21. From the factors we have mentioned (hope, family/friend support, and internal strength), which one plays the most significant role for you? Why?

22. Is there anything else you would like to share with us regarding your recovery journey after the incident, or about what has helped you?

23. What advice would you like to give to other women who find themselves in a similar situation to yours?

Annex IV

Amharic version interview guide

የመረጃ ቀጽ (ለተሳታፊዎች)

ስሜ ንፁህ ክብረወርቅ ይባላል፤ በአዲስ አበባ ዩኒቨርሲቲ የሁለተኛ አመት ክሊኒካል ሳይኮሎጂ ተማሪ ነኝ። በAWSAD መጠለያ ቤት እና በጥቁር አንበሳ ሆስፒታል ለሚገኙ የፆታ ጥቃት ተቋቋሚዎች፣ አወንታዊ ተስፋ፣ የመቋቋም አቅም፣ የማህበረሰብ ድጋፍ፣ በፅናት እና በጥንካሬ መቆም ያላቸውን ስሜታዊ ወይም ስነልቦናዊ ተጽዕኖ ለመርምርና ለመረዳት የምርምር ጥናት በማካሄድ ላይ እገኛለው።

ቃለመጠይቁ ሁለት ዋና ዋና ክፍሎች ይኖረዋል፡

1. ስለራስዎ የግል የጀማሪ መረጃ (መሰረታዊ መረጃ)።
2. ስለ ጾታዊ ጥቃት ጋር ተያይዞ ያጋጠሙዎት ተሞክሮዎች እና የመከላከል አቅም (አወንታዊ ተስፋ፣ የመቋቋም አቅም፣ የማህበራዊ ድጋፍ እና በፅናት እና በጥንካሬ መቆም)ላይ የሚያተኩሩ ጥያቄዎች።

ሚስጥራዊነት

በዚህ ጥናት ውስጥ የሚሰበሰቡ መረጃዎች በሙሉ በሚስጥር ይቀመጣሉ። ስምዎ እና ማንነትዎ ከማንም ጋር አይጋራም። በምትኩ በሁሉም የምርምር ሰነዶች ልዩ ኮድ ይጠቀማል። የድምፅ ቅጂዎች እና የተሰበሰቡ መረጃዎች በጥንቃቄ ይቀመጣሉ እንዲሁም ለጥናቱ ዓላማ ብቻ ያገለግላሉ።

ተሳትፎ

በዚህ ጥናት ውስጥ ተሳትፎ በፈቃደኝነት ነው። ቃለ መጠይቁ በግምት 45–60 ደቂቃዎች ይቆያል እንዲሁም በድምፅ ቅጂ ይመዘገባል። ተሳትፎ ከመስጠት እንዲሁም በማንኛውም ጊዜ ያለ ምንም አሉታዊ ዉጤት ጥናቱን የማቋረጥ መብት አልዎት።

የጥናቱ ጥቅም እና ጉዳት

ይህ ጥናት ቀጥተኛ የግል ጥቅም ላይኖርዉ ይችላል፤ ይሁን እንጂ ተሳትፎዎ የጸታዊ ጥቃት ተጋላጭ ሰዎች የሚያግዙአቸዉን የመቋቋም ዘዴዎች የበለጠ ለመረዳት አስተዋጽኦ ያደርጋል። ጥናቱ ላይ መሳተፍ የሚያስከትለዉ አሉታዊ ችግር የለም፤ ነገር ግን አንዳንድ ጥያቄዎች ከባድ ትዝታዎችን ሊያስነሱ እና የመረበሽ ስሜት ሊፈጥሩ ይችላሉ። በማንኛውም ሰዐት ምቾት ካልተሰማዎት፣ እረፍት መዉሰድ፣ ጥያቄዎችን ማለፍ፣ ወይም ቃለ መጠይቁን ሙሉ በሙሉ የማቆም መብት አለዎት።

በተጨማሪ ጥያቄዎች ካሉ ወይም በዚህ ጥናት ዙሪያ ተጨማሪ መረጃ ማግኘት ከፈለጉ ፡

ንፁህ ክብረወርቅ

ስልክ፡ +251954208474

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የአእምሮ ሕክምና ክፍል፣ የክሊኒካል ሳይኮሎጂ ፕሮግራም፣ አዲስ አበባ ዩኒቨርሲቲ፤ ስልክ፡ (+251)118962052

በመረጃ የተደገፈ የስምምነት ቅጽ

መረጃውን አንብቤ ተረድቼ ተቀብያለሁ፣ የጥናቱን ዓላማ፣ ሂደት፣ አደጋዎች እና ጥቅሞች በሙሉ ተረድቻለሁ። ተሳትፎ በፈቃደኝነት መሆኑን እና በማንኛውም ጊዜ ማቆም እንደምችል ተረድቻለሁ። ቃለ መጠይቁ በድምፅ እንደሚቀዳ እና ተመራማሪው የግላዊ ሚሰጥሬን እንደሚጠብቅ ተገልጸልኛል። በምርምሩ ላይ በፈቃደኝነት ለመሳተፍ ተስማምቻለሁ::

ከታች በፊርማዬ ፣ በዚህ የምርምር ጥናት ውስጥ በፈቃዴ እንደምሳተፍ እጸድቃለሁ።

የተሳታፊ ፊርማ፡ _____

ቀን፡ _____

ክፍል አንድ፡ -ግላዊ መረጃ

1.እድሜ?

2. ስለራስህሽ በጥቂቱ ለትነግሪኝ ትችያለሽ? ወደዚ ከመምጣትሽ በፊት ህይወትሽ ምን ይመስል ነበር?

3. እንዴት ወደዚህ ቦታ መጣሽ?

ክፍል ሁለት፡ ከስሜታዊ ወይም ስነልቦናዊ ጫና ጋር የተያያዙ ጥያቄዎች

4. ከጥቃቱ በኋላ ምን አይነት የተለየ የስሜት፤ የአስተሳሰብ ወይም የባህሪ መቀየር አስተዉለሻል?

5. ጥቃት ከደረሰብሽ በሁዋላ ያለዉ ህይወትሽ ምን ይመስላል?

6. አሁን ላይ የምትችገሪብት እና ከባድ የሆነብሽ የባህሪ ወይም የስሜት ለውጥ አለ? ካለ ምንድነው?

ክፍል ሶስት፡ ከአወንታዊ ተስፋ ጋር የተገናኙ ጥያቄዎች

7. አስቸጋሪ በምትያቸዉ ጊዜያት ላይ ስለወደፊት ህይወትሽ ስታስቢ ምን ምን ይመጣልሽ ነበር? አሁንስ?

8. ምን አይነት ነገሮች ተስፋ ይሰጡሻል?

9. ባለፈው ሳምንት ወይም ወር ውስጥ ተስፋ ያደረግሽበት ወይም ነገሮች ትንሽ ሊሻሻሉ እንገሚችሉ የተሰማሽ ጊዜ ነበር እስቲ ስለሱ በደንብ ንገሪኝ

ነገሮች እንደሚስተካከሉ እንዲሰማሽ የሚያደርግሽ ምንድን ነው?"

ክፍል 4፡ የመቋቋም/የመመለስ አቅምን የሚዳስሱ ጥያቄዎች

10. ነገሮች በጣም ከባድ ሲሆኑ ተሰፋ ሳትቆርጪ እንድትቀጥዪ የሚያግዝሽ ምንድን ነው?

11. ከደረሰብሽ ጥቃት እንድታገግሚ ያገዘሽ ጥንካሬ ወይም አቅም አለ ወይ? ካለ ምንድነዉ?

13. ይህ ኃይል ወይም ጥንካሬ ከየት የመጣ ነዉ?

13. በዚህ ሁሉ ሂደት ውስጥ ወደፊት እንድትቀጥዪ የሚያበረታሽ ዉስጣዊ አቅም ምን ይመስልሻል?

14. የሚያግዙሽ የተወሰኑ እምነቶች፣ እሴቶች ወይም ልምምዶች (ለምሳሌ፡ ጸሎት፣ግላዊ አስተሳሰብ) አሉ?

በጣም ተስፋ በቆረጥሽበት ወቅት መልሶ ቀና እንዲያደርግሽ የረዳሽ 'አንድ ነገር' ምንድነው?"

ክፍል 5፡ የማህበረሰብ ድጋፍ ከማግኘት ጋር ተያይዘዉ ያሉ ጥያቄዎች

15. ከእነዚህ ክስተቶች በኋላ ከጎንሽ የነበረ ወይም ያገዘሽ ሰዉ አለ? (ቤተሰብ፣ ጓደኞች፣ አዚህ እርዳታ ምታገኚበት ቦታ ያሉ ሰዎች፣ ወዘተ.)

16. ከቤተሰብ ከጉደኛ በአካባቢሽ ካሉ ሰዎች ወይም ከዚህ ያገኘሽዉ ድጋፍ አለ? ምንድነዉ?

17. ይህ ድጋፍ ለመልሶ ለማገገምሽ ወይም ካለሽበት ችግር እንድትወጪ በምን መልኩ ጠቅሞሻል ? ምን ያህል አስፈላጊ ነበር?

18. እርዳታ ፈልገሽ ከመጣሽ በኋላ ምን አይነት ድጋፍ አግኝተሻል? ተመሳሳይ ተሞክሮ ካላቸው ሌሎች ሴቶች ጋር መተዋወቅሽ ምን ረዳሽ?

ካገኘሽው ድጋፍ ውስጥ በጣም የጠቀመሽ የትኛው ነው? ለምን?

ክፍል 6፡ በፅናት እና በጥንካሬ መቆምን የሚዳስሱ ጥያቄዎች

19. ከባድ በምትያቸዉ ቀናት ነገሮችን የመቆጣጠር አቅም እንዳለሽ ተሰምቶሽ ያዉቃል? ስለሱ ትንስ ልትነግሪኝ ትችያለሽ?

20. ከጥቃቱ በኃላ ተግዳሮቶች እዳሉ ሆነዉ እጅ ሳትሰጪ ህይወተን መቀጠል እንድትችዪ ያገዘሽ ነገር ምን አለ?

21. ከጥቃቱ በፊት በህይወትሽ ላይ ከባድ የሚባል ነገር ገጥሞሽ አልፈሽዉ ታዉቂያለሽ ? እሱን ማለፍሽን ማወቀሽ አሁን ላይ አግዞሻል በምን በኩል አገዘሽ?

ክፍል 7፡ ማጠቃለያ

ከጠቀስናቸው ነገሮች (ተስፋ፣ የቤተሰብ/ጓደኛ ድጋፍ፣ እና የውስጥ ጥንካሬ) ላንቺ ይበልጥ ትልቁን ድርሻ የሚይዘው የትኛው ነው? ለምን?"

22. ከጥቃቱ በሁላ መልሶ ስለ ማገገም ጉዞሽ፤ ወይም የረዳሽ፤ ለእኛ መጋራት የምትፈልጊው ነገር አለ?

23. ካንቺ ጋርተመሳሳይ ሁኔታ ዉስጥ ላሉ ሌሎች ሴቶች ምን ምክር መስጠት ትፈልጊያለሽ?