COLLEGE OF HEALTH SCIENCES

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PREVALENCE OF PTSD IN INDIVIDUALS WHO HAVE BEEN SEXUALLY ASSAULTED AND ITS RISK FACTORS (IN THE CASE OF IFSO, OPRIFS, AWSAD, GANDHI, ABRHOT AND EWLA)

By

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FEVEN TECLEHAIMANOT

ADVISORS:

1st PROFESSOR MESFIN ARAYA (MD, PhD, PROFESSOR OF PSYCHIATRY, AAU)

2nd DR CLARE PAIN (MD, ASSOCIATE PROFESSOR OF PSYCHIATRY, AAU, UoT)

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Approval of the Board of Examiners:

Supervisor

Name_____Signatutre_____Date_____

Reviewer

Name_____Signatutre_____Date_____

ABSTRACT

Sexual assault is one core reason in developing PTSD. Little research has been conducted to measure prevalence of PTSD on sexually assaulted victims and why some victims develop PTSD and others do not. The objective of this study was to see the prevalence of PTSD and to identify or illustrate risk factors that are related to developing PTSD. The research design of the study was both Quantitative and Qualitative. In the quantitative research method, the survey included all individuals who could be available. Descriptive qualitative research design was used to illustrate individual experiences of risk factors. The study participants are individuals who have been sexually assaulted and who are currently getting service or treatment at EWLA, Abrhot, Gandhi, OPRIFS, AWSAD and IFSO in Addis Ababa. PTSD CheckList 5 which is a self-report questionnaire and key informant semi-structured interview was used to collect data from the study participants. The data were analyzed using frequency, percentage, through Statistical Package for the Social Sciences version 16.0 statistical packages and thematic analysis. The results of this study showed that, PTSD is 46.48% prevalent. The major risk factors for PTSD were sex, gender, educational status, type of contact with perpetrator, number of perpetrator, past medical illness, substance abuse, economical and marital status of the victim's family, parenting style, sub cities the victims came from, past psychiatric illnesses and negative childhood experience such as abuse. It is important that research continue on the topic of prevalence of PTSD and its risk factors in individuals who have been sexually assaulted.

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LISTS OF ABBREVIATIONS

ASD	Acute Stress Disorder
APA	American Psychiatric Association
AWSAD	Association for Women's Sanctuary and Development
EWLA	Ethiopians Women Lawyers Association
HIV	Human Immune Virus
IFSO	Integrated Family Service Organization
MDE	Major Depressive Episodes
NGO	Non Governmental Organization
OPRIFS	Organization for Prevention, Rehabilitation & Integration of Female Street Children
PCL-5	Posttraumatic stress disorder Check List 5
PTSD	Post Trauma Stress Disorder
SPSS	Statistical Package for the Social Science
UK	United Kingdom

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CHAPTER ONE

1.1 BACKGROUND OF THE STUDY

According to American Psychiatric Association (APA), Posttraumatic stress disorder (PTSD) can be defined as; "a Psychiatric Disorder that can occur in people who have experienced or witnessed a traumatic events such as a natural disaster, a serious accident, a terrorist act, war or combat, rape or other violate personal assault." PTSD involves a pattern of symptoms that some individuals develop after experiencing traumatic events such as sexual assault. The symptoms of PTSD are organized into four clusters these include repeated thoughts of the assault, memory and nightmares, avoidance of thoughts, feelings and situations related to assault, negative changes in thoughts and feelings and increased arousal (for example:- difficulty sleeping and concentration, jumpiness, irritability). ((Ranna Parekh, 2017)).

The diagnosis of PTSD cannot be made on the basis of symptoms alone. There has to be a traumatic event that precedes the development of the disorder. Following a traumatic event many people will have some symptoms for a short period of time after the trauma. It yet implies most people do not get PTSD just because they go through one. (Kessler. R.C, 2000).

As cited by Yohannes Mehretie and Mihiret Abreham, 2017 Sexual violence was found a major problem among the students with 45.4% life time prevalence. The finding was higher than the prevalence (37.3%) among female college students in Bahirdar. Another study from Madawalabu University revealed 41.1% life time prevalence of sexual violence which is close to this finding. However, it was lower than the prevalence among female Ambo university students 76.4%.

It was reported that sexual assault was continued as a pervasive problem in the United States. One survey estimates that 19 percent of women and 2 percent of men in the United States have been sexually assaulted at some point in their lifetime. Similarly, within the armed forces, 23 percent of women and 4 percent of men service members report having been sexually assaulted during their military service. (Sarah Michal Greathouse, et al, 2015).

Rape is a crime that is defined as unwanted sexual act that results in oral, vaginal or anal penetration. There are two major types of rape mentioned in general. The first one is Forcible Rape; which involves unwanted sexual penetration obtained by the use of force or threat of force. The second is Drug or Alcohol facilitated rape which happens to occur when the victim is passed out or highly intoxicated because of voluntary or involuntary consumption of alcohol or drug. Rape is not only for women rather it can also happen to boys and men. (Dean G. Kilpatrick, Ananda B. Amstadter, 2007).

One study that examined PTSD symptoms among women who were raped, found that almost all (94 out of 100) women experienced these symptoms during the 2 weeks immediately following the rape. Nine months later, about 30 out of 100 of the women were still reporting this pattern of symptoms. The national women's study reported that almost one of every three of all rape victims develop PTSD sometime during their lives. (National Center for PTSD, 2017).

1.2 STATEMENT OF THE PROBLEM

"Sexual assault and other interpersonal traumas are more likely to result in PTSD than other types of trauma" (Boney-McCoy & Finkelhor, 1995; Hamblen, 2002).

According to Yohannes M & Mihiret A, 2017 Lifetime sexual violence was found to be 45.4%. However, 36.1% and 24.4% of respondents reported experiencing sexual violence since entering

university and in the current academic year respectively. Life time sexual violence was positively associated with witnessing inter-parental violence as a child, rural childhood residence, having regular boyfriend, alcohol consumption and having friends who drink regularly; while it was negatively associated with discussing sexual issues with parents.

On the study which was aimed at identifying factors that determine the psychosocial effects severity of child sexual abuse, respondents who survived rape and child prostitution were more symptomatic than those who were married early. Respondents for whom less time had elapsed since their first experience of abuse demonstrated a significantly higher level of post-traumatic stress disorder symptoms, negative reactions by others, self-blame, and guilt than those for whom more time had elapsed since such an experience. (Wondie Y, Zemene W,2011).

As Walsh K1, Danielson CK's research implied on their particular work called "National prevalence of posttraumatic stress disorder among sexually revictimized adolescent, college, and adult household-residing women", Current PTSD was reported by 20% of revictimized adolescents, 40% of revictimized college women, and 27.2% of revictimized household-residing women. When they compared this result with nonvictims, odds of meeting past 6-month PTSD were 4.3 to 8.2 times higher for revictimized respondents and 2.4 to 3.5 times higher for single victims.

Rape has been found to be the trauma most commonly associated with PTSD among women. It is therefore important to be able to identify those individuals at greatest risk of developing PTSD. (Tiihonen Möller A1, Bäckström T2, 2014).

The study was intended to measure the prevalence of PTSD in individuals who have been sexually assaulted and describe the risk factors that made them vulnerable to develop PTSD.

1.3 OBJECTIVE OF THE STUDY

1.3.1 GENERAL OBJECTIVE OF THE STUDY

The general objective of the study was to measure and describe the prevalence and risk factors of PTSD in individuals who have been sexually assaulted in Integrated Family Service Organization (IFSO), Organization for Prevention Rehabilitation & Integration of Female Street children (OPRIFS), Association for Women's Sanctuary and Development (AWSAD), Gandhi Memorial Hospital, Abrhot and Ethiopian Women Lawyer Association (EWLA).

1.3.2 SPECIFIC OBJECTIVES OF THE STUDY

- To screen for prevalence of PTSD in individuals who have been sexually assaulted
- To identify risk factors for the development of PTSD following sexual assault.

1.4 LEADING RESEARCH QUESTIONS

1. How common is PTSD in individuals who have been sexually assaulted?
2. What are the risk factors for developing PTSD following sexual assault?

1.5 SIGNIFICANCE OF THE STUDY

The study has the following significances:-

- The study was able to answer the research questions which are mentioned above.
- The study indicated how common PTSD is in individuals who have been sexually assaulted in IFSO, OPRIFS, AWSAD, Gandhi Memorial Hospital, Abrhot and EWLA.
- The study indicated why some victims developed PTSD after being traumatized and did not recover at the same rate as individuals who were symptomatic but who did not develop PTSD.
- For future reference

1.6 DELIMITATION OF THE STUDY

The study was delimited to measure the prevalence of PTSD in individuals who have been sexually assaulted and the risk factors associated with PTSD and elaborate the exposure factors in developing PTSD in IFSO, OPRIFS, AWSAD, Gandhi Memorial Hospital, Abrhot and EWLA in Addis Ababa, Ethiopia.

1.7 LIMITATION OF THE STUDY

The study faced the following limitations:-

- Lack of literature specifically in the prevalence and risk factors for PTSD in individuals who have been sexually assaulted that had been done in our context.
- Shortage of time.
- It was very hard to find the institutions, participants and their addresses.
- It was strictly forbidden to meet the victims personally.

1.8 OPERATIONAL DEFINITION

PTSD: - is a mental disorder with involves the basic diagnostic criterias in DSM V.

Sexual assault: - the full range of forced sexual acts, including forced touching or kissing, verbally coerced intercourse and harassment; and vaginal, oral and anal penetration.

Risk Factors: - according to this study risk factors are exposure factors which make some one more vulnerable to PTSD.

Prevalence: - percentage or number of events (PTSD) in a given population (individual who have been sexually assaulted) and developed PTSD at designated time.

CHAPTER TWO

REVIEW OF RELATED LITERATURES

2 PTSD

2.1 DEFINITION OF PTSD

PTSD is a mental disorder that can develop after a person is exposed to any particular traumatic event, such as sexual assault, warfare, traffic collisions, or other threats on a person's life. The symptoms for PTSD may include disturbing thoughts, feelings, or dreams related to the events, mental or physical distress to trauma-related cues, attempts to avoid trauma-related cues, alterations in how a person thinks and feels, and an increase in the fight-or-flight response. To diagnosis PTSD, these symptoms have to last for more than a month after the event. Individuals with PTSD are at a higher risk of suicide. (American Psychiatric Association, 2013).

It's normal to have upsetting memories, feel on edge, or have trouble sleeping after we witness or experience life-threatening event, like combat, a natural disaster, a car accident, or sexual assault. But, according to National Center for PTSD, PTSD is a mental health problem that some people develop after experiencing or witnessing such type of events and show some symptoms of PTSD; which usually start soon after the person experience or witnesses those traumatic events, but they may not appear right away. Sometimes they take longer time to appear like months or years later. They also may come and go over many years. In any way if the symptoms last longer than four weeks, cause great distress, or interfere with work or home life or has effect in any day to day activity, PTSD may be diagnosed.

Many studies of post-disaster psychological adjustment have been conducted during the past few decades. The majority suggest that the victims of disasters are likely to exhibit some degree of

posttraumatic stress symptoms following the event. Moreover, it is proposed that if disaster victims do not receive proper posttraumatic psychological support within a certain period of time, their symptoms might deteriorate into more chronic psychological disorders, such as posttraumatic stress disorder /PTSD (Zhang Y, Ho SMY, 2011).

2.2 SYMPTOMS OF PTSD

According to National Center for PTSD, there are four types of symptoms that are mentioned of PTSD, which may not be exactly the same for everyone cause, each and every person experiences symptoms in their own particular way.

The first symptom cluster is the occurrence of unwanted sensory re-experiencing, often called "Flash backs" in which reliving the event (called re-experiencing symptom), When the person has bad memories or nightmares. They may feel like as if they are going through the event again.

The second symptom cluster is when the person avoids situations that remind of him/her exactly like the event. They may also try to avoid situations or people that trigger memories of the traumatic event and avoid talking or thinking about the event at all.

Having more negative beliefs and feelings is the third symptom cluster. The way the person used to think of themselves and others may change after the trauma. Feeling guilt or shame or, not being interested in activities that person used to enjoy and feel that the world is dangerous and find it hard to trust anyone at anytime may be some. That person may not be happy easily after this. The Fourth and the last symptom cluster are called hyperarousal symptoms such as feeling keyed up, jittery or the person may feel over alert and on the constant lookout for danger. The person also may have trouble concentrating or sleeping and suddenly get angry or irritable, startle easily, or act in reckless or self injurious ways (like smoking, using drugs and alcohol, or driving dangerously.

2.3 RISK FACTORS FOR DEVELOPING PTSD

PTSD is believed to be developed by the experience of a wide range of traumatic events and, in particular if the trauma is extreme, can occur in persons with no predisposing conditions.(Spoont, Michele; et al, 2013).

Childhood trauma, chronic adversity, and familial stressors are high predictors of increase risk for PTSD and also risk for biological markers of risk for PTSD after a traumatic event in adulthood. The National Center for PTSD notes that adults who were in foster care as children have a higher rate of PTSD. If someone had experience bullying when they were a child or an adult then it's believed that it might correlated with the development of PTSD. After children grow up, peritraumatic dissociation in children is a one main predictive indicator of that they may develop PTSD later in their life. This effect of childhood trauma, which is not well-understood, may be a marker for both traumatic experiences and attachment problems. Proximity to, duration of, and severity of the trauma make an impact and interpersonal traumas cause more problems than impersonal ones.

On other study, "Children who have been both physically/sexually abused appear to be at highest risk of psychiatric disturbance. PTSD, though common (circa one-third of victims) which is generally comorbid with other affective disorders." (Joseph E. O, et al., 2010). Some studies have tried to see if there is any relationship between intrusive thoughts and intentional control responses. It turns out that, the more there is suppression the more it increases the frequency of unwanted intrusive thoughts. As a result, these studies results suggest that suppression of intrusive thoughts may be important in the development and maintenance of PTSD.

The other risk of PTSD according to (National Center for PTSD) is that, if an individual has been exposed to domestic violence, he/she is literally predisposed to the development of PTSD. There

is also a strong relation between mothers that experienced domestic violence during the perinatal period of their pregnancy and PTSD.

Sexual assault in the military is a leading cause for female soldiers developing PTSD; a female soldier who is sexually assaulted while serving in the military is nine times more likely to develop PTSD than a female soldier who is not assaulted. A soldier's assailant may be her colleague or superior officer, making it difficult for her to both report the crime and to avoid interacting with her assailant again.

However, it doesn't mean that being exposed to a traumatic experience does automatically indicate that an individual will develop PTSD. Rather, it implies that there is a strong association between the development of PTSD and the person's who were exposed to any traumatic events.

When we see the risk factors for post-traumatic stress disorder among UK Armed Forces personnel, posttraumatic stress symptoms were associated with lower rank, being unmarried, having low educational attainment and a history of childhood adversity. Exposure to potentially traumatizing events, in particular being deployed to a 'forward' area in close contact with the enemy, was associated with posttraumatic stress symptoms. Appraisals of the experience as involving threat to one's own life and a perception that work in theatre was above an individual's trade and experience were strongly associated with posttraumatic stress symptoms. Low morale and poor social support within the unit and non-receipt of a home-coming debriefing were associated with greater risk of post-traumatic stress symptoms.

Among the Factors which can have a higher risks on developing and accelerating PTSD includes:- gender, age at trauma, and race that predicted PTSD in some populations but not in others. There are also these factors such as education, previous trauma, and general childhood adversity that predicted PTSD more consistently but to a varying extent. According to the

populations studied and the methods used; and factors such as psychiatric history, reported childhood abuse, and family psychiatric history that had more uniform predictive effects. Individually, the effect size of all the risk factors was modest, but factors operating during or after the trauma, such as trauma severity, lack of social support, and additional life stress, had somewhat stronger effects than pretrauma factors. (Brewin, Chris R. and Andrews, 2000).

According to a study in china which investigate psychological reactions of survivors of the 512 Wenchuan earthquake in China and the risk factors associated with those reaction, Significant risk factors associated with PTSD symptoms included: (1) being female; (2) older age; (3) higher exposure to traumatic events during the earthquake; and (4) negative affect in Type-D personality. On the research which investigated the incidence of posttraumatic stress disorder among earthquake victims in Taiwan, it was reported that women tended to exhibit more PTSD symptoms than men. In addition, age and severity of injuries were both positively related to PTSD scores. (Zhang Y, 2011).

When we see the risk factors for PTSD following rape, they included a history of depression, alcohol abuse, or experienced injury during the rape. (Acierno R1, Resnick H, 1999).

2.4 SEXUAL ASSAULT

In study which was conducted in Limmu Gnet High School by Israel Bekele et al 2017, Of the 354 participants, 113 (31.9%) were sexually assaulted.

In a study aimed to determine sexual violence and associated factors among high school students in Harar town, Eastern Ethiopia, it was found that sexual violence among in school adolescents were 25%. As contributing factor for the incident, addictive drugs like alcohol (18%), chat and shish (7.2%) were mentioned. Other factors such as; use of physical force (15%), false promise (43%) and use of power (7.2%) were reported contributing factors. Females dressing

style, their act, peer pressure, revenge and males emotionality identified as contributing factors for sexual violence. It was also found that there were different consequences like abortion (32.2%), vaginal discharge (28.6%), genital trauma (25%), and unwanted pregnancy (14.2%) following the violence. (Jote Markos Cafo, et al., 2014).

A study conducted in Addis Ababa reveled a life time prevalence of completed rape among male students was 4.3% with 95% confidence interval between 2.95% and 5.72%. This prevalence in the last 12 months was 5/1000 with 95% CI 0.8 to11.3 per 1000. Similarly, life time prevalence of sexual harassment experienced by male students was 68.2% with a 95% CI ranging between 65.02% and 71.36%. Regarding their relation with perpetrator, 20 (66.7%) of the perpetrators were known by the victims. Out of the students who experienced rape, for 5 (23.8%) happened in the victim's house and for 8 (38.1%), it was in rapist house. Twelve (52.5%) of the victims didn't share the adverse act to anyone. Victims of rape were asked why they did not report to any body and keep it secret. As a reason, ten (45.5%) rose not knowing what to do, 6 (27.3%) of the victims mentioned they were frightened of the perpetrator and the rest reported fear of stigma. (Rahel Tesfaye H., et al 2013).

In Nigeria a study conducted by Afusat O, 2014 revealed that the lifetime occurrence of assaultive violence was 62.5% in males and 33.6% in females. When we see exposure risk for PTSD, females had a higher risk than males following assaultive violence (odds ratio = 4.0, 95%) confidence interval (2.0 – 8.3).

According to Resnick, H.S., 1993 it was found that life time exposure to any type of traumatic event was 69%, where as exposure to crimes including sexual or aggravated assaults or homicide of a close relative or friend occurred among 36%. According to this study the rate of PTSD was

significantly higher among crime which included sexual or aggravated assault than non crime victims which is 25.8% versus 9.4%.

Rape is an established risk factor for mental health disorders, such as PTSD, major depressive episodes (MDE), and substance use disorders. (Zinzow HM1, Resnick HS e al, 2012).

According to , Lammers K, Martin L, Seedat S. Women who are survivors of rape are more exposed and expected to have higher risk for posttraumatic stress disorder (PTSD) and it's already been identified as traumatic dissociation has been identified as a precursor of PTSD. On their study, they describe a traumatic dissociation as one significant predictor of PTSD and depression. As a result, the linear combination of prior dissociation, current dissociation, and resilience together significantly explained 20.7% of the variance in PTSD. Even if, traumatic dissociation significantly predicts PTSD, if it is identified as early as possible; they suggest identification and management may reduce the risk of developing PTSD at all. Although, the Interventions has to focus on promoting resilience this also could successfully help in reducing the risk of dissociation following rape.

Many both women and men rape survivors' exhibit symptoms of PTSD, and this literature which has being done recently suggests, the survivors' beliefs about sex and control may affect PTSD symptoms. The present study examined beliefs about sex and power as potential mediators of the relationship between rape and PTSD symptoms for men versus women. For that matter, women reported higher levels of lifetime history of rape than men (19.7% for women; 9.7% for men). While rape history predicted PTSD symptoms for both genders, beliefs about sex and power were shown to be a significant partial mediator of this relationship for men, but not for women. This literature results suggested that, survivors' beliefs about sex and power are connected and can affect their PTSD symptoms. In addition to that, results illustrate how sexual violence

against men may reaffirm male gender roles that entail power and aggression, and ultimately affect trauma recovery. (Calton JM, et al 2015).

2.5 PREVALENCE OF PTSD

Several studies have emphasized in the impact of sexual assault and other criminal acts on documenting PTSD in women. As cited by Terence M., et al. (2006), "13% of 4008 participants reported a completed rape. Of those who were raped, lifetime and current PTSD rates were 32% and 12%, respectively. Similarly, Resnick et al. (1993) estimated that 36% of women had been criminally victimized, with 14.3% experiencing attempted rape or molestation and 12.7% experiencing a completed rape. They estimated lifetime and current PTSD rates to be 12% and 5%, respectively. Among those who were exposed to criminal victimization, rates of lifetime and current PTSD were 26% and 10%, respectively. It was also stated that the rates of prevalence of PTSD tend to be higher in less economically developed countries than in more developed countries. For example, among a geographically diverse sample of Mexican adults, lifetime PTSD prevalence was estimated to be 19% (Norris et al. 2003). In addition, among adult Israeli residents, Bleich et al. (2003) found that 9.4% met criteria for current PTSD, with higher rates among women (16.2%) than among men (2.4%)." ((Terence M., et al. 2006)).

According to Walsh K. et al, 2012 Population prevalence estimates suggest that 769 000 adolescent girls, 625 000 college women, and 13.4 million women in US households reported sexual revictimization. Further, 154 000 sexually revictimized adolescents, 250 000 sexually revictimized college women, and 3.6 million sexually revictimized household women met criteria for past 6-month PTSD. Findings highlight the importance of screening for sexual revictimization and PTSD in pediatric, college, and primary care settings.

In a research which studied to analyze the PTSD prevalence six months after sexual assaults and also to identify the major risk factors for developing PTSD found that, thirty-nine percent of the women had developed PTSD at the six month assessment, and 47% suffered from moderate or severe depression. The research also stated, the major risk factors for PTSD as having sexually being assaulted by more than one person, suffering from acute stress disorder (ASD) shortly after the assault, having been exposed to several acts during the assault, having been injured, having co-morbid depression, and having a history of more than two earlier traumas. In addition to this, ASD on its own was found to be a poor predictor of PTSD because of the substantial ceiling effect after sexual assaults. (Tiihonen Möller et al, 2014).

According to Abdella R. et al, 2015 study finding, it was reported that before treatment (56.7%) of participants who were in the treatment group showed moderate level of PTSS, (36.7%) reported mild level. 6.7% showed high or severe level. According to this study, it was reported that from all the participants in the control group (26.7%) showed moderate level of PTSS, the rest (26.7%) and (3.3%) showed mild and severe level of PTSS respectively.

When we see the overall prevalence rate of 4% for the general population, the rate in rescue/recovery occupations ranged from 5% to 32%, with the highest rate reported in search and rescue personnel (25%), firefighters (21%), and workers with no prior training for facing disaster. The lifetime prevalence of PTSD is significantly higher in women than men. Lifetime prevalence of PTSD varies from 0.3% in China to 6.1% in New Zealand. The prevalence of PTSD in crime victims is between 19% and 75%; rates as high as 80% have been reported following rape. (Javidi, Yadollahie M. 2012).

In countries that are non-Western and developing, higher rates of PTSD were observed. "A larger and fairly representative samples of men and women age 16 or older living in Algeria, Cambodia, Ethiopia, and Gaza, de Jong et al. (2001) found high rates of PTSD in each sample (37.4%,28.4%, 15.8%, and 17.8%, respectively). In Algeria and Cambodia, and consistent with findings in the United States, women had higher rates of PTSD than did men (43.8% versus 32.2% and 34.2% versus 20.6%, respectively). In contrast, in Ethiopia and Gaza, women possessed similar or lower rates of PTSD in comparison with men (15.2% versus 16.6% and 13.5% versus 22.6%, respectively)." ((Terence M., et al. 2006)).

According to the study which had been done by Zinzow HM and Resnick HS, Women with rape histories involving with the two kinds of rape; the substance facilitation and forcible tactics reported the highest current prevalence of PTSD (36%), MDE (36%), and AA (20%). Some demonstrated that this victim group was also at highest risk for psychiatric disorders, after controlling for demographics and childhood and multiple victimization history. Comparing both groups, women with substance-facilitated rapes reported higher prevalence of substance abuse in comparison to women with forcible rape histories. When we see the comparison between the rape victims and the non rape victims, there is comorbidity between PTSD and other psychiatric disorders was higher among rape victims in comparison to non-rape victims.

2.6 RISK FACTORS FOR SEXUAL ASSAULLTED INDIVIDUALS IN DEVELOPING PTSD

Among the causes of PTSD on the view of rape survivors specifically, the development of PTSD is common in the aftermath of sexual assaults. An increased risk of developing PTSD is always causal relation by a combination of victim vulnerability and the extent of the dramatic nature of

the current assault. By identifying those women at greatest risk of developing PTSD appropriate therapeutic resources can be directed. (Tiihonen Möller., et al 2014).

According to (Acierno R. et al, 1999), they try to identify different separated risk factors for rape and physical assault, and also identify separate risk factors associated with post-rape PTSD and post-physical assault PTSD in general. Generally speaking, past victimization, young age, and a diagnosis of active PTSD increased women's risk of being raped. On the other hand, past victimization, minority ethnic status, active depression, and drug use were associated with increased risk of being physically assaulted. When we see the risk factors for PTSD following rape, they included a history of depression, alcohol abuse, or experienced injury during the rape.

There are many broad risk factor categories of PTSD. With regard to familial psychopathology, Anisman et al. (1979) suggested that, there may be an association between a genetic component with variability in sensitivity to environmental stress. In regard to demographic factors, as cited by Terence M., Amy D., and Casey T. (2006), with respect to gender, "women appear to be more at risk for developing PTSD than are men (Breslau et al. 1999; Kessler et al. 1995). Similar gender differences in PTSD prevalence rates have been found in a variety of samples (e.g., Kosovar Albanians; Cardozo et al. 2003), yet the average weighted effect size across studies is small (r = 0.13; Brewin et al. 2000), and elucidating the mechanisms (i.e., psychological or biological) involved in these differences surely requires additional scientific study. Age at the time of a traumatic event is also one important determinant. Across 29 studies, Brewin et al. (2000) found that the average weighted effect of age on PTSD was minimal (r = 0.06)."

Kessler et al. 1995 stated that marriage appeared to confer some level of protection when one was exposed to a traumatic event even when holding trauma exposure constant in the analyses.

According to Brewin et al. 2000, it was mentioned that prior life trauma and cumulative adversity may increase risk of PTSD following a later trauma whether the trauma occurred in childhood or as an adult and/or the time passed since the trauma. On the other hand, study conducted by Further, Bowman & Yehuda, 2004 mentioned some individuals with prior trauma and life adversity might develop adaptive coping skills that may protect them from PTSD.

Prior existence of a psychiatric illness was found to confer a small degree of risk for the development of PTSD, according to Brewin et al. 2000).

According to Rosenman (2002), it was found that in experiencing rape or molestation, it was one of the events that were likely to increase one's odds of developing PTSD.

Epstein JN1, Saunders BE and Kilpatrick DG stated that, it's very important to see the impact of factors that predispose childhood rape victims to develop posttraumatic stress disorder (PTSD) which is supposed to be much significant in understanding both the impact of childhood rape and the development of PTSD as a psychological disorder. 3,220 of women were interviewed about their history of rape, trauma-related variables, and PTSD status. It was consistent with research on crime victims, life threat and physical injury discriminated PTSD status in a sample of childhood rape victims.

2.7 LEGAL FRAMEWORKS OF SEXUAL ASSAULT IN ETHIOPIA

Ethiopia is a federal republic composed of nine regions and two administrative cities. The supreme law of the land, which is the Federal Constitution, serves as an accord between the regions and the federal government. Accordingly, power is shared between the regions and the federal government. For instance, while the regions are mandated to legislate on family law, the Federal Government is empowered to enact the penal and labor law. With respect to children

sexual assault and violence, to administer justice, courts are now frequently citing the principle of 'best interest of the child', which principle is also incorporated in national laws including the Federal Constitution and the family law. With respect to violence against children, there is no one comprehensive law dealing with all types and aspects of violence. The management of violence itself is multisectoral. Thus it is a shared responsibility between diversified laws as well as institutions. First, FDRE Constitution, secondly penal law and its procedure law are among the relevant legislations to the problem of violence against victims. The following are the categories in the law under which the different forms of sexual violence may fall:

- Rape on a girl child of 13-18 by a person of the opposite sex will result in an aggravated case punishable with rigorous imprisonment up to 20 years. (Art 623(2)(a).
- Sexual intercourse with a girl of 13-18 years by a person of the opposite sex will be punishable with a maximum rigorous sentence of 15 years regardless of the girl's consent for the act. (629(1)) The punishment will be aggravated to 20 years in the cases where the victim is the pupil, apprentice or servant of the offender, or is in any other way directly dependent upon or subordinate to the offender.
- Any act corresponding to a sexual act with a boy of 13-18 by a person of the opposite sex is punishable with imprisonment of 3 months to 5 years. (629(2))
- Sexual offence on a female child below the age of 13 is punishable with rigorous imprisonment of 15 to 25 years. (630(1))
- Any act corresponding to a sexual act on a male child below the age of 13 is punishable with a rigorous imprisonment of 6 months to 7 years. (630(3))
- Any sexual act on a female or male child of age 13-18 by a person of the same sex shall be punishable with a rigorous imprisonment of 3 to 15 years. (633(2)(c)

- Any sexual act on a male child below the age of 13 by a person of the same sex shall be punishable with a rigorous sentence of 5 to 25 years. (634) (The Federal Ministry of Labor and Social Affairs, 2005).

2.8 THEORETICAL FRAMEWORKS

COGNITIVE MODELS

There was theoretical basis for PTSD in the emotional processing theory framework which was developed by Foa E.B. and Riggs D.S. (1993). It was developed by combining the model of learning with a cognitive model and Lang's theory of emotion. According to them, Patients with PTSD could be characterized by two types of cognitive content:

1. They view the world as an exceptionally dangerous place;

2. They see themselves as particularly incompetent people.

As cited by ((Ivanna Shubina, 2014)), it was raised that cognitive model of emotional disorders assumed that:

1. The way of thinking influences the life events interpretation and leads to certain emotional reactions.
2. Key beliefs influence the perception and interpretation of the information regarding the future/ coming trauma.
3. To modify key beliefs they should be matched to the previous schemes (assimilation) or adjusted to the schemes (accommodation).

On the other side, cognitive model of PTSD which is developed by Ehlers and Clark (2000) assumes that "PTSD appears when the person is processing the trauma and its consequences in a

way, which causes a sense of current threat. Then there are two key processes in this model: the first is, negative assessment of trauma and its consequences; the other one is, coding of traumatic event memories. The behavior of people and their ways of coping with trauma and its consequences often make the cognitive change impossible and maintain a disorder. A sense of threat is sustained by a negative appraisal of the traumatic event or its consequences, and post-traumatic behavior." ((Ivanna Shubina, 2014))

A CONDITIONING MODEL OF THE ETIOLOGY OF POSTTRAUMATIC STRESS DISORDER

According to Keane & Barlow (2002) "there were three components of vulnerability which were proposed as a triple vulnerability model of PTSD etiology based on theoretical descriptions of anxiety and fear. These components are pre-existing psychological variables, pre-existing biological variables, and the experience of a traumatic event. Unlike specific phobia, PTSD is hypothesized to emerge from one special chain of events in which intense basic emotions, such as true alarms which might include rage, disgust, or distress, resulting from the overwhelming effects of traumatic events, which happens to lead learned alarms. Learned alarms occur during exposure to situations that symbolize or resemble an aspect of the traumatic event, such as anniversaries of the trauma and thoughts, feelings, and memories (i.e., cues) of the event. As in any phobic reaction, the development of learned alarms can result in persistent avoidance of stimuli associated with the trauma. These are defining features of PTSD. ((Terence M. Keane, 2006)).

With respect to factors influencing in the development of PTSD, McFarlane and Yehuda (1996) have proposed a theoretical model. In this model they have raised family history, personality,

coping style, the reaction of the environment and life events as a factors influencing the PTSD development. As a result PTSD does not develop as a direct consequence of traumatic events; rather it arises from the acute distress, strong post-traumatic reaction (Lis-Turlejska, 2002). ((Ivanna Shubina, 2014)).

TREATMENT MODALITIES FOR SEXUAL ABUSE SURVIVORS

"Most treatment modalities adopt one or more of four basic therapeutic goals: the first one is, symptom relief, which may be accomplished by encouraging the child to think differently about the event, teaching the child to manage his or her aberrant behaviors, facilitating the expression of negative affect, affirming the child's experience, and providing emotional support (Rust & Troupe, 1991); the second is, de-stigmatization, which may be achieved by group affirmation from other child victims and the therapist's supportive stance (Kruczek & Vitanza, 1999); the third goal would be increasing self -esteem through cognitive and interpersonal exercises, role plays, and games (Hill, 2006); and finally preventing future abuse by changing the victim's environment and/or behaviors and awareness." ((Rachel L.W, 2008)).

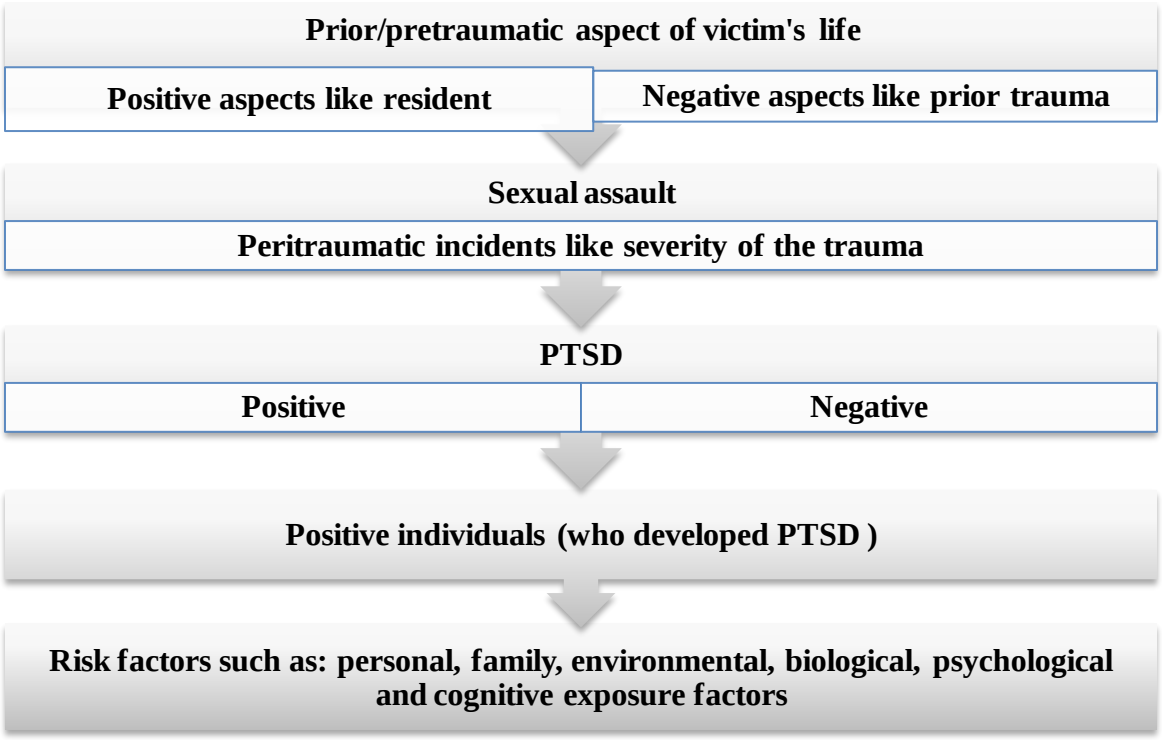
The basic assumption in a cognitive therapy developed by Resick and Schnicke (1992) was "PTSD symptoms are caused by conflicts between new information provided by a traumatic event and earlier schemes. Cognitive therapy is focused on identifying and modifying these conflicts namely: a sense of security, trust, power, respect and sense of closeness (McCann et al., 1988). ((Ivanna Shubina, 2014)).

2.9 CONCEPTUAL FRAMEWORK OF THE STUDY

"Conceptual framework is a set of coherent ideas or concepts organized in a manner that makes them easy to communicate to others (Schwartz, 2006)." For the study to measure the prevalence

of PTSD one has to be exposed to actual or threatened events; According to this study, sexual assault in one of the DSM V of criteria A. By using the self report questionnaire (PCL-5), the screening was carried out. Some are at risk when others are not.

Figure 1: Conceptual framework



CHAPTER THREE

RESEARCH METHODS

3.1 DESIGN OF THE STUDY

The research design of the study was both Quantitative and Qualitative. In the quantitative research method, the survey included all individuals who could be available. Descriptive qualitative research design was used to illustrate individual experiences of risk factors.

3.2 DESCRIPTION OF THE STUDY AREA

The study was conducted indifferent governmental and nongovernmental organizations which are currently engaged in giving health care, economic support and/or any other services for individuals who have been sexually assaulted at Addis Ababa. This study was conducted in IFSO, OPRIFS, AWSAD, Gandhi Memorial Hospital, Abrhot and EWLA.

3.3 POPULATION OF THE STUDY

The study participants are individuals who have been sexually assaulted and who are currently getting service or treatment at IFSO, OPRIFIS, AWSAD, Gandhi Memorial Hospital, Abrhot and EWLA in Addis Ababa.

Included

- Female or male who have been sexually assaulted
- Voluntary participation
- Key informants who work in those institutions
- Children older than 6 years

Excluded

- Participants who declined to be included.
- People who didn't speak Amharic.

3.4 SAMPLING TECHNIQUES

Availability sampling technique was used to sample participants. Participants were first identified by various people including their counselors and the project manager of each respective institution. Once the potential study were identified, they were approached by their counselors and caregivers and were given a brief explanation of the study and then were invited to participate in the study. For those who agreed, a written informed consent form was given and filled accordingly for study phase I. For study phase II, key informants were approached, informed and invited to participate in the study and after they agreed, a written informed consent were given for a taped interview for study phase II. A structured self report questionnaire for study phase I and a taped interview for study phase II were conducted.

3.5 PARTICIPANT SAMPLING

The data was collected from IFSO OPRIFS, AWSAD, Gandhi Memorial Hospital, Abrhot and EWLA in Addis Ababa.

3.6 METHOD OF DATA COLLECTION

PTSD CheckList 5 (PCL-5) which is a 20-item self-report questionnaire that assesses the 20 DSM V symptoms of PTSD and key informant semi-structured interview was used to collect data from the study participants. For study phase I, participants also gave details about their socio-demographic characteristics which were used to analyze the structured questionnaire at the

end. The data collection form included information such as sex, age, educational level, income status, marital status, type of assault, number of perpetrators involved, type of contact the victim has with the perpetrator/s etc... Filling the questionnaire took from5-10 minutes on average. Once they filled this, filling the questionnaire were carried out by the counselors and caregivers. For study phase II, after the key informants were taken to a quit room, using the interview guide their responses recorded on tape. The recorded interviews lasted about 40-55 minutes on average with supplementary notes taken as needed. Participants were told that the recorded information will be used anonymously.

3.7 METHODS OF DATA ANALYSIS AND INTERPRETATION

The data collected was interpreted by organizing; editing, classifying and finally describing the data by using SPSS 16 for study phase I. For study phase II, the tape recorded information was transcribed and then translated into English for analysis. All the English translations were compared against the original Amharic transcripts. There were no significant differences. The data was then coded manually. The main categories mentioned at first in the interview guide were the starting point and were included as themes. They were then described and elaborated.

3.8 ETHICAL CONSIDERATIONS

The study was conducted after ethical approval was obtained from Department of Psychiatry, College of Health Sciences, Addis Ababa University and the institutions research ethics committee. The purpose and aim of the study was explained to all participants by counselors and the caregivers for study phase I and for study phase II, by the principal investigator for the key informants and completion of informed consent was ensured. Confidentiality was maintained.

CHAPTER FOUR

STUDY PHASE I

Results

4.1 The socio-demographic characteristics of participants

Sample

A total of 71 participants filled the self report questionnaire that was prepared to see the "Prevalence of PTSD". There was an attrition rate of the study population (N=29) due to start of schooling period, difficulty contacting them and some declined to give consent. The characteristics of the participating individuals are presented in Tables 1. Among the participants, 54 (76.1%) were female victims. The other 17 participants were male victims. Most of the participants 45 (63.4%) were Orthodox in religion. 63(88.7%) of the participants were single.

SPSS 16 was used to compute the frequency of Socio-demographic characteristics and response of study participants to the individual item of the PCL-5 and the frequency for PTSD, percent of participants responding extremely high on each item of the PCL-5 and finally, Chi-square to see the associations of the variables with PTSD.

Table I: Socio-demographic characteristic of study participants

Socio-demographic characteristics		Number	Percent
Sex	Male	17	23.9
	Female	54	76.1
Religion status	Orthodox	45	63.4
	Muslim	20	28.2
	Protestant	6	8.5
	Married	8	11.3
Marital status	Single	63	88.7
	Addis Ababa	51	71.8
Region	Oromia	7	9.9
	Others	13	18.3
Types of assault	Rape	56	78.9
	Others	15	21.1
Number of perpetrator/s	1 person	66	93
	2 and above	5	7
	1	14	19.7
Relationship of the victim with the assaulter	2	10	14.1
	3	36	50.7
	4	11	15.5
Condition of the victim at the time of the assault	Fully conscious	47	66.2
	Sub conscious	16	22.5
	Unconscious	8	11.3

Table II: Response of study participants to the individual items of PTSD (PCL 5)

No	Items	Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?	16(22.5)	12(16.9)	10(14.1)	5(7.0)	28(39.4)
2	Repeated, disturbing dreams of the stressful experience?	19(26.8)	16(22.5)	7(9.9)	8(11.3)	21(29.6)
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	26(36.6)	7(9.9)	15(21.1)	8(11.3)	15(21.1)
4	Feeling very upset when something reminded you of the stressful experience?	7(9.9)	14(19.7)	8(11.3)	6(8.5)	36(50.7)
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding,	31(43.7)	12(16.9)	4(5.6)	7(9.9)	17(23.9)
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	21(29.6)	9(12.7)	4(5.6)	8(11.3)	29(40.8)
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	19(26.8)	9(12.7)	6(8.5)	6(8.5)	31(43.7)
8	Trouble remembering important parts of the stressful experience?	32(45.1)	14(19.7)	6(8.5)	5(7)	14(19.7)
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	27(38)	11(15.5)	13(18.3)	7(9.9)	13(18.3)
10	Blaming yourself or someone else for the stressful experience or what happened after it?	26(36.6)	11(15.5)	10(14.1)	5(7)	19(26.8)
11	Having strong negative feelings such as fear, anger, guilt, or shame?	18(25.4)	6(8.5)	17(23.9)	8(11.3)	22(31)
12	Loss of interest in activities that you used to enjoy?	26(36.6)	12(16.9)	5(7)	11(15.5)	17(23.9)

13	Feeling distant or cut off from other people?	26(36.6)	16(22.5)	5(7)	8(11.3)	16(22.5)
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	24(33.8)	7(9.9)	12(16.9)	4(5.6)	24(33.8)
15	Irritable behavior, angry outbursts, or acting aggressively?	26(36.6)	10(14.1)	8(11.3)	16(22.5)	11(15.5)
16	Taking too many risks or doing things that could cause you harm?	39(54.9)	10(14.1)	8(11.3)	2(2.8)	12(16.9)
17	Being "super-alert" or watchful or on guard?	19(26.8)	10(14.1)	11(15.5)	11(15.5)	20(28.2)
18	Feeling jumpy or easily startled?	20(28.2)	11(15.5)	7(9.9)	12(16.9)	21(29.6)
19	Having difficulty concentrating?	18(25.4)	16(22.5)	13(18.3)	7(9.9)	17(23.9)
20	Trouble falling or staying asleep?	24(33.8)	12(16.9)	10(14.1)	4(5.6)	21(29.6)

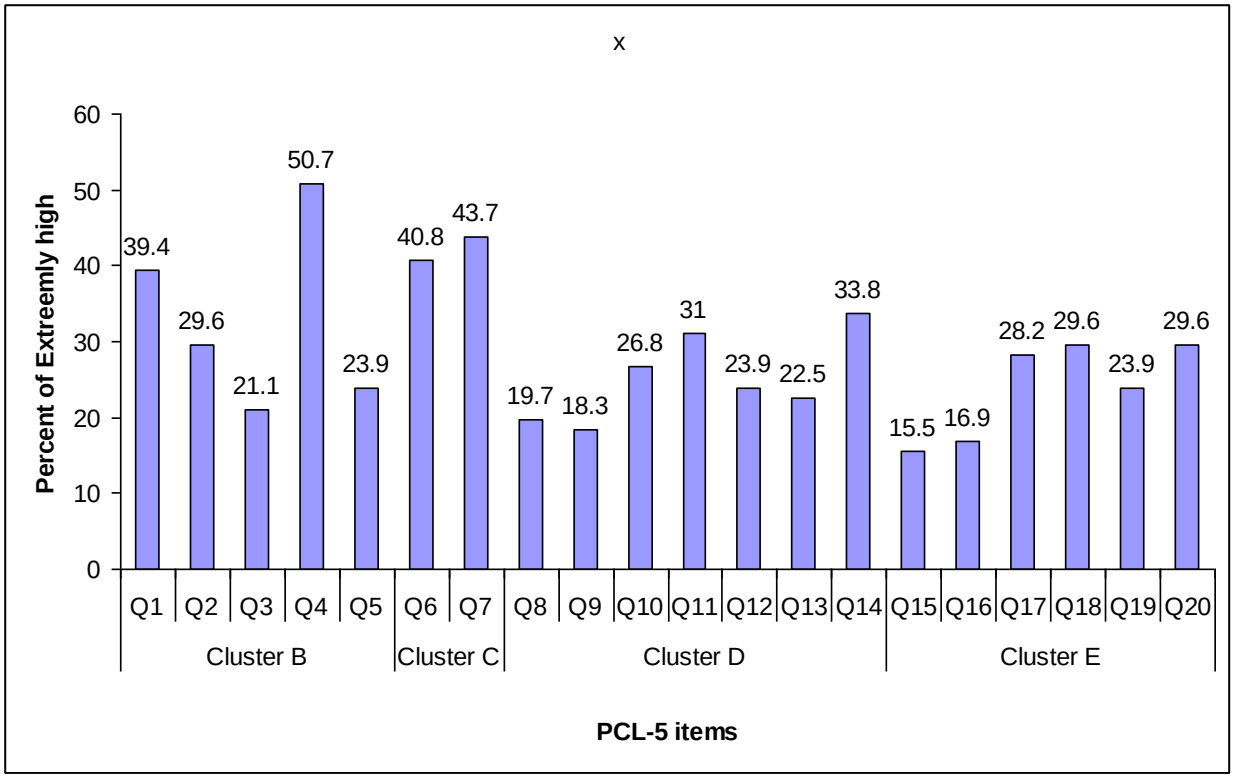


Figure 1: Percent of participants responding extremely high on each item of PCL-5

In contrast, symptoms of recurrent, involuntary, and intrusive distressing memories of the assault, intense or prolonged psychological distress at exposure to internal or external cues that

symbolize or resemble an aspect of the event(s) which are Cluster B, avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the sexual assault, avoidance of or efforts to avoid external reminders, Cluster C and persistent inability to experience positive emotions, Cluster D and finally, exaggerated startle response and sleep disturbance which are Cluster E symptoms were more common.

PTSD	**Freq**	**percent**
0	38	53.52
1	33	46.48
Total	71	100.00

Table III The prevalence of PTSD in the participants

From the whole participant, 33 (46.48%) were found to be positive in PTSD. So, it was found that the prevalence of PTSD is said to be 46%.

Socio-demographic characteristics						
		PTSD		**Total**	**Chi-square value**	**P-value**
		Negative	**Positive**			
sex	Male	11	6	17		
		64.70	35.30	100.00	1.124	0.289
	Female	27	27	54		
		50.00	50.00	100.00		
Religion status	Orthodox	25	20	45		
		55.60	44.40	100.00	1.075	0.584
	Muslim	9	11	20		
		45.00	55.00	100.00		
	Protestant	4	2	6		
		66.70	33.30	100.00		
Marital status	Married	1	7	8		
		12.50	87.50	100.00	6.099	0.014
	Single	37	26	63		
		58.70	41.30	100.00		

Region	Addis Ababa	32	19	51		
		62.70	37.30	100.00	6.908	0.032
	Oromia	3	4	7		
		42.90	57.10	100.00		
	Others	3	10	13		
		23.10	76.90	100.00		
Types of assault	Rape	31	25	56		
		55.40	44.60	100.00	0.359	0.549
	Others	7	8	15		
		46.70	53.30	100.00		
Number of perpetrators	1 person	37	29	66		
		56.10	43.90	100.00	2.430	0.119
	2 and above	1	4	5		
		20.00	80.00	100.00		
Mental state of the victims in the time of the assault	Fully conscious	25	22	47		
		53.20	46.80	100.00	2.100	0.350
	Sub conscious	7	9	16		
		43.80	56.20	100.00		
	Unconscious	6	2	8		
		75.00	25.00	100.00		
Institutions	IFSO	20	14	34		
		58.80	41.20	100.00		
	OPRIFS	10	1	11		
		90.90	9.10	100.00	18.160	0.003
	AWSAD	7	7	14		
		50.00	50.00	100.00		
	Gandhi	0	7	7		
		0.00	100.00	100.00		
	EWLA	1	1	2		
		50.00	50.00	100.00		
	Abrhot	0	3	3		
		0.00	100.00	100.00		

Table IV Associations of characteristics of participants with PTSD

The majority of characteristics included in the analysis were not able to reach statistical significance. This may be due in part to the small number of individuals included in the analysis.

Statistical significance was found for three variables included in the research specifically for marital status, region and institutions.

STUDY PHASE II

Results

Sample

A total of 8 key informants were interviewed. The characteristics of respondents are presented in table V. From the participants 6 were females.

The respondents were both counselors and social workers. Among the key informants 6 of them were counselors who have worked in different institutions including hospitals and NGOs. The other two were social workers who work in a same position like the counselors.

All the interviews except one were completed at a single appointment. The one counselor had a very busy schedule because; she is the only professional in the foster home. So, the interview was done after postponing number of appointments.

Table V Socio-demographic characteristics of key informants

Characteristics	**Number of key informants**
Job	
Counselor	6
Social worker	2
Sex	
Female	6

Male	2
Level of education	
Masters degree	7
First degree	1
Institutions	
IFSO	3
AWSAD	2
Gandhi	1
Arhot	1
OPRIFS	1
Experience of key informants	
0-5 years	4
Above 5 years	4

Themes identified

The following were the major themes arising from the thematic analysis.

1 Personal risk factors

I. Sex

With respect to sex, there were only 2 institutions which work with both sexes. The one is NGO with a foster home for victims who have been sexually assaulted who are both male and female

survivors which also happen to cover 48% of the sample in the study. The other is a private clinic that gives a psychological treatment for every individual with any level of mental illness.

From the respondents, 3 of them believed that gender can be taken as a risk factor for developing PTSD. One key informant doesn't think it can play a role directly by its own without combining other risk factors. Two more participants believe "gender" plays a great role on developing PTSD. The reasons are mainly, the society blame female victims for getting assaulted, expectations of the society that are set as a rule/constructs for every female how to act living in one particular community and society.

Females versus Males

Most of the participants think that female victims are exposed to develop PTSD. One participant mentioned his reason;

> "….. *It is without any doubt, females. But it is not only because of the trauma or the assault they went through, there will be additional multiple factors according to Ethiopia. The additional factor may include; the society will make the victims (female) to feel guilt for getting sexual assaulted. The society usually blames female victims for being assaulted*." (002)

The same participant mentioned that the question that the society usually raises when a female in Ethiopia get assaulted sexually puts female victims more predisposed.

> *"….the female victims who came to the clinic, most of them came already after developing severe PTSD. That shows you that, PTSD is dominant in female victims…. But, the society is the one who predispose female victims to PTSD. Because, they will be*

asking question that they wouldn't have for male victims, like; how was her dressing style, maybe she wore shorts (that's her fault), was she out late? What time did it happen? Why did she go alone? . The society expects females not to go out late, not to go alone. But, isn't it her right? So, these things will be aggravating factors, addition to her sex."(002)

One other respondent thinks both sex and gender can be a risk factor for PTSD and females are more exposed to PTSD than males.

"…Their shyness, the society's feedback for the assault, the stereotype, not being able to be confident and their self esteem will increase the fact for females to have high probability to develop PTSD than males ever do."(003)

The same respondent does believe that the PTSD will be aggravated if there are additional factors other than sex and gender.

"…Their former/prior personality, strength, assertiveness, confidence and self esteem will have an influence too. But, from my experience the female's strength, their assertiveness, confidence and self esteem is lower than males."(003)

The rest of the respondents believe that neither sex nor gender play a role in developing PTSD. Some respondents believe that it can only be a risk factor for being assaulted not for developing PTSD.

II Age

It was found that, all of the victims believe that PTSD can appear in any age. But, age can be a risk factor in different age groups. Three of the respondents believe that, the victims who are

assaulted at the age of knowing themselves well and the one who knows what happened to them go through the symptoms of PTSD when they are compared with victims who are very little.

> *"...adolescents are at advanced risk of developing PTSD. The one who are very little can get out of it easily if they get medical treatment and get rid of their physical pain and psychological support before it reaches PTSD. I can't number it but the one who can understand and who are aware are at higher risk in both sexes."(008)*

Other respondent from the same institution respond that the one who know themselves are the one who are at higher risk of developing PTSD for the reason:-

> *"....We always gets amazed by this thing. When they are very little kid, they don't even know what exactly happened. Although, some may manifest it in a very different way, those kids who are very little are at lesser risk of developing PTSD. So, you don't see the symptoms of PTSD in fewer than 9 years old of age kids. Rather, because they are kids, they will forget about it, make friends and play and they will be living their life. The more their age's increases, the more they are at the risk of developing PTSD. The smaller they are, the lesser they develop PTSD."(003)*

According to one respondent, it was found that, there are three main age regions which are at advanced risk of developing PTSD. This respondent at first believe that victims that are assaulted when they start knowing themselves, the one who don't reach puberty and who particularly are at 14-15 age are more exposed to PTSD.

> *"...But, the victims who are in the age of raising the question "Why" and the victims who are in the age of expecting an answer for that kind of questions are the one who are in*

higher age. So, from my experience, I have seen those in higher age develop PTSD from the very little ones."(001)

Other respondent believes the same. Although, he thinks the age for both sexes is a little different when it comes to manifestation.

"*… from my experience, from the males that I have seen, most of the victims are found to be in "early adolescence". I think in this age, the PTSD will be manifested in different way. But the way they manifested is different and sometimes not visible to us. For the girls, as some study show us, the age they develop both primary and secondary sexual characteristics is 15 and around and that's the age which they more exposed to PTSD. (002)*

Other respondent believes age is one of the risk factors in developing PTSD and according to her experience, unlike the other professionals, she believes the "very little" victims who don't know what happened in them are the one who are exposed to PTSD.

"….from my experience, when they are very little kids, it will take them a very long time until they understand "what happened to them". But, they manifest PTSD in different way like; anger, being afraid, bed weighting and recruitment and even in therapy kids are hard to deal with. Because, you can't communicate easily and you can't tell or express what happen to them verbally. For that, the risk increases at them."(004)

According to the other participant who has the same thought like the one who is mentioned above, the victims who are very little, who are particularly below 6 of age are at higher risk of developing PTSD. Because, the very little victims have the tendency to repress what happened than understanding it and they have the tendency to develop hater for males and get scared of

them. The rest two respondents believe that victims who are under age of 18 are generally more exposed than the one who are above 18 years of age victims. The last respondent also believe that victims below 18 are exposed and specifically victims from 11-18 are the one who are more exposed to PTSD.

Most of the respondents believe that, the risk of being exposed to PTSD will increase when there is additional aggravating factor which can be combined with age.

III Educational background status

The majority, which are 6 of respondents believed that educational level of the victims play crucial role and is one of a contributing factor in exposing the victims into PTSD. In regard to having a formal education and higher educational status and not having any formal education, respondents were grouped into two themes.

Three of the respondents believe having a formal education and higher grade level and victims who are able to hold a diploma and above educational status have lower risk of developing PTSD.

> *"....Personally, victims who have a better educational status have the lowest risk of developing PTSD. ...Having formal education in general increase the victims understanding level and decrease their risk of developing PTSD. The other reason is, the more she is learned, the lesser she is going to be exposed to sexual assaults at the first place."(005)*

One respondent believes that there is another class of victims that she saw in her experience who are highly exposed to PTSD with respect to their educational background status comparing with other victims, who are "Night students" no matter what their educational grade level is.

> *"....For the victims who are night learners, whether they are in a higher or lowest educational background, they are at strongly higher risk of developing PTSD. The reason is, they are struggling to win life by working day and by learning at night and when they get assaulted, it made them question everything..."What did I ever do to the world or people or any existing thing to hate me and let me suffer this much?" and that made them go through the trauma over and over again." (001)*

The other two respondents believe educational background status of the victim's is a risk factor for developing PTSD. But, they believe that the more the victim's educational status increases the more they are close to develop PTSD.

> *"...from my experience, their age and educational status go side by side. When their age increases, their educational background status increases too.(grade). As I told you before, the more their age increases, the more they manifest PTSD. So, their level of grade will increase too. I personally believe that, "the more your awareness and understanding increases, the more your psychological burden increases too". (003)*

Regarding the educational background status, the rest two respondents don't believe it is one of the risk factors in developing PTSD.

IV Type of contact with perpetrator/s

With respect to the type of contact the victim's have with the perpetrator/s, it was found all key informants bolster the type of contact with perpetrator/s is one risk factor in developing PTSD. All believe the victims who are assaulted by close family and parents have higher or advance risk of developing PTSD than other victims who are assaulted by strangers and other perpetrators.

As a reason, key informants have raised: the victims get to see their perpetrator every day, the fact that they share the same bloodline, the fact our religious and cultural status strictly forbids sexual assault (specially by a family or parent and relatives), the society's attitude towards family and relatives that they should be protective and supportive not some sort of assaulters and the issue of trust can aggravate the risk to develop PTSD, for the victims who are assaulted by family and relatives.

> *"…this is one of the crucial risk factors in exposing PTSD. The reason is, first, you will be able to see them over and over again if the perpetrator is family or relative. Even if you fight not to recall about the trauma, not to have a flashbacks, not to have a nightmare, and want to avoid memories at all, it will be impossible because your assaulter is going to be there as a reminder. That definitely will not help you to cope. The second reason is as researches show us; around 90% of our society is religious. Most of the religions that have a lot of believers and even our cultures and values don't support a close family marriage at all. It will be taken as a sin." (002)*

The other reason is unpleasant consequences that the assault brings in the family like divorce and prosecution.

"... family instability and family crisis" will happen in the family... the family will be grouped. Some may think it is the victims fault not the parent or relatives who cause the assault. The other side may blame the assaulter and take the issue to the court. When the blood line gets tight, then the more higher it gets for the victim to develop PTSD." (003)

The other reason which was raised from participants was victims who were perpetrated by parents and relative needs longer time and much work and effort to rehabilitate.

"...the more their relation is tight, the more PTSD, the more problem there is. The more time and effort it needs. For by strangers, they persuade themselves that they never going to see him and that assure them they can forget about it."(005)

Concerning the victims who were assaulted by strangers, it was found that they have lesser probability of developing PTSD.

"...The victims who have been assaulted by a stranger have less probability of developing PTSD. Because, they don't raise a question of "trust". The victims who have been assaulted by family and relative always ask, "How can a family, relative or a person who share same blood line like you; would do such thing?" When we see the victims who are assaulted by a complete stranger, they keep themselves busy by asking, "Who might that be?" They don't ask "Why me? Or what did I do wrong?" like others. These questions are for victims who knew the perpetrator. This people don't know who assault them. So, they will ask "Who might that be? Who is behind this? Or what is their goal or aim for doing this?" Their probability of developing PTSD is there, but, it is low." (001)

It was found that the victims who were assaulted by neighbor get better chance and higher probability of developing PTSD than the one who were assaulted by a strangers and employees.

> *"...if I have to put an order, after family and then relative, I will put neighbor. They will be verbal abuse whenever he sees her because he is a neighbor. Polices sent the victims late." (004)*

It was also found that victims who were assaulted by employers, teachers and other authority figures are at higher level of developing PTSD next to the victims who were assaulted by family, relatives and neighbors.

> *"...the probability of developing PTSD in females who have been assaulted by their employers is very high for so many reasons. The first is, most of all are not educated. Second, when we see their economical background status, they are in the lowest economical background status. Third, most of them are migrants and new for the placement or resident they working for. So, after the assault, there will be stimulus generalization". (001)*

Finally, as aggravating factor for developing and manifestation of PTSD, six of the respondents raised our justice system problem, the verdict and sentence to perpetrators.

> *"....Even the justice process has its own impact. When the perpetrators do not get punished at all or at less, it has a great influence at the victim's mental health in general. It will expose them." (003)*

V Number of perpetrators

Except for two participants, all key informants reported that the number of the perpetrator is one of the crucial risk factors in developing PTSD in survivors of both rape and other type of sexual assault survivors.

> *"...When we talk about the number, we are talking about the societal impact in the victims. For the victims who are a survivor of a gang rape and who were sexually assaulted by more than one person, the societal feedback will be completely different. The society will maximize it. Then the comparison will be with the individuals who have not been assaulted and also with the individual who have been assaulted by only one person. There is going to be a strong feeling of guilt, shame and pity than others. You will be saying, at least hers is by one person and once which is going to be another additional aggravating factor for those victims to develop PTSD." (002)*

On the other hand, the rest two respondents mentioned they believe the "number of the perpetrator/s" can be a risk factor for only rape survivors not other type of sexual assault.

> *"... In some cases it is different because they function exactly the same as the victims who were assaulted by one. It depends on the cases and other exposure factors. Some, who were assaulted by one, may develop severe PTSD than the victims who were sexually assaulted by more than one." (006)*

VI Risk factors that were added by key informants

Almost half of the respondents suggested there are more risk factors that expose some victims who went through the same event. From the additional risk factors the informants added: some are; economical status of victims, personality of victims, family status of victims, relationship

with perpetrator including caregivers (mostly for females), police (for male victims) and other important individuals who we expect their protection and care.

List of risk factors that one participant added

- Poverty
- Residency and the environment the victim lives at (before and after the assault)
- The place they get perpetrated
- Being an orphan or not
- Past assault or abuse history
- Child headed family

According to another key informant, it was mentioned that, not having safe environment after the assault, unpleasant consequences like; when the victim get HIV or pregnancy because of the sexual assault and finally our raising or parenting style and socio-cultural status of the victims are other potentially contributing risk factors for developing PTSD.

The other risk factors raised by participants are religion and personal behavior of the victim (his/her former or prior personality of the victims).

> *"...I want to add the victim's former personal behavior as a risk factor. I believe Victims who were lonely; victim's who don't have strong social relation with others and who were initially detached are at risk of developing PTSD."(002)*

> *"...may be religion. For example: there are religions that strictly forbid sexual assault. For example in Muslim community, if a girl had a sexual contact before marriage it is a great sin and if she gives birth because of that, then it makes it worse.(005)*

2 Family risk factors

With respect to family risk factors, there are sub-categories which are raised as a risk factor in most of the victims and the first one is;

I. Family past psychiatric illnesses

Only two of the respondents found to be the supporter of family past psychiatric illnesses being one of the risk factors in sexually assaulted victims. The reasons mentioned were; the family with mental illnesses will not be able to give the care, protection and treatment the victims deserve and need. The other reason is the society's feedback for mentally ill family.

Majority of the respondents (5 of them), responds they never had such kind of experience in their life. Some stated they have few experience but, they don't know how to associate it.

> *"...Honestly speaking, we have never asked about this deeply. I don't have enough data to decide whether it can be taken as a risk factor or not. So, I will pass this question if you don't mind." (001)*

One respondent stated that we are being obsessed with genetics and that this respondent doesn't believe in such kind of thing that much.

> *"...I think we are really obsessed with genetics. Once, I have read an article that said genetics is 21th century demon". If you remember 19th and 20th century, it was believed that mental illnesses were caused by demons and then psychological problems. But, now in the 21 century, the demon is genetics. Everything will be attributed to genetics. Personally, we are giving a lot of credit for genetics and I don't think it has that much involvement."(002)*

II. Substance abuse

Regarding substance abuse, it was found two dimensions in the respondents. One is when the family, caregiver or the relative the victims live with are substance abuser. The other is when the victim him/herself is a substance abuser.

Concerning the side that both can be taken as a risk factor, four respondents believed it could be taken as a risk factor.

> *"…If the victim is a substance abuser, it has a different effect and risk concerning PTSD. When we say different, when the victim abuse a substance, they may use it as a coping mechanism… On the other hand, if the victim's families are substance abusers like chat, alcohol and cigarette and other additional drugs, then the victims are at risk of developing PTSD. Because, that family might not provide the help, care and support the victim need. They might even provoke her; abuse her verbally and emotionally, whenever they take the substance or loss the substance. I have seen victims who their parents abuse them verbally and emotionally after they have been sexually assaulted. Most of the victims wanted to commit suicide because of that."(001)*

> *"…Normally, in the family that abuses substance, there is always a conflict… no matter how much help you provide here, they only learn that they are not needed, that they are not enough and that no one cares..(003)*

> *"…it is one of the risk factors in developing PTSD on the victims who abuse substance. ….most psychiatric cases get worse and aggravated if the patient uses any kind of substance. There is this concept that we call "comorbidity" too. If you are a drug abuser then you are vulnerable to other mental illnesses too.(004)*

On the other hand, there were three key informants who don't have that kind of experience.

"…. The victims that we see in this institution, the majority are kids and I never seen substance abuser victims. Regarding the family being a substance abuser or not, we don't really ask that kind of question honestly. So I can't say."(007)

One last respondent personally doesn't believe being in the family who is substance abuser is a risk factor in develop PTSD. But, he thinks, the victim being substance abuser is exposed somehow.

"…: I don't know, I don't think so. How can it been related? I don't see how it affects the victims. If the family is substance abuser then it can only be affecting the person himself/ herself, not the victim."(002)

"…He/she will be using it as a coping mechanism and when they reach "regret" stage, he/she will not only be regretting about the substance but also they have got a trauma they regret about so, that will aggravate the PTSD. In that case, it can be another risk factor (the substance)." (002)

III. When there is individual/s in the family who is aggressive, bad tempered and does unusual thing by his/her nature. (Including the victim).

Five participants stated that being an aggressive, bad tempered and who does unusual thing by his/her nature can be taken as one of the risk factors under Family risk factors.

"…it has an influence in the patient's psychological wellbeing. Whenever they get irritated, they won't be rational and think about the victims. This people are capable of using "displacement" as a defense mechanism. As a result, they might use the victim's situation as a coping mechanism for dealing with their aggression and unusual habits.

This will lead the victim to remember it every day and even blame her/hisself for being abused and for letting someone else in the family uncomfortable. For that, the victims will have recurrent, involuntary, and intrusive distressing memories of the event, dissociative reactions like flashbacks, intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the assault. So, that means, these whole things increase the risk for the victims to develop PTSD." (007)

"...victims who have been sexually assaulted need very warmth environment. At least, until they rehabilitate. Otherwise, they will associate everything with themselves. They will link and associate every single thing with their problem(s)."(006)

Particularly one respondent believe if the aggression and bad temperament are in the victim; that might help and protect them than exposing them.

"....it might help them. You never know. If they are aggressive, it might help them to displace their anger on other things and not repressing emotions and memories to oneself and one way or another it might be a way they can get relief at. I think it will help them not to have repression as a defense mechanism and distress about the event. I don't think being serious, decent and being in a good manner is a guarantee or a protective factor at all. Still, you will have the chance to develop PTSD."(004)

IV. Marital and other status of family

All participants except for one agree marital status of the family as a risk factor for developing PTSD and also in exposing victims for a sexual assault. They also added parenting and raising

style the victim's family follows and their economical status as risk factors for developing PTSD.

> *"…being an orphan is one risk factor for the assault… Even having any kind of marital status, the kind of the family member like the kind of father or mother they are will matters too… I think when your social support increase, not only your psychological wellbeing but also your medical wellbeing will get better. If there is no family to support you, not good marital status in your family and when the family members are problematic your probability of developing PTSD will be advanced." (004)*

The same participant believed that the parent of the victims live in matters first and secondly their economical background status of the victim's family or caregivers matter.

> *"….if the victim is a girl, and then it is going to be very hard to tell her single dad that she is raped, no matter how good he is and no matter how close they are, there is still gender difference and may be it would have been better if her mom is there. But, that figure is not there in the house. Plus, the type of the family raising style that family follows matters too. For example if you look in to the victims somewhat, at first, they will be telling you the pain (physical perhaps) not about the pain the trauma caused. So, they might not get someone to share that with."(002)*

> *"….Growing up with step father or step mother will increase the risk for assault and that will increase the level of developing PTSD…for example if she gets assaulted by her step dad and tell her mother, she might not believe her at the first place so the problem will be complicated… and if she didn't tell her, there be repetitive assault---on the other hand if*

her mom believes her, she will be divorced and there will be financial problem. Either way, the risk increases."(005)

Regarding the marital, economical and raising and parenting style of the victim's family, only one participant is found to believe it has an effect only for the assault not for developing PTSD.

".... I do think marital status of the family and their economic background has a great influence on the assault not for developing PTSD."(001)

As an additional factor under the "Family risk factors", two respondents added the question of justice and trust issues as a risk factor in developing PTSD.

"....the other thing that I didn't add when the perpetrator is family and relative is, people will expect you not to take the case to court just because the assaulter is a family. They will compromise with the victim which let the victims not to get justice. The fact that justice wasn't serving for you will increase the risk of developing PTSD on some level. Whether the verdict is enough or not, it will help them to get some relief."(002)

"....in my opinion because we give much trust for relatives and neighbor and because of our culture, we don't usually suspect something may happen and warn our kids. Especially, for males. But, if you look the prevalence in both sex, majority perpetration are by neighbor and family. So, family has to start questioning our culture and value. We are capable of breaking them and families are not alert of that. Family has to take care for his son and daughter too."(008)

3. **Environmental risk factors**

In the case of environmental risk factors, it was meant to find sense of difference between the victims who are from rural area of the country and the victims who are from urban area of the country in a broader way in those institutions. But, unfortunately it was found almost all of the institutions accept and admit victims from only Addis Ababa, from the different 10 sub cities. Although, most of the victims are home maids/servants who are originally from rural area of the country, most are assaulted in Addis Ababa.

With regard to the sub cities the victims came from, almost all respondents believe it is a risk factor for both getting assaulted and also for developing PTSD. Almost half of the respondents raised the living style of the sub city the victims live in and their economical status compel them to get assaulted at the first place and then expose them to develop PTSD then. The other reason that were raised by the respondents was, some sub cities like Addis Ketema sub cities housing environment and their child rearing style.

> *"....we can see the sub city they came from as a risk factor and most clients came for Adiss ketema and Yeka sub city. Especially Adiss ketema. The place we accept the victims around those sub cities are filled with people who are poor or have lowest income group. They are sub cities where children are whatever they want like staying out until 5-6 PM, peoples who rent bed, and they are even houses in which there will be bunch of people who are staying the night (strangers). I think as long as they go through poverty and other different problems in their life, the victim's probability of developing PTSD will be advanced too. When the number for sexual assault increases the risk for PTSD will increase too."(004)*

"....if you allow me to see it in the sub city level then, the victims that lived in a very crowded area like Addis ketema kifle ketema, there is a chance of people hearing and discussing about the assault easily and that will hurt them indeed. They will feel guilt and shame to even get out of their home. So, living in sub cities like Addis ketema and yeka expose victims to develop PTSD."(003)

"...addis ketema kifle ketema is the 1st one.. Their living style (called "Debal") where you enter by one door but is for 2 family households without a door which can differentiate the 2 family. In one compound, there will be 10 households with many alcoholic, perpetrators and other maladaptive behavior individuals within it. 2nd most homes in day are bars then the kids will have to play until the mom ends selling her alcohol until midnight sometimes. The other is there is loft in every home which peoples who cannot afford pension pay rent it for one night. This all exposed the victims to assault and PTSD."(008)

Two participants believe that victims from crowded and the sub cities where the adolescents and substance abusers spend their day insulting and harassing the girls who are passed and the place where commercial sex workers live majorly have lesser probability of developing PTSD than the victims who lived in a sub city like bole and related sub cities.

"...By the way the trauma is going to be developed into PTSD, when the trauma is for the first time in physiological and psychological means and when it is entirely for the first time that happened in their life too. I think when there is a moderate harassment and verbal assault; it will establish readiness in both unconscious and conscious way. There are places that people live intensely like Teklehaimanot, Piasa and merkato.. in such kind

of places, everybody knows what happened to whom and they talk about everything all the time. But, the people who don't live in the place that doesn't have intense relation will never learn about such kind of issues. So, the first ones, won't have sense of uniqueness. That, I think will decrease their risk for PTSD. They have this schema which makes them believe that humans are capable of doing anything."(002)

One respondent believe that for the victims who are from urban originally and from sub cities like Addis ketema and alike has lesser effect than the victims who are from rural area of the country originally and in a sub cities that people lives in a calm and compounded homes. Despite of the other factors, these victims exposed more to PTSD.

"…for a victims who lived in a city and sub city where there is a harassment, a lot of provoking and touching, the probability may be lower. The reason is, they adapted mild and moderate harassments. They eventually accept that it is okay to be provoked, verbally abused and sometimes harassed. Because, that's what they have been learning in their environment. So, they might be exposed to the assault more but not for developing PTSD. I think the same is true for the city where there are people from different cultural background lives in; like Addis Ababa. But, when we see victims from rural area and from people with the same cultural background, being assaulted is really a taboo. The society prohibits and strictly forbid harassment, rape and generally sexual assault. In some placements, boys and girls cannot even stand together. So, the victims from such kind of placement have only been learning that being harassed and assaulted is not normal and is a taboo. So, they have fear of stigma. They fear that the society will discriminate them. They have this question in their mind that might keep them in the trauma recruitment, having flashbacks and other symptoms of PTSD; which is "How?"

"How is this possible?" So, the risk of being assaulted is low, but, the probability for the development of PTSD is high."(001)

Two participants raise issues that we need to work on with regard to the environmental risk factors. The first is, we need quantified research and study on the prevalence of Assault and PTSD and its risk factors. The second participant states the gap in the awareness of what our society are becoming capable of.

"....there is no awareness on what our society is becoming capable of regarding sexual assault and homosexuality. We don't know what we are getting to. I think the prevalence being low in rural areas is a risk factor too. In urban the number for the assault is getting high because of our parenting style, low educational status and low economical background. We need to work on that."(007)

4 Biological risk factors

Under this category, past medical illnesses history and any disease, behavioral and thinking ability problem that runs in the family were raised as a risk factor. All participants stated past medical illness can be an exposure factor for developing PTSD. Almost all of the participants have never have a history and/or experience on the behavioral and thinking ability problem of the victims. It was found that from the key informants who had a chance to see a victim with such problem, they have sent them all to see a psychiatrist.

"....there is the impact of their disease as a disease, psychologically, physically and mentally. But, when this is added, then they will be like "What did I ever do? Even God has forgotten about me" and I have seen victims with a neurodevelopment disorder and it increases the risk."(002)

"....From my experience, the victims with past medical illness, they always ask "How can they do this to me?", "one way I am sick and now am raped, and now I am assaulted sexually?""(001)

As an additional suggestion, one participant states their comment as follow:-

"....Even the victims who never had any mental or medical illnesses before but who happen to be found positive are the one who are at high risk other than any victims in the institution. So, it will increase. Even there is a difference in developing a PTSD, when it is an attempt and when there is penetration. The first group will get relief by saying "I am still virgin". The second, they have a lot to complain and worry about. So, victims with more than one problem will be like "what is going to be my life?" surprisingly, they don't share it with others, not even with their best friends. So, when the number of the problem increases, there probability of developing PTSD will increase too." (004)

5 Psychological risk factors

With respect to the psychological factors, two sub themes have been constructed and almost all respondents happen to believe on them.

I. Past psychiatric illness history

More than half of the respondents believe that having past psychological illness is one risk factor for developing PTSD.

"....Yes, without any doubt. Their past psychiatric illness will play a role in affecting their life in the past and even in the present by making them lonely and other symptom of

the comorbid disorder they already have which is an aggravating factor for developing a PTSD."(002)

"...I think they are more exposed to PTSD more than the victims who don't deal with known medical or psychiatric illnesses. In the case of the psychiatric illnesses, they are first exposed to the sexual assault not only for developing PTSD. They are even exposed to repetitive rape and sexual assault (by the same person or by different individuals at different time)."(004)

Some participants mentioned that they have never seen a victim with known past psychological disorder history. One participant stated they don't usually keep a record on the past psychological illness history and that she doesn't have a collect data on this.

II. Negative childhood experience

All of the participants stated negative childhood experience of victims as one of the greatest risk factor that can potentially expose or protect victims from developing PTSD.

Five participants stated that having negative childhood experience, specially victims who were abused sexually, physically, emotionally, verbally and/or psychologically are very exposed developing PTSD for reasons like, victims with such experience will be miserable because of the abuse they had either consciously or unconsciously, the coping mechanism they used in the past and so forth.

".... they are predisposed. What happens in childhood stays in your whole life. Not only for the childhood. When you finally grow up and experience the same thing, whether you

handled it well or not you will think of the world as a chaos and the assaulters as a demon. Besides "the child is the father of the man" it will increase the risk." (005)

".... They are very exposed to develop PTSD. The thing I mentioned before like sense of uniqueness and loneliness will be seen more at them than any other victims. Such kind of patients think that they are born with it, like they are cursed and that it is all about luck and they are not lucky."(002)

"....The one thing that I always remember about my patients is that, no matter how hard, complicated and abusive childhood they had, it is always better than what they have gone through in the recent assault. So, they have higher risk of developing PTSD other than the victims with no history of any abuse in their life."(001)

It was found that, having negative childhood experience will help a victims to cope well and not to be exposed to PTSD, rather it can be a protective factor; although it depends on how the victims handled it in their childhood.

".... I see it in two different ways. I have seen victims with a physical abuse history and they are surely predisposed to PTSD on some level than the victims that didn't have the same experience. Victims who had such a hard childhood experience and cope with positive, rational and strong way will have great adaptive and recovery plans. So, they don't take the blame and they will be looking for better answers than that and it help them a lot. On the other side, victims who had been abuse, and handled it in a weak and self blaming way, then it will expose them more to PTSD than helping them to cope."(003)

"....The first is the one who have been assaulted before and revictimized now, they may totally frustrate, have negative attitude towards the world, males and other related things with the assault, trust no one, being hopeless and hard to treat. So it will expose them to PTSD and can be aggravating factor too. The second is, the past assault can be taken as protective factor; as a lesson and experience and since they already have been through it and cope, now they will be resilient."(008)

One participant believed that victims who had been sexually assaulted and other negative childhood experience, they don't usually expose to PTSD just because they had been through one in their childhood. She stated additional aggravating factors and that the type of abuse they had been through matters too.

"...I think it depends. Some may get a relief from what they had been through. It will increase their probability of developing PTSD and even their risk for the sexual assault to begin with. But, I think it needs other aggravating factors like their economical/financial status and I believe the abuse they had been through in their childhood matters too.?"(004)

Three respondents raised additional factors which they believe that have to be added as a risk factor under psychological risk factors. From the factors as a risk which the participants added is victim's belief on curse.

".... I want to add one factor which is "how religious are they?" I think it has its own sketch to aggravate PTSD and to protect and rehabilitate too. The more religious they are, the more the PTSD can be aggravated. I have also victims who are religious

believing that it was for good and God has a reason for it. So, I have seen both. So, maybe we can add religion."(002)

"....Yes. I want to add one thing. Victims who are lonely, who undermine themselves, who avoid peoples and the one who discriminate themselves are at higher risk of developing PTSD too."(001)

6 Cognitive risk factors

With regard to the cognitive risk factors, the awareness about PTSD and the way the victims express about the nature and severity of the situation that happened to them have been raised. Not even one respondent believe that there is a victim who has an awareness about PTSD and regarding to the way the victims express about the nature and severity of the situation that happened to them, almost all of the respondents believe it cannot be taken as a risk factor for PTSD.

The participants were asked for risk factors based on their experience; under cognitive risk factors category. Some has added risk factors from what they have seen in their experience. It is all mentioned below.

"....the victims who have great self-confidence, the one who raised learning that they are lovable, strong and good self acceptance have a good sense of acceptance and the trauma will have an effect on them. But, they will not be exposed to PTSD."(003)

".....sometimes, over-commitment and over confidence can be an exposure factor for PTSD."(001)

One respondent stated an additional factor and suggestion for male victims specifically.

"....there is no awareness on male's rape and assault. People even polices ask "what? Males also can be sexually assaulted? They can be raped as females does?" so the reason that there is no awareness that a male can be assaulted can increase the exposure risk for males than it does for females. Any society can understand that females can be sexually assaulted but we don't know males also do. Most victims don't want to go to school ever again and most of our victims tried to commit suicide. Almost all. The second is no one thinks/knows they need a treatment like female victims. No one knows they need a medical care or psychological treatment for the traumatic event they have been trough. People don't know it is a crime. Family of the victims thinks as soon as their kid is raped or assaulted in some way that he is going to be gay. So the lack/no awareness expose male victims to develop PTSD."(008)

7 Recommendations

At the end of the interview all the key informants were asked if they had any thoughts in prevention and interventions that help reducing and stopping sexual assault in both sexes and then PTSD. Most reported that so as to decrease and to be able to stop sexual assaults we have to work with the government, religious leaders, schools, professionals and mainly Medias.

All of the respondents recommend that our Medias have to work in creating awareness for both sexual assault and PTSD like what have been done for HIV in the past. They have to work in both the prevention and intervention of sexual assault and PTSD. They all wanted PTSD to be raised as an impact of assault like Fistula and HIV.

All of the respondents recommended that we have to look into our justice system again very deeply. The government has to work on revising our justice system regarding the punishment,

the time/ appointment gap, on evidence they look, on using psychologist on determining how hurt the victims are psychologically like what they did physically.

Three of the respondents stated that victims have to be sent to institutions and hospitals as fast as possible; especially for male victim.

Almost more than half of the participants recommended that we need to work on our raring and parenting style. Almost all of the participants reported that all have to work in family support. All believed that if the family support is zero, the professional and the institutions cannot do anything for the victim's psychological wellbeing.

Three respondents recommended that we need to work with our religious leader. Because, our people is a believer and the religious leaders can play a great role in prevention and intervention of sexual assault and PTSD.

Almost all respondents stated that we all have stop with the positive stereotypes. One respondent recommended that, we have to work on prevention to stop and reduce PTSD from developing and administer trainings and group counseling which will help the victims that there are people in the same road who shares the same experience as them and yet survived and they can share and learn techniques and make friends so far.

CHAPTER FIVE

DISCUSSION

This mixed-methods study targeted a group of individuals who have been sexually assaulted. The purpose of the current study was to measure the prevalence of PTSD in those individuals and identify the risk factors that expose some victims to develop PTSD when others do not.

It was found the prevalence rate of PTSD in individuals who have been sexually assaulted in this study is 46.48%. This finding is consistent with two other findings. In a study which was conducted in Ethiopia, specifically in one of the institutions that this research was conducted at too: OPRIFS and Kechene, 63.4% of participants from the treatment group showed moderate or severe level of PTSS (56.7%) moderate and (6.7%) severe. According to the study, majority of the participants in the control group as well were at moderate which is (60%) and severe (6.7%) level of PTSS. (Abdella R. et al., 2015). In another study which aimed in analyzing the PTSD prevalence six months after sexual assaults and identify the major risk factors for developing PTSD, Thirty-nine percent of the women had developed PTSD at the six month assessment, and 47% suffered from moderate or severe depression. (Tiihonen Moller et al., 2014). On the other hand in study which was conducted by Creamer, M., et al, 2001, it was found that the estimated 12 month prevalence of PTSD was 1.33%.

According to the key informants in this study, it was found that almost all of the risk factor themes are risk factors for developing PTSD. sex, gender, educational status, type of contact with perpetrator, number of perpetrator, past medical illness, substance abuse, economical and marital status of the victims, parenting style, sub cities the victims came from, past psychiatric illnesses and childhood abuse history have found to be the major risk/exposure factors in developing

PTSD among the victims of sexual assault, according to the key informants responses. No past study has found which integrated all of the risk factors studied simultaneously using key informants that measure the themes constructed in this study. However, there were many studies which their findings stated most of the risk factors that this study studied as a major risk factor too. According to Tiihonen Moller et al, it was identified that the major risk factors for PTSD were having been sexually assaulted by more than one person, suffering from acute stress disorder (ASD) shortly after the assault, having been exposed to several acts during the assault, having been injured, having comorbid depression, and having a history of more than two earlier traumas. (Tiihonen Moller et al., 2014). The result for the number of perpetrator/s, having past psychiatric illness and having a history of past trauma is consistent with this study. Regarding the number of the perpetrators, victims who were sexually assaulted by two and more perpetrators happen to be more associated with PTSD than victims who were by one. 80% of the victims who were perpetrated by two were found to be positive in PTSD. Except for two participants, all key informants reported that the number of the perpetrator is one of the crucial risk factors in developing PTSD in survivors of both rape and other type of sexual assault survivors.

It was found in this study that female victims are highly exposed to PTSD than male victims. It was also found that not only being a female but the gender difference and role as a female expose females to develop PTSD than males. This is because of negative societal reaction and positive stereotype mainly. Because the society blame them for even going through the trauma there will be self blame and feeling of guilt. It was found in this study that, of all the female participants N=54 (76.1%) 27 or 50% of the female victims had association with PTSD. whereas, among the 17(24%) of male victims, 6(35%) of them are found to be associated with PTSD. There are findings which suggest that negative social reactions and avoidance coping are the strongest

correlates of PTSD symptoms and that the association typically observed between victim self-blame and PTSD symptoms may be partially due to the effect of negative social reactions from others in a society. (Sarah E. Ullman, et al, 2007). In study done by Norris, F. et al, 2003, it was found that persons of lower socio-economic status and being a woman were the highest risk for PTSD. This result is consistent with this study.

According to Creamer, M., et al, 2001 females were at greater risk than males within the subsample of those who had experienced trauma. Prevalence was also higher among the never married and previously married respondents. But, it was found that it was lower among respondents aged over 55. For both men and women, rape and sexual molestation were the traumatic events most likely to be associated with PTSD. Except for sex, the reverse is true for this study. Prevalence of PTSD was most likely to be associated with PTSD among the married respondents. So, it was found that there was an association and it was statistically significant. Regarding to the type of assault the victims went, PTSD were more likely to be associated with not raped victims. Rather it was associated with "others" type of sexual assault although the association was not statistically significant.

It was found that the number and type of assault are among one of the advanced risk factors. In this study it was also found that victims who were assaulted by more than one perpetrator were more likely to be associated with PTSD. As it was mentioned earlier, of all the participants who were assaulted by more than 1 person, 80% of them were found to be prevalent to PTSD. This might be because of the societal feedback for gang rape and severity of the assault in general and there are also studies which results suggest that people respond more negatively to victims who experience more violent assaults or perhaps that survivors of more severe assaults tell more

people, increasing the likelihood that they will receive negative reactions and that will expose victims to develop PTSD. (Sarah E. Ullman et al., 2007).

With respect to marital status as a risk factor, all except one key informant believed it has an effect in both exposing the victims to assault and also for PTSD. According to Kessler et al. 1995, it was stated that marriage appeared to confer some level of protection when one was exposed to a traumatic event even when holding trauma exposure constant in the analyses. In this study, it was found that from all single participants who covered 88.7% of the study 41.30% found to be positive. Whereas, from all married participants (11.3%), 87.50% were PTSD positive and the association was significantly associated with PTSD. In contrast, in Breslau et al.'s (2004) Detroit trauma survey, marital status was not significantly associated with PTSD. (Terence M. Keane, Amy D. Marshall, & Casey T. Taft, 2006).

Some participants in this study have expressed having no formal educational status or having lower level of educational grade level and low income status increase the risk of victims to develop PTSD. Study which was done by Sarah L. Halligan, & Rachel Yehuda,, 2000 stated also lower levels of education and income, and being divorced or widowed are risk factors for PTSD. In another study which was conducted by Sarah E. Ullman & Leanne R. Brecklin, 2002 Ethnic minority women with less formal education were found to be at higher risk of PTSD.

It was found all participants support that the victims who have been assaulted by the family, relatives and neighbors are at higher and advanced level of developing PTSD. This might be because the victims have so much to remember, sharing the same blood line, need longer time and effort for recovery and because of the conflict in the family after the assault. It was also found that women assaulted by known offenders had more psychological symptoms and poorer

self-rated recovery in regressions controlling for assault history, assault characteristics, postassault coping, and social reactions. Less education, greater perceived life threat, and more negative social reactions were related to more PTSD symptoms. (Sarah E, et al, 2007).

Regarding to psychological risk factors, two sub categories was raised in conducting this study and it was found that, under the past psychiatric illnesses more than half of key informants represent it as one of the risk factors for PTSD. On the other side several studies identified the prior existence of a psychiatric condition as a risk factor for the development of PTSD. The presence of psychopathology such as an addictive disorder or conduct disorder may also lead to exposure to traumatic events themselves. Increasing evidence suggests that prior life trauma and cumulative adversity may increase risk of PTSD following a later trauma. It was found that five participants stated the same and together, these studies suggest that prior trauma and life adversity may sensitize people to later traumas. It is possible that some individuals might develop adaptive coping skills that may protect them from adverse responses to future traumas and that is what the rest of the key informants in the study raised. In a sample of Mexican adults, Norris et al. (2003) found that exposure to violence in childhood was related to the chronicity of PTSD in which this study also found that more than half of the key informants agreed on. (Terence M. Keane, et al, 2006). In another study it was stated that Prior Psychiatric Disorders and Personality Dimensions were one of the highest risk factors in developing PTSD. (McFarlane, 1989). According to a study conducted by Breslau, N. (2002), it was stated that there are three factors which are identified as having relatively uniform effects; which are (1) pre existing psychiatric disorders (2) family history of disorders and (3) childhood trauma. It was also stated that women are at a higher risk for PTSD than are men, following exposure to traumatic events. It was also found that in this study, those three factors are the potential risk

factors for developing PTSD for different reasons. More than half of the respondents believed that having past psychiatric illness is one of the greatest risk factors in developing PTSD. It was also found that victims with past psychiatric illnesses are exposed to the assault at the first place and it was mentioned that they are even exposed to continuous and repetitive rape and sexual assault.

Although majority of the respondents in this study which are five of them responds they never had such kind of experience, two of the key informants for a reason such as the family not being able to take care of themselves to begin with and not being able to give care, protection and treatment that the victim's deserve and need and because of the societies feedback for mentally and physically ill family, have raise it as a risk factor for developing PTSD. Childhood trauma/ negative childhood experience is one of the major factors in this study in which all of the participants agreed up on. Except for three, five of the respondents believed that it exposes victims to PTSD by having a negative effect or influence. On the other hand, three of the participants mentioned that it can either be exposure or protective factor.

CHAPTER SIX

Conclusions

Sexual assault is obviously often a traumatic experience that has many consequences throughout the person's life. This study finding and other evidences have proven that although all victims that go through trauma don't develop PTSD, still most does and there are risk factors that expose those victims to develop PTSD. The compliance of actors who are exposed to assault but diminish its seriousness also contributes to the persistence of the assault and rape. Social actors in the institutions of school, family and peer groups can do something about denial, blaming the victim, and male privilege. Until the problem of assault and rape is approached as system wide phenomena, it will continue. It is our hope that this paper contributes to the naming and identification of the problem, the recognition of its complexity, and awareness of the responsibility that we all have for these societal wide phenomena. By identifying those victims at greatest risk of developing PTSD appropriate therapeutic resources can be directed.

Recommendations

It is important that research continue on the topic of prevalence of PTSD and its risk factors in individuals who have been sexually assaulted. The severity of this issue and the significant implications it has on the lives of survivors has been well established. There is much to be learned on how clinician and all therapists can best help survivors of sexual assault overcome its long-term effects. Further research is needed to address best practice and treatment interventions for survivors. The effects of sexual assault last into adulthood and clinicians need to be well trained in order to provide the best services possible. Victims have to get access to psychological treatment as soon as possible. We have to work on creating awareness in both the severity of the

assault and the long term effect like PTSD, we have to work on our raring style, we have to work in family support and we hope this research will be replicated with larger sample and more professionals and it is recommended the risk factors for PTSD has to be figured out by studying with quantitative method. Finally, it is recommended to stop with the negative societal reaction and positive stereotype.

Appendix 1 PCL 5

No	In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2	Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it) ?	0	1	2	3	4
4	Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating) ?	0	1	2	3	4
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8	Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11	Having strong negative feelings such as fear, anger, guilt, or shame?	0	1	2	3	4
12	Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13	Feeling distant or cut off from other people?	0	1	2	3	4
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being "superalert" or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

Appendix 2

የመጠይቅ ቅፅ

ተራ ቁጥር	ዖታዊ ጥቃቱ ከደረሰብዎት በ ፣ ወር ውስጥ ምን ያህል ተረብሸው ነበርን?	በጭራሽ	በትንሹ	መካከለኛ	በመጠኑ	በጣም
፣	ስለ ጥቃቱ በተደጋጋሚ የመረበሽ እና ያልተፈለጉ ትውሰታዎች መኖር ?					
2	ስለ ጥቃቱ ተደጋጋሚ የሚረብሹ ህልሞት ማየት					
3	በድንገት ያ ጥቃት እንደገና እየደረሰብዎ ያለ ያህል ወይም እዛ ጥቃት ላይ እንደገና እስካሉ እስኪመስሎት ድረስ ተሰምቶት ወይም ታይቶት ያውቃል?					
4	ጥቃቱን የሚያስታውሶት ነገር ላይ ሲሆኑ በጣም የመናደድ ስሜት ይታይቦታል?					
5	የሆነ ነገር ጥቃቱን ሲያስታውሶት በጣም ጠንከር ያለ አካላዊ ምላሽ (ለምሳሌ እንደ ልብ ምት መጨመር፣ መተንፈስ አለመቻል እና ማላብን) የመሳሰሉትን አሳይተው ያውቃሉ					
6	ስለ ጥቃቱ የሚያስታውሶትን ትውሰታዎች፣ ስሜቶች እና እሳቤዎች ማስወገድ?					
7	ውጫዊ የሆኑ ጥቃቱን የሚያስታውሶትን ነገሮች (ለምሳሌ፡ ሰዎች፣ ቦታ፣ ንግግር፣ እንቅስቃሴዎች፣ ነገሮች እና ሁኔታዎች) ማስወገድ እና ከነዚ ነገሮች መራቅ ይታይቦታል					
8	የደረስዎበትን ዖታዊ ጥቃት ዋና/ጠቃሚ ትውሰታዎችን ለማስታወስ መቸገር/አለመቻል?					
9	በጣም ጠንካራ የሆነ መጥፎ አመለካከት ስለራስዎ፣ ስለሌሎች ወይም ስለምትኖሩበት አለም በአጠቃላይ (ለምሳሌ፡ እኔ በጣም መጥፎ ነኝ፣ የሆነ በጣም ትልቅ ችግር አለብኝ እኔማ፣ ማንም አይታመንም እና አለም በአጠቃላይ አደገኛ ነች) ብሎ ማሰብ?					
10	ራስዎን ወይም ሌሎችን ለደረስዎበት ጥቃት ወይም ከዛ በኃላ ለተፈጠሩት ነገሮች ሁሉ መውቀስ?					
11	ጠንከር ያለ መጥፎ ስሜት ይሰማዎታል (ፍርሃት፣ ንዴት፣ የጥፋተኝነት ስሜት ወይም ሀፍረትን የመሳሰሉ)?					
12	ከዚህ በፊት ያዝናናዎት እና ያስደስትዎት የነበርዎት ነገር ላይ ፍላጎት ማጣት ይታይቦታል?					
13	ከሌሎች የመራቅ ወይም ግንኙነትዎን የማቆም ስሜት ይታይቦታል?					
14	ጥሩ ስሜት ያለመሰማት ችግር (ለምሳሌ ደስተኛ መሆን አለመቻል)?					
15	በጣም የሚያበሳጩ ባህሪዎትን ማሳየት፣ ንዴትን መቻቻም አለመቻል ወይም በሀይለኝነት ንዴትዎን መግለፅ?					
16	በጣም አደገኛ ነገሮችን ማድረግ ወይም ሊጎዳዎት የሚችሉ ነገሮችን ማድረግ?					
17	ሁሌም በጣም ጥንቁቅ፣ በዙሪያዎ ያሉትን ነገሮች ሁሉ በደንብ መከታተል (ማየት)፣ ሙሉ ጥበቃ ላይ መሆን?					
18	ስጋት ወይም በቀላሉ መጨነቅ እና ድንጉጥ መሆን					
19	ሀሳቦን መሰብሰብ አለመቻል?					
20	እንቅልፍ ሊወስዶ አለመቻል ወይም መተኛት አለመቻል?					

Appendix 3

Informed consent

The prevalence of PTSD in individuals who have been sexually assaulted and its risk factors: in the case of IFSO, OPRIFS, AWSAD, Gandhi Memorial Hospital, Abrhot and EWLA.

Dear participant Mr./ Miss/ Mrs.....

The main purpose of this study is to see the prevalence of one of the common mental illness; which we call it PTSD in the mental health, in individuals who have been sexually assaulted in IFSO, OPRIFS, AWSAD, Gandhi memorial Hospital, Abrhot and EWLA and its risk factors who developed PTSD after they have been sexually assaulted.

This study is going to be conducted by me Feven T/haimanot, who is learning my masters degree in clinical psychology at Black lion campus department of psychiatry and I am doing my thesis on the topic and purpose that has been mentioned above. It has been approved by the department of psychiatry. I would really appreciate your participation and I am asking you to complete a survey.

The participation is completely voluntary and you are participating in this study only because you want to participate. If you choose to participate, please sign to show your agreement and complete the survey according to the directions provided.

The person administering the survey will collect all responses in about 10-15 minutes.

Signature ..... Date .....

Thank you for your time and participation in the matter.

Feven T/haimanot

Sex A) male B) female

Age .....

Religion A) orthodox B) Muslim C) protestant D) others

Marital status A) married B) single C) divorced D) widowed E) others

Region A) Addis Ababa B) Oromia C) others

How long had it been since you have been sexually assaulted? .....

The type of assault A) rape B) other

The number of individuals who caused the assault .....

Your relation with that particular individual (s) A) family B)relative C) stranger D) neighbor

In the time of the assault, you were A) fully conscious B) sub conscious C) unconscious

Appendix 4

የመጠይቅ ስምምነት ቅፅ

የፖስትትራውማቲክ ስትረስ ዲስኦርደር መጠን እና የመጋለጫ ምክንያቶች ፤ ጾታዊ ጥቃት በደረሰባቸው ተጠቂዎች ላይ፡ በ ኢፍሶ፣ ኦፐሬፍስ፣ አውሳድ፣ ጋንዲ መታሰቢያ ሆስፒታል፣ አብርሆት እና ኢውላ፡፡

ይህ ጥናት የሚደረገው በእኔ በተማሪ በፌቨን ተ/ሀይማኖት፤ አሁን ላይ በጥቁር አንበሳ ግቢ ሳይካትሪ ዲፓርትመንት የ2ተኛ ድግሪዬን በ ክሊኒካል ሳይኮሎጂ እየሰራሁ ሲሆን፤ ይህ ጥናት የመመረቂያ ፅሁፌ ሲሆን፡ ጥናቱም የሚደረገው በ አአ ዩንቨርሲቲ ጥቁር አንበሳ የ ሳይካትሪ ዲፓርትመንት እውቅናና ድጋፍ ነው፡፡ በዚህ ጥናት ላይ ሊሳተፉም ስለሆነ ከልብ ዐመሰግናለሁ፡፡

እዚህ ጥናት ላይ እየተሳተፉ ያሉት በሙሉ ፍቃደኝነት ና መሳተፍ ስለፈለጉ ብቻ ነው፡፡ ለመሳተፍ ከወሰኑ በፊርማዎ እንዲያረጋግጡልኝ እና ከሚቀጥለው ገፅ ላይ ለተቀመጡት ጥያቄዎች የመመለሻ ትእዛዞችን በመከተል እንዲሞሉ በትህትና እጠይቃለሁ፡፡ በጥናቱ ላይ የተገኘው ውጤት ስሞን ባልጠቀሰ መልኩ የጥናቱ የመጨረሻ አካል (የውጤቱ ዘገባ ክፍል) ላይ መካተት አለበት፡፡

ጥያቄዎቹን መልሶ ለመጨረስ ከ 10-15 ደቂቃ ይወስዳል፡፡ ከ 10-15 ባለ ደቂቃ ውስጥ ጥያቄዎቹን እያስሞላ ያለው ሰው መጥቶ ይሰበስባል፡፡

ፊርማ .....

ቀን.....

ስለ ተሳትፎዎ እና ስለ ጊዜዎ ከልብ አመሰግናለሁ

ፌቨን ተ/ሀይማኖት

ጾታ ሀ) ወንድ ለ) ሴት

ዕድሜ .....

ሐይማኖት ሀ) ኦርቶዶክስ ለ) ሙስሊም ሐ) ፕሮቴስታንት መ) ሌሎች

የትዳር ሁኔታ ሀ) ያገባ ለ) ያላገባ ሐ) የፈታ መ) የሞተበት ሠ) ሌሎች

ከልል ሀ) አዲስ አባባ ለ) ኦሮምያ ሐ) ሌሎች .....

ጥቃት ከደረስዎበት ምን ያህል ጊዜ ሆኖት.....

ጥቃቱ ሀ) የመደፈር ጥቃት ለ) ሌሎች

ጥቃት ያደረሰው ግለሰብ(ኦች) ቁጥር/ብዛት.....

ጥቃት ካደረሰው(ሱት) ግለሰብ(ኦች) ጋር ያልዎት ግንኙነት ሀ) የቅርብ ቤተሰብ ለ) ዘመድ ሐ) የማያቁት ሰው(ኦች) መ) ጎረቤት

ጥቃቱ ሲደርስ ሀ) በጉቋ ህሊና ላይ ሆነው ነው ለ) ግማሽ ንቃተ ህሊና ላይ ሆነው ነው ሐ) ሙሉ በሙሉ ራስን ባለማወቅ

Appendix 5

Topic guide

The following questions are designed to guide the interview. The questions are designed for the purpose of identifying the risk factors for developing PTSD after sexually assaulted. Whenever it's necessary, the questions were modified before administering the interview.

Personal risks

- Age
- Educational background
- Type of contact with perpetrator/s
- Number of perpetrator/s

Family risks

- Family past psychiatric illness history
- Substance history in the family (i.e. alcohol, chat, and cigarette)?
- Is there anybody in the family who is aggressive, bad tempered and does unusual thing by his/her nature?
- Marital status of family
- From childhood until now, is there anything that victims could mention as a problem in the family?

Environmental risk

- Resident of the victims
- What can you possibly tell me about the place/s the victims live/ed in?

Biological risks

- Any known medical illness history
- Is there any disease, behavioural and thinking ability problem that runs in the family?

Psychological risks

- Past psychiatric illness history
- Negative childhood experience

Cognitive risks

- Awareness about PTSD?
    - If yes, was it before or after the violence?
    - What and how did they know?
- Expression about the nature and severity of the situation that happened to them

Recommendation

Appendix 6

የቃለ መጠይቅ ቅፅ

ከዚህ በታች ያሉት ጥያቄዎች ቃለመጠይቁን እንዲመሩ የተዘጋጁ ናቸው፡፡ ጥያቄዎቹ የተዘጋጁት ተጠቂዎቹ ያታዊው ጥቃት ከደረሰባቸው በኃላ ለ ፖስትትውማቲክ ስትረስ ዲስኦርደር እንዲጋለጡ መጋለጫ ምክንያት የሆኑዋቸውን ነገሮች ለመናገር እንዲቻል ነው፡፡ እንደአስፈላጊነቱ ጥያቄዎቹ ከቃለ መጠይቁ በፊት ለቃለ መጠይቁ ተሳታፊ ምቹ ና አግባብ ባላቸው መልኩ ተስተካክለው ቀርበዋል፡፡

1. ግላዊ መጋለጫ ምክንያቶች
    - የተጠቂው እድሜ
    - የተጠቂው የትምህርት ደረጃ
    - ተጠቂው ከጥቃቱ አድራሹጋር ያለው ግንኙነት
    - የአጥቂው ብዛት
2. ቤተሰባዊ መጋለጫ ምክንያቶች
    - በቤተሰብው ውስጥ የታወቀ የአዕምሮ ህመም ያለበት ሰው አለ?
    - በቤተሰቡ ውስጥ (ተጠቂውን ጨምሮ)የሱስ አምጭ ንጥረ ነገሮችን የሚጠቀም ሰው አለ(ለምሳሌ እንደ መጠጥ፣ ጫት እና ሲጋራ)?
    - በቤተሰቡ ውስጥ በጣም ንዴቱን መቆጣጠር የማይችል፣ ንዴቱን ባልተለመደ መልኩ የሚገልጽ፣ ብስጩ እና በአጠቃላይ ነገሮችን ባልተለመደ መልኩ የሚገልጽ እና የሚያደርግ ሰው ሲኖር
    - የቤተሰብዎ የትዳር ሁኔታ እንዴት ነው?
3. አካባቢያዊ መጋለጫ ምክንያቶች
    - የሚኖሩበት አካባቢ
    - ስለሚኖሩበት/የነበሩበት ቦታዎች
4. ስነ-ህይወታዊ መጋለጫ ምክንያቶች
    - የታወቀ ህመም
    - በቤተሰቡ የሚሄድ በሽታ፣ የባህሪ ና የአመለካከት ችግር ወይም ሌሎች በቤተሰቡ ውስጥ የሚቀባበሉት ነገር ብለው የሚጠቅሱት ነገር አለ?
5. ስነ-ልቦናዊ መጋለጫ ምክንያቶች
    - የታወቀ የአዕምሮ ህመም አለብዎት?
    - እስኪ ስለ ልጅነቶ ያጫውቱኝ?
6. አመለካከታዊ መጋለጫ ምክንያቶች
    - ስለ ፖስትትራውማቲክ ስትረስ ዲስኦርደር ቀድመው የሚያውቁት ነገር ነበር?
        - አዎ ከሆነ፤ ከጥቃቱ በፊት ነው ወይስ ቢኃላ?
        - ምንድን ነው የሚያውቁት?
        - እንዴት አወቁ?
    - ስለደረሰባቸው ጥቃት ባህሪውን እና የችግሩን መጠን መግለጽ የቻሉት መንገድ
7. በመጨረሻ ሪኮመንድ ሚያደርጉት ነገር

Budget items	Number of items	Cost per item	Total cash cost
Transportation			5000
Research assistant	1		2600
Interview tapes /digital recorders	2	900	1800
Internet			2400
photocopies			1000
Paper, pens and notebooks			700
Questionnaire administers	5	600	3000
Printing and binding of thesis			750
Total			17,250

Appendix 7

Appendix 8

Informed consent 2

Prevalence of PTSD in individuals who have been sexually assaulted and its risk factors: in the case of IFSO, OPRIFS, AWSAD, Gandhi Memorial Hospiatal, Abrhot and EWLA.

I agree to participate in a thesis projected by Feven T/haimanot who is learning her master's degree in Addis Ababa University Black lion campus.

The purpose of this document is to specify the terms of my participation in the project through being interviewed.

1. I have been given sufficient information about this study. The purpose of my participation as an interviewee in this project has been explained to me and is clear.
2. My participation as an interviewee in this study is voluntary.
3. Participation involves being interviewed by Feven T/haimanot. The interview may take from 40-45 minutes. I allow the researcher to take notes during the interview and I also allow the recording by audio tape of the interview.
4. I have the right not to answer any of the questions. If I feel uncomfortable in any way during the interview session, I have the right to withdraw from the interview.
5. I have been given a copy of this consent form co-signed by the interviewer.

……..

Name of the participant

……

Participant's signature

……

Date

…….

Researcher's signature

…….

Date

Appendix 9

የቃለ መጠይቅ ቅጽ

የፖስትትራውማቲክ ስትረስ ዲስኦርደር መጠን እና የመጋለጫ ምክንያቶች፤ ጾታዊ ጥቃት በደረሰባቸው ተጠቂዎች ላይ፡ በ ኢፍሶ ፣ ኦፐሪፍስ፣ አውሳድ፣ ጋንዲ መታሰቢያ ሆስፒታል፣ አብርሆት እና ኢውላ፡፡

በዚህ ፌቨን ተክለሀይማኖት በተባለች በ አዲስ አበባ ዩንቨርሲቲ በጥቁር አንበሳ ግቢ የ2ተኛ ድግሪ የመመረቂያ ጽሁፉን በምትሰራው ጥናት ላይ ለመሳተፍ መስማማቴን መግለጽ እወዳለሁ፡፡

የዚህ ዶክመንት ጥቅም በዚህ ጥናት ላይ በቃለመጠይቁ ላይ የሚኖሩትን አንድአንድ ጉዳዮች በግልጽና በደንብ ለማስቀመጥ ነው፡፡

1. ስለጥናቱ የተማላ ና ግልጽ የሆነ ሙሉ መረጃ ተሰጥቶኛል፡፡ በዚህ ጥናት ላይ እንደተጠያቂ ያለኝን ጥቅም እና ሚና በደንብ ተነግሮኛል፤ ግልጽም ነው፡፡
2. በዚህ ጥናት ላይ እንደተጠያቂ በቃለመጠይቁ ላይ እየተሳተፍኩ ያለሁት በሙሉ ፍቃደኝነት ነው፡፡
3. ተሳትፎዬ ቃለመጠይቁ ላይ መጠየቅ ሲሆን፤ ቃለመጠይቁ በ ፌቨን ተ/ሃይማኖት በምትባል ግለሰብ ይሆናል፡፡ ቃለመጠይቁ በግምት ከ40-45 ደቂቃ ይወስዳል፡፡ ጠያቂዋ በምትጠይቀኝ ሰአት በጽሁፍም ሆነ በድምጽ የምፈልገውን መረጃ እንድትወስድ ፈቅጄላታለሁ፡፡
4. የትኛውንም ጥያቄዎች ያለመመለስ መብት አለኝ፡፡ በማንኛውም ሰአት በቃለመጠይቁ ምቾት ካልተሰማኝ፡ ቃለመጠይቁን የማቆም መብት አለኝ፡፡
5. የዚህን የቃለ መጠይቅ ስምምነት ቅጽ ኮፒ የቃለ መጠይቁ ጠያቂ ፊርማ ያለበት ተሰጥቶኛል፡፡

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