ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND LANGUAGE STUDIES

SCHOOL OF PSYCHOLOGY

ADVERSE CHILDHOOD EXPERIENCE AND MENTAL HEALTH CONCERN AMONG CLIENTS VISITING ERQ MA'ED PSYCHOLOGICAL SERVICES

BY

BETELEHEM BEKELE

October 2025

Addis Ababa, Ethiopia

ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND LANGUAGE STUDIES

SCHOOL OF PSYCHOLOGY

ADVERSE CHILDHOOD EXPERIENCE AND MENTAL HEALTH CONCERN AMONG CLIENTS VISITING ERQ MA'ED PSYCHOLOGICAL SERVICES

A THESIS SUBMITTED TO SCHOOL OF PSYCHOLOGY ADDIS ABABA UNIVERSI-TY IN PARTIAL

FULFILLMENT OF THE REQUIREMENTS FOR THE MASTER OF ARTS DEGREE IN COUNSELING

PSYCHOLOGY

BY: Betelehem Bekele

ADVISOR: Belay Tefera (PH.D.)

October 2025

Addis Ababa, Ethiopia

ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND LANGUAGE STUDIES SCHOOL OF PSYCHOLOGY

ADVERSE CHILDHOOD EXPERIENCE AND MENTAL HEALTH CONCERN AMONG CLIENTS VISITING ERQ MA'ED PSYCHOLOGICAL SERVICES

Submitted by: Betelehem Bekele ________________ ________________

Signature Date

Approval of the Board of Examiner

1. Advisor: Belay Tefera (Ph.D.) ____________________ ________________

   Signature Date

2. Internal Examiner

   Name:__________________ ____________________ ________________

   Signature Date

3. External Examiner

   Name:__________________ ____________________ ________________

   Signature Date

Declaration

I, hereby declare that this research thesis titled "Adverse Childhood Experience and Mental Health Concern among Clients Visiting Erq Ma'ed Psychological Services" is my original work and has not been submitted or presented to other academic or professional qualification. The research did not incorporate any previous published materials from other authors except for those appropriately cited and acknowledged.

.

Betelehem Bekele

Signature __________________

Date ______________________

This thesis has been submitted for examination with my approval as advisor

Belay Tefera (Ph.D.)

Signature __________________

Date ___________________________

Acknowledgement

I would like to thank my advisor Belay Tefera (Ph.D.) for his remarkable advice and guidance in this study. In addition, to this I would like to express my appreciation to all participants and individuals who directly or indirectly provided the necessary materials and support for the realization of this thesis.

Acronyms

ACE: Adverse Childhood Experience

ACEs: Adverse Childhood Experiences

ACE-IQ: Adverse Childhood Experiences International Questionnaire

DASS-21: Depression, Anxiety, and Stress Scales - 21

MANOVA: Multivariate Analysis of Variance

PTSD: Post-Traumatic Stress Disorder

SPSS: Statistical Package for the Social Sciences

WHO: World Health Organization

Abstract

Adverse childhood experiences (ACEs) including physical and emotional abuse, neglect, and household dysfunction have lasting impacts on adult mental health. This study examined the relationship between ACEs and mental health concerns, focusing on depression, anxiety, and stress among clients visiting Erq Ma'ed Psychological Services. A total of 70 clients who met inclusion criteria participated in the study; since all eligible individuals were included, no sampling technique was applied. Data were collected using the Adverse Childhood Experiences International Questionnaire (ACE-IQ) and the Depression, Anxiety, and Stress Scale (DASS-21). Analyses included correlations, chi-square tests, multivariate analysis of variance (MANOVA), and multiple regressions. Results showed that 85.7% of participants reported exposure to high levels of ACEs (4+ ACEs). High ACE exposure was significantly associated with greater depression and anxiety, though stress did not differ significantly across exposure levels. Sexual abuse, emotional abuse, parental separation or death, and family member incarceration were found to uniquely predict higher depression and anxiety scores. Gender analysis revealed that women reported significantly higher mental health distress related to interpersonal ACEs compared to men.The findings suggest that cumulative and interpersonal childhood adversities contribute substantially to adult psychological distress. Discussion highlights the consistency of these findings with global evidence linking ACEs to adult psychopathology, emphasizing the urgent need for trauma-informed and gender-sensitive mental health interventions within the Ethiopian context. The study concludes that early screening for ACEs in counseling settings is essential for effective prevention and treatment. Future research should include larger and more diverse samples, employ longitudinal designs to clarify causal pathways, and explore protective factors such as resilience and social support that may buffer the effects of childhood adversity.

Keywords: adverse childhood experiences, mental health, depression, anxiety, stress, gender differences.

Table of Contents

Declaration ... i

Acknowledgement ... ii

Acronyms ... iii

Abstract ... iv

Table of Contents ... 1

List of Tables ... 3

1. Introduction ... 4

1.1. Background of the Study ... 4

1.2. Statement of the Problem ... 5

1.3. Research Question ... 6

1.4. Objective ... 6

1.4.1. General Objective ... 6

1.4.2. Specific Objective ... 6

1.5. Significance of the Study ... 7

1.6. Delimitation of the Study ... 7

1.7. Limitation of the Study ... 7

1.8. Operational Definition ... 8

2. Literature Review ... 9

2.1 Introduction ... 9

2.2 Overview of Adverse Childhood Experiences ... 9

2.3 Global Evidence Linking ACEs and Mental Health Outcomes ... 10

2.4 Mechanisms Linking ACEs to Psychopathology ... 11

2.5 Adverse Childhood Experiences in Low- and Middle-Income Countries ... 11

2.6 Adverse Childhood Experiences and Mental Health in Ethiopia ... 12

2.7 Conceptual Framework ... 12

3 Research Methodology ... 14

3.1 Introduction ... 14

3.2 Study Design ... 14

3.3 Study Location ... 15

3.4 Study Population and Sampling Method 15
3.5 Study Variables 16
3.6 Data Sources and Data Collection Techniques 16
3.7 Pilot Study 18
3.8 Data Analysis Methods 18
3.9 Ethical Issues 19
Result and Discussion 20
4.1 Socio Demographic Characteristics of the Participants 20
4.2 Multivariate Analysis 26
4.3 Multiple Linear Regressions 27
4.4 Mann–Whitney U Test Results 28
4.5 Discussion 30
5 Conclusion and Recommendations 33
5.1 Conclusion 33
5.2 Recommendations 33
References 35
APPENDEX: A 41
APPENDEX: B 54

List of Tables

Table 1 Respondents Socio Demographic 20
Table 2 Descriptive Statistics for Mental Health Outcomes........ 21
Table 3 Descriptive Statistics by Severity Scale of Mental Health Outcomes 21
Table 4 Frequencies of Adverse Childhood Experiences by number of ACEs 22
Table 5 Frequencies of Adverse Childhood Experiences by Types of ACEs........ 22
Table 6 Prevalence of Depression Severity Levels by Exposure to Adverse Childhood Experiences (ACEs)........ 23
Table 7 Prevalence of Anxiety Severity Levels by Exposure to Adverse Childhood Experiences (ACEs) 24
Table 8 Prevalence of Stress Severity Levels by Exposure to Adverse Childhood Experiences (ACEs) 25
Table 9 Gender Differences in Mental Health Outcomes across ACEs 28

1. Introduction

1.1.Background of the Study

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur before the age of 18, including various forms of abuse (physical, sexual, or emotional), neglect, and household dysfunction such as parental separation, domestic violence, substance misuse, or mental illness. The original Adverse Childhood Experiences Study conducted by Felitti et al. (1998) in the United States demonstrated that ACEs are highly prevalent and have a strong, graded relationship with poor mental and physical health outcomes in adulthood. Subsequent global studies have replicated these findings, showing that ACEs significantly increase the risk of depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders across diverse cultural and socioeconomic settings (Hughes et al., 2017; WHO, 2020).

Globally, the World Health Organization (WHO) has recognized ACEs as a major public-health concern and developed the ACE International Questionnaire (ACE-IQ) to enable standardized measurement across countries (WHO, 2020). According to international meta-analyses, over 60% of adults report at least one ACE, and approximately one in six report four or more (Hughes et al., 2017). The evidence consistently supports a "dose–response" pattern, where exposure to multiple ACEs leads to a higher likelihood and greater severity of mental-health problems later in life (Felitti et al., 1998; Merrick et al., 2019).

In the African context, research indicates that ACEs are widespread and exert long-term consequences on psychological well-being. Analyses using the Violence against Children Surveys (VACS) across multiple sub-Saharan African countries revealed high exposure to physical, sexual, and emotional abuse, as well as household dysfunction (Together for Girls, 2024). Cumulative ACE exposure in these populations has been associated with higher risks of depression, anxiety, suicidal ideation, and substance-use problems (Amene et al., 2024; Brown et al., 2023). African-based studies also emphasize the intergenerational effects of ACEs, suggesting that childhood adversity not only affects individuals' mental health but may also influence parenting and social functioning later in life (Brown et al., 2023). These findings underscore the importance of early prevention, trauma-informed care, and culturally relevant interventions in African settings.

In Ethiopia, recent empirical evidence demonstrates that ACEs are common and have substantial impacts on mental health. A national-level study among university students found that approximately four out of five respondents reported at least one ACE, and those with four or more ACEs

were significantly more likely to experience depression and anxiety (Gezahegn et al., 2025). Another study conducted in Bahir Dar among psychiatric patients and their attendants reported high rates of childhood abuse and neglect, with ACE exposure strongly associated with psychological distress (Assefa Fentahun et al., 2024). Additional studies have highlighted the links between specific ACE types—such as emotional and sexual abuse, parental separation, and exposure to violence—and elevated risks of depression, anxiety, and stress (Mihret et al., 2024; Berhanu et al., 2025). However, Ethiopian studies have also identified gender-based differences: women tend to report higher rates of emotional and sexual abuse, while men more frequently experience physical violence or neglect (Gezahegn et al., 2025).

These local findings mirror international trends and point to the need for more focused investigation among individuals actively seeking psychological services. Understanding how ACEs collectively and individually relate to presenting mental-health problems within clinical populations can inform more effective assessment and intervention strategies.

1.2.Statement of the Problem

Adverse Childhood Experiences (ACEs), which include abuse, neglect, and household dysfunction, are well-established risk factors for a wide range of mental health disorders throughout life. Research globally demonstrates a strong, dose-response relationship between ACEs and conditions such as anxiety, depression, and post-traumatic stress disorder (Felitti et al., 1998; Hughes et al., 2017).

However, within the Ethiopian context, there remains a significant knowledge gap. Despite the high prevalence and well-documented impacts of ACEs worldwide, their specific relationship with adult mental health outcomes in Ethiopia remains underexplored (Tesfaye et al., 2022). This gap is compounded by socio-cultural factors: common disciplinary practices, such as corporal and verbal punishment, are often normalized and perceived as beneficial, potentially obscuring their recognition as adverse experiences; and mental health issues are frequently attributed to spiritual causes, leading individuals to seek help primarily from traditional or religious sources rather than clinical settings (Alem et al., 2009; Hailemariam et al., 2020).

Three critical gaps in the literature are evident. First, there is limited empirical research examining the link between ACEs and mental health outcomes in Ethiopian adults. Second, existing studies have not adequately explored the differential impact of specific and cumulative types of

ACEs on distinct mental health conditions, such as anxiety versus depression. Third, the potential moderating role of gender in the relationship between ACEs and mental health remains largely uninvestigated, leaving a gap in understanding vulnerable subgroups (Anda et al., 2006; Bellis et al., 2019).

Therefore, this study aims to address these gaps by systematically examining the relationships between various types of ACEs and specific mental health outcomes among adults in Ethiopia. The findings will help inform culturally-sensitive public health interventions, guide clinical mental health practice, and challenge societal norms that minimize the long-term consequences of childhood adversity.

1.3.Research Question

- What are the aggregate impacts of adverse childhood experience regarding mental health concerns?
- How do different types of adverse childhood experience uniquely affect specific mental health concerns?
- Which adverse childhood experiences are more strongly affecting female/male in mental health concerns?

1.4.Objective

1.4.1. General Objective

Main objective is to study adverse childhood experiences and their association with mental health concerns among Clients Visiting Erq Ma'ed Psychological Services.

1.4.2. Specific Objective

- To find out what are the impacts of adverse childhood experience on mental health concerns.
- To determine how do different types of adverse childhood experience uniquely affect specific mental health concern.
- To determine which adverse childhood experiences are more strongly affecting mental health concerns in female and male

1.5.Significance of the Study

This study is expected to serve multiple purposes and provide valuable insights into the relationship between Adverse Childhood Experiences (ACEs) and adult mental health concerns. First, it aims to contribute to the growing understanding of ACEs by emphasizing their predictive value in explaining adult psychological well-being and mental health outcomes. By exploring whether specific types of childhood adversities have differential effects on adulthood mental health, the study will help identify which experiences are most detrimental and thus require targeted prevention and intervention efforts. Furthermore, the study seeks to distinguish between the aggregate effects of multiple ACEs and the impact of individual adverse experiences, thereby enhancing comprehension of how cumulative childhood trauma shapes later mental health. It also aims to examine potential gender differences in the influence of ACEs, clarifying whether women or men are more vulnerable to certain mental health outcomes following early adversity. Practically, the findings are expected to inform clinicians, policymakers, and mental health practitioners about the importance of early screening for ACEs, gender-sensitive interventions, and the development of trauma-informed psychological services. Ultimately, the study will contribute to the broader body of evidence necessary for designing effective mental health promotion and prevention strategies within the Ethiopian context.

1.6. Delimitation of the Study

This study is delimited to examining the relationship between adverse childhood experiences and mental health concerns among clients visiting Erq Ma'ed Media and Psychological Service P.L.C. The research focuses specifically on this population and does not include individuals from the general community. The study also limits its scope to psychological outcomes, excluding other potential impacts of childhood adversity such as physical or social effects. These delimitations were established to make the study manageable within the available time, energy, and resources.

1.7. Limitation of the Study

The major limitation of this study is the lack of relevant and up-to-date literature conducted in Ethiopia on adverse childhood experiences and mental health. Furthermore, since the data were collected only from clients visiting Erq Ma'ed Media and Psychological Service P.L.C., the find-

ings cannot be generalized to the wider community. Time and resource constraints also restricted the inclusion of a larger and more diverse sample, which may have influenced the comprehensiveness of the results.

1.8. Operational Definition

Adverse Childhood Experiences (ACEs): Adverse Childhood Experiences (ACEs) are exposures to any form of abuse, neglect, or household dysfunction before the age of 18, as assessed using the World Health Organization's Adverse Childhood Experiences International Questionnaire (ACE-IQ). The ACE score was calculated by summing the number of adverse categories reported (World Health Organization, 2018).

Mental Health Concerns: Represents the presence and severity of psychological distress symptoms specifically depression, anxiety, and stress as assessed using the Depression, Anxiety, and Stress Scale (DASS-21).

Depression: A mental health condition characterized by persistent sadness, loss of interest or pleasure, and reduced energy.

Anxiety: An emotional state involving excessive worry, nervousness, and physical symptoms of tension.

Stress: A state of mental or emotional strain resulting from demanding circumstances.

Aggregate ACEs: The total number of adverse experiences reported by a participant, calculated by summing the number of ACE categories experienced (ranging from 0 to 13). Higher totals reflect greater exposure to childhood adversity.

Gender: A demographic variable categorized as male or female for the purpose of analysing potential differences in ACE exposure and mental health outcomes.

2. Literature Review

2.1 Introduction

The experience of adversity during childhood has long been recognized as a determinant of health and psychological well-being across the life span. Adverse childhood experiences (ACEs) encompass diverse forms of abuse, neglect, and household dysfunction that occur before the age of 18 and have lasting implications for mental, emotional, and behavioural health (Felitti et al., 1998; WHO, 2020). The purpose of this literature review is to synthesize existing empirical and theoretical knowledge regarding the relationship between ACEs and mental health outcomes, with particular emphasis on the Ethiopian context. The review aims to (a) present global and regional evidence on ACE prevalence and effects, (b) discuss theoretical mechanisms explaining how early adversity contributes to adult psychopathology, and (c) identify research gaps relevant to psychological services in Ethiopia.

2.2 Overview of Adverse Childhood Experiences

Adverse childhood experiences refer to potentially traumatic events that can undermine a child's sense of safety, stability, and bonding (Centers for Disease Control and Prevention [CDC], 2016). These include physical, sexual, or emotional abuse; neglect; and household dysfunction such as parental substance use, mental illness, domestic violence, or incarceration (WHO, 2018; Marques, 2020). The landmark study by Felitti et al. (1998) demonstrated a graded, dose–response relationship between the number of ACEs and a wide range of adult health outcomes, including depression, anxiety, post-traumatic stress disorder (PTSD), substance abuse, and suicidality. Subsequent international studies have consistently replicated this pattern (Merrick et al., 2017; Nelson et al., 2024), confirming ACEs as one of the most robust psychosocial predictors of poor mental health across populations.

Globally, ACEs are highly prevalent. A systematic review by Hughes et al. (2017) estimated that more than half of adults worldwide have experienced at least one ACE, and approximately one-sixth have experienced four or more. The consequences extend beyond individual distress to social and economic domains, as adults with higher ACE exposure show increased health-care utilization, unemployment, and interpersonal difficulties (Bellis et al., 2019). Although most of these findings derive from high-income countries, emerging evidence suggests comparable or high-

er exposure levels in low- and middle-income countries (LMICs) where poverty, conflict, and social instability amplify vulnerability (Hillis et al., 2016).

2.3 Global Evidence Linking ACEs and Mental Health Outcomes

Over the past two decades, extensive empirical evidence has demonstrated that adverse childhood experiences (ACEs) are strongly associated with a wide spectrum of mental health problems in adulthood. The relationship is typically cumulative — meaning that as the number of ACEs increases, so does the likelihood of developing psychological disorders (Felitti et al., 1998; Merrick et al., 2017). Meta-analyses across diverse populations confirm that individuals with multiple ACEs are at significantly greater risk of depression, anxiety, post-traumatic stress disorder (PTSD), and substance-use disorders (Nelson et al., 2024; Hughes et al., 2017).

A global meta-analysis by Hughes et al. (2017) encompassing 37 studies from 22 countries found that exposure to four or more ACEs was associated with a fourfold increase in the risk of depression and a sevenfold increase in the likelihood of alcoholism or illicit drug use. Similarly, a comprehensive review by Merrick et al. (2017) revealed that individuals with a history of childhood adversity had significantly higher odds of experiencing mental distress, suicidal ideation, and behavioural disorders. The findings highlight the robust and consistent association between early adversity and psychopathology across different cultural and socioeconomic contexts.

From a public health perspective, the burden of mental disorders attributable to ACEs is substantial. The World Health Organization (WHO, 2020) estimates that ACE-related mental health conditions account for a large proportion of disability-adjusted life years (DALYs) worldwide. In addition, longitudinal studies have provided compelling evidence that ACEs not only increase the risk of mental illness but also exacerbate symptom severity, chronicity, and treatment resistance (McLaughlin et al., 2012; Anda et al., 2006). Individuals with multiple adversities are more likely to experience recurrent depression and anxiety disorders that persist into adulthood and old age.

Gender and contextual differences have also been documented. Steel et al. (2014) found that women are disproportionately affected by ACE-related mental health conditions, particularly mood and anxiety disorders, while men show higher rates of substance-use disorders. Similarly, Kessler et al. (2010) reported that early exposure to abuse and neglect mediates gender dispari-

ties in the lifetime prevalence of depression and PTSD. These findings underscore the importance of considering sociocultural and gendered pathways when examining the consequences of early trauma.

2.4 Mechanisms Linking ACEs to Psychopathology

The association between ACEs and mental health outcomes is underpinned by several theoretical and biological mechanisms. Prominent among these are attachment theory and neurobiological models of stress regulation.

Attachment theory posits that early relationships with caregivers shape a child's sense of safety, self-worth, and capacity for emotion regulation (Bowlby, 1988; Ainsworth, 1989). When children experience abuse, neglect, or inconsistent caregiving, they develop insecure or disorganized attachment patterns that compromise their ability to trust others and manage emotional distress (Crittenden & Ainsworth, 1989; Thompson & Kaplan, 1996). Such maladaptive internal working models persist into adulthood and are associated with anxiety, depression, and interpersonal dysfunction (Grummitt et al., 2020). Empirical studies have linked childhood attachment insecurity with heightened risk for mood and personality disorders (Mikulincer & Shaver, 2019).

A complementary body of research focuses on the neurobiological consequences of chronic early stress. Prolonged exposure to abuse, neglect, or family dysfunction deregulates the hypothalamic–pituitary–adrenal (HPA) axis, which governs the body's stress response (Neigh et al., 2009; Coates, 2010). Over activation of the HPA axis leads to abnormal cortisol levels, structural changes in the amygdala and hippocampus, and impaired regulation of emotions and memory (Kendall-Tackett, 2001; Gunnar & Quevedo, 2007). These alterations heighten vulnerability to anxiety, depression, and impulsive behaviors in later life. Neuroimaging studies further reveal that individuals exposed to ACEs exhibit reduced prefrontal cortex volume and heightened amygdala reactivity, indicating persistent hyper vigilance and threat sensitivity (Teicher & Samson, 2016).

2.5 Adverse Childhood Experiences in Low- and Middle-Income Countries

While most early research on adverse childhood experiences (ACEs) originated from high-income countries, growing evidence from low- and middle-income countries (LMICs) highlights that the prevalence and consequences of ACEs may be even more severe in these settings (Hillis

et al., 2016; Meinck et al., 2017). Socioeconomic instability, limited access to mental health services, and sociocultural tolerance of violence often compound the risks associated with early adversity.

In many LMICs, children are frequently exposed to community violence, political conflict, and poverty-related stressors that exacerbate the effects of family-level ACEs (Cluver et al., 2017). For instance, studies in sub-Saharan Africa reveal that physical and emotional abuse, domestic violence, and parental loss due to illness or migration are highly prevalent and closely linked to depression, anxiety, and behavioral problems among adolescents and adults (Meinck et al., 2017; Kidman, 2019). A systematic review by Hughes et al. (2019) reported that the prevalence of at least one ACE among African youth exceeded 60%, with many experiencing multiple overlapping adversities.

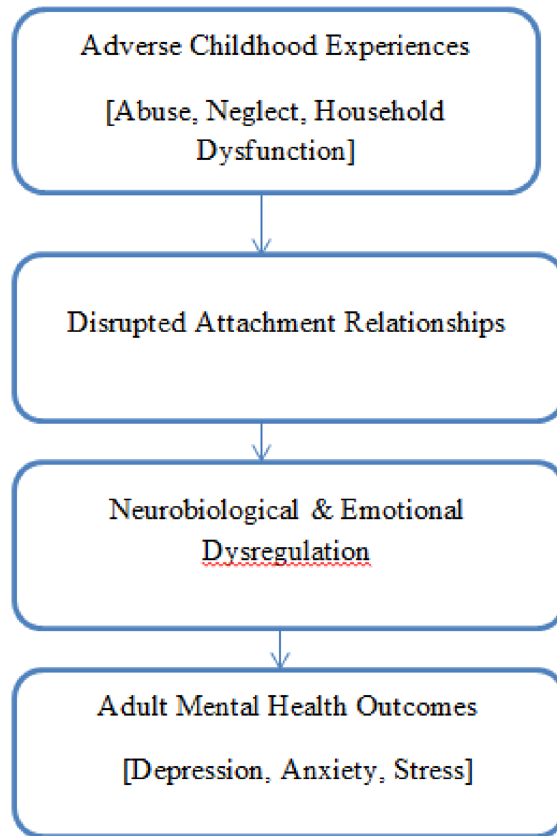
2.6 Adverse Childhood Experiences and Mental Health in Ethiopia

Within the Ethiopian context, empirical evidence on ACEs and their mental health implications remains limited but growing. National and regional studies indicate that mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia are increasingly prevalent (Zergaw et al., 2023). Factors such as gender, marital status, socioeconomic hardship, and chronic illness have been identified as significant predictors of common mental disorders (Habtamu et al., 2022).

Kassa and Abajobir (2018), in a systematic review and meta-analysis, reported that approximately 21.6% of Ethiopians experience a common mental illness, with depression accounting for nearly one-fifth of cases. Notably, women were found to be 1.5 times more likely to develop mental disorders than men, suggesting possible gendered exposure to or responses to ACEs. Despite this, few Ethiopian studies have explicitly examined childhood adversity as an etiological factor, revealing a significant gap in the literature.

2.7 Conceptual Framework

The conceptual framework integrates psychosocial and biological models to explain how early adversity influences adult mental health outcomes. Specifically, ACEs (abuse, neglect, and household dysfunction) disrupt secure attachment and stress regulation systems, leading to increased vulnerability to depression, anxiety, and related disorders.



The framework illustrates the hypothesized pathways through which ACEs contribute to adult mental health outcomes.

3 Research Methodology

3.1 Introduction

This chapter discusses data source, data collection techniques, study design, data collection procedure and instrument, data analysis method, in general the study procedures and the method that will be used to conduct the study related to its objective that discussed in chapter -one.

3.2 Study Design

To successfully achieve the objectives of the study and adequately respond to the research questions, a descriptive correlational research design was employed. This design focuses on describing the nature and strength of the relationship between two or more variables rather than establishing cause-and-effect relationships (Lappe, 2000). In the present study, the descriptive correlational design was used to examine the association between Adverse Childhood Experiences (ACEs) and mental health concerns among clients attending psychological services.

The choice of a descriptive correlational design is particularly appropriate for several methodological and ethical reasons. First, the variables under investigation namely ACEs and mental health outcomes cannot be ethically manipulated or experimentally controlled, as they involve participants' past life experiences and existing psychological states. Therefore, an experimental design would be neither feasible nor ethical. The correlational approach allows the researcher to explore naturally occurring variations in participants' experiences and determine how these variations are related to mental health outcomes such as depression, anxiety, and stress.

Second, this design aligns closely with the study's objective, which is not to test causality but rather to describe and quantify the strength and direction of the relationships between different forms of ACEs (e.g., abuse, neglect, and household dysfunction) and specific mental health concerns. Through correlation, the study seeks to identify whether individuals with higher exposure to ACEs report higher levels of mental health difficulties, and whether there are gender differences in these relationships.

Third, the descriptive aspect of the design allows for the detailed characterization of the prevalence and distribution of ACEs and mental health problems among clients visiting psychological services. This information provides an essential context for interpreting the correlational findings and contributes to a comprehensive understanding of the research problem. The combination of

descriptive and correlational components thus enables a multidimensional analysis one that captures both the patterns of exposure and the relationships among variables within a real-world clinical context.

Finally, employing a descriptive correlational design provides a strong methodological foundation for generating evidence-based insights that can inform intervention strategies, early screening practices, and mental health policy. By identifying significant associations between ACEs and mental health outcomes, the study can contribute valuable information for practitioners and policymakers aiming to design gender-sensitive and trauma-informed psychological services.

In summary, the descriptive correlational research design was selected because it is the most appropriate and ethically sound approach for exploring the naturally occurring relationships between ACEs and mental health concerns, consistent with the non-experimental nature of the variables and the overall aim of the study to describe and interpret associations rather than infer causality (Lappe, 2000).

3.3 Study Location

This study was conducted at Erq Ma'ed Media and Psychological Service P.L.C, which is located in Bole Sub-City, Woreda 04, Addis Ababa, Ethiopia, on the eighth floor of the N.B. Building. The center provides a range of psychological services, including individual counselling, psychotherapy, Marriage Counselling, and training through both in-person and media-based platforms.

3.4 Study Population and Sampling Method

The study population consisted of clients who visited Erq Ma'ed Media and Psychological Service P.L.C. during the data collection period from June to August 2025. A total of seventy (70) clients participated in the study. Participants were selected based on specific inclusion criteria: (a) being 18 years of age or older, as the Adverse Childhood Experiences International Questionnaire (ACE-IQ) and the Depression, Anxiety, and Stress Scale–21 (DASS-21) are designed for adult respondents (World Health Organization, 2018; Lovibond & Lovibond, 1995); (b) being able to read and understand the questionnaire to ensure reliable responses; and (c) being first-time visitors to the center, since individuals already in therapy might have changing emotional states that could affect the accuracy of DASS-21 results.

Although all eligible clients during the data collection period were invited to participate, participation was voluntary, and some individuals declined to take part. Therefore, the final sample comprised 70 respondents who met the inclusion criteria and provided informed consent. The sample size was determined by the number of available and consenting clients within the time constraints of the study; therefore, no probability sampling technique was applied.

3.5 Study Variables

This study focused on two main variables. The dependent variable was mental health, assessed through symptoms of depression, anxiety, and stress. These outcomes were measured using the 21-item Depression Anxiety Stress Scale (DASS-21), a validated self-report tool.

The independent variable was adverse childhood experiences (ACEs), which were measured using the Adverse Childhood Experiences International Questionnaire (ACE-IQ). The ACE-IQ captures a wide range of childhood adversities, including Physical Abuse, Emotional Abuse, Physical Neglect, Emotional Neglect, Sexual Abuse, Family Substance Use, Family Crime, Family Mental Illness, Parent death/separation, Household Violence, Bullying, Community Violence, and Collective Violence.

3.6 Data Sources and Data Collection Techniques

Primary data sources were used in this study. The data were collected from clients visiting Erq Ma'ed Media and Psychological Service P.L.C. Quantitative data were obtained using two standardized psychometric instruments: the Adverse Childhood Experiences International Questionnaire (ACE-IQ) and the Depression Anxiety Stress Scales–21 (DASS-21).

Adverse Childhood Experiences International Questionnaire (ACE-IQ)

The ACE-IQ, developed by the World Health Organization (WHO, 2018), was used to assess participants' exposure to adverse childhood experiences before the age of 18. This tool was selected because it provides a comprehensive, internationally validated measure of childhood adversities and allows for cross-cultural comparison. It captures 13 categories of adverse experiences, including physical abuse (2 items), emotional abuse (2 items), sexual abuse (2 items), physical neglect (2 items), emotional neglect (2 items), domestic violence (2 items), parental separation or divorce (1 item), household substance abuse (2 items), household mental illness (2 items), incarcerated household member (1 item), peer violence (2 items), community violence (2

items), and collective violence (2 items). In total, the ACE-IQ contains 43 items assessing the frequency and presence of these experiences.

Responses are provided using a combination of Yes/No and frequency-based scales (e.g., "once," "a few times," "many times"). Scoring can be conducted in two main ways:

(1) Binary scoring, where each ACE category is scored as 0 (absent) or 1 (present), yielding a total ACE score ranging from 0 to 13; and

(2) Frequency scoring, which considers the number of times each event occurred.

For this study, the binary scoring method was used, in which endorsement of any experience within a category is scored as 1, with higher total scores indicating greater exposure to adversity.

The ACE-IQ has been validated in multiple countries, including low- and middle-income contexts similar to Ethiopia (e.g., Kazeem, 2015; Meinck et al., 2017). It has demonstrated acceptable internal consistency (Cronbach's $\alpha \approx .80$) and robust construct validity. Prior to data collection, the instrument was reviewed by local psychologists to ensure cultural relevance and language appropriateness for the study population.

Depression Anxiety Stress Scales–21 (DASS-21)

The DASS-21, developed by Lovibond and Lovibond (1995), was used to assess participants' current levels of emotional distress across three domains: depression, anxiety, and stress. It was selected because it is a brief, reliable, and widely validated instrument that effectively distinguishes between the three affective states, which are central to the current study's objectives. The tool contains 21 items, divided equally into three subscales of seven items each.

Participants rate each item on a 4-point Likert scale, ranging from zero ("Did not apply to me at all") to three ("Applied to me very much or most of the time"), reflecting their experience over the past week. Scores for each subscale are summed and then multiplied by two to obtain final scores, with higher values indicating greater severity of symptoms. The DASS-21 has shown excellent internal consistency, with Cronbach's alpha coefficients of .94 for depression, .87 for anxiety, and .91 for stress. The scale has been used and validated in various African contexts, including Ethiopia, demonstrating good psychometric properties (e.g., Tesfaye et al., 2019).

3.7 Pilot Study

A pilot study was conducted with seven participants drawn from the target population. The purpose of the pilot study was to assess the clarity and comprehensibility of the instruments. Reliability testing was not conducted because both instruments the Adverse Childhood Experiences International Questionnaire (ACE-IQ) and the Depression, Anxiety, and Stress Scale (DASS-21)had already been translated into Amharic and psychometrically validated in previous Ethiopian studies. Therefore, this pilot primarily focused on ensuring that the wording and phrasing were easily understood by participants in the present study context. Feedback from the pilot participants was used to confirm that the items were clear, culturally appropriate, and suitable for use in the main data collection.

3.8 Data Analysis Methods

The Statistical Package for Social Sciences (SPSS) was used to analyse the data obtained from the mixed questionnaires. A one-way multivariate analysis of variance (MANOVA) was performed to examine the cumulative influence of adverse childhood experiences (ACE) on mental health concerns. The independent variable was ACE exposure group (low, moderate, high), and the dependent variables were depression, anxiety, and stress scores (continuous outcomes).

The overall multivariate effect was assessed using Wilks' Lambda (Λ), with an alpha level of 0.05. Where significant effects were observed, follow-up univariate ANOVAs and post hoc pairwise comparisons (Tukey's HSD/Bonferroni) were carried out to identify specific group differences.

The study also examined whether different types of adverse childhood experiences (ACEs) uniquely predict specific mental health outcomes: depression, anxiety, and stress.

Multiple linear regression were conducted for each dependent variables to investigate the unique effect of different types of adverse childhood experiences, whether the overall model was significant at $p < 0.001$, and explained 50% of the variance in depression, anxiety and stress scores (Adjusted $R^2 = 0.50$).

A series of Mann–Whitney U tests were conducted to examine whether adverse childhood experiences (ACEs) differentially affect males and females in their mental health outcomes. The in-

dependent variable was gender (male vs. female), and the dependent variables were depression, anxiety, and stress scores (continuous outcomes) for each ACE type.

The Mann–Whitney U test was chosen as a nonparametric alternative to the independent-samples t test, since the outcome variables were not normally distributed. The test was conducted separately for each ACE × outcome combination, with an alpha level of .05.

3.9 Ethical Issues

One of the key factors in research is ethics. And because the study involved sensitive personal experiences, I made sure to follow ethical guidelines throughout the research process. Before data collection; I informed all participants about the purpose of the study and obtained their informed consent.

I explained that the questionnaire was strictly for academic purposes and that their participation was completely voluntary they could choose not to fill it out or stop at any time if they felt uncomfortable or emotionally triggered.

I also assured them that their responses would remain anonymous and confidential; no names or identifying information were recorded. In addition, I reminded participants that psychological support was available at Erq Ma'ed if any questions brought up distress.

These steps ensured that the study respected the participants' dignity, privacy, and emotional safety at every stage.

Result and Discussion

4.1 Socio Demographic Characteristics of the Participants

This section presents the description of the respondents who participated in this study.

Table 1 Respondents Socio Demographic

Type of variables	Variables	Frequency	Percentage	Type of variables	Variables	Frequency	Percentage
Sex	Male	23	32.86	Marital status	Single	37	52.86
	Female	47	67.14		Married	27	38.57
Age group	18-25	13	18.57		Divorced	6	8.57
	26-30	27	38.57		Widowed	0	0
	31-35	13	18.57	Parental Living status	Both alive and still married	28	40
	36-40	11	15.71		Both alive but divorced	13	18.57
	above 41	6	8.57		One of them is alive	20	28.57
Education Level	can't read and write	0	0.00		Both are not alive	9	12.86
	Elementary	7	10.00	Employment type	Working for private Company	39	55.71
	High school	25	35.70		Working at Government office	10	14.29
	Degree	30	42.90		Unemployed	21	30
	Masters and Above	8	11.40	Current place of residence	Addis Ababa	67	92.9
					Out of Addis	3	7.1

A total of 70 participants were included in the study. The majority were female (67.1%) and single (52.9%). Most participants were between 26 and 30 years old (38.6%) and resided in Addis

Ababa (92.9%). Over half (55.7%) were employed in private organizations, while nearly 43% held a bachelor's degree or higher.

- **Frequencies of Adverse Childhood Experiences (ACEs) and Descriptive Statistics for Mental Health Outcomes**

Table 2 Descriptive Statistics for Mental Health Outcomes

Mental Health outcomes	Frequencies (%)	n	Mean (M)	Standard deviation (SD)
Depression	-		21.85	9.69
Anxiety	-		22.34	9.91
Stress	-		17.02	9.05

Mental health outcomes, participants reported Severe levels of anxiety (M = 22.34, SD = 9.91) and depression (M = 21.85, SD = 9.69), along with moderate levels of stress (M = 17.02, SD = 9.05).

Table 3 Descriptive Statistics by Severity Scale of Mental Health Outcomes

	Severity Scale	Frequencies	Percent (%)
Depression	Normal	4	5.70%
	Mild	11	15.70%
	Moderate	21	30%
	Severe	14	20%
	Extremely Severe	20	28.60%
Anxiety	Normal	10	14.30%
	Mild	3	4.30%
	Moderate	18	25.70%
	Severe	9	12.85%
	Extremely Severe	30	42.85%
Stress	Normal	21	30%
	Mild	9	12.90%
	Moderate	11	15.70%
	Severe	16	22.90%
	Extremely Severe	13	18.60%

As shown in Table 3, Anxiety was the most common mental health concern, with 81.4% of participants reporting moderate to extremely severe symptoms. Depression followed by (78.6%) participants reporting moderate to extremely severe symptoms, while stress affected 57.2% of the participants.

Table 4 Frequencies of Adverse Childhood Experiences by number of ACEs

Adverse Childhood Experiences by level/number of (ACE)	**Frequencies**	**Percent (%)**
Low(0-1)	2	2.90%
Moderate (2-3)	8	11.40%
High (4+)	60	85.70%

Among the participants, 85.7% reported being exposed to high levels of ACEs (4+ ACEs), followed by 11.4% moderate levels ACEs (2–3 ACEs) and 2.9% low levels of ACEs (0–1 ACEs).

Table 5 Frequencies of Adverse Childhood Experiences by Types of ACEs

Specific ACE Types	**Frequencies**	**Percent (%)**
Physical Abuse	55	78.60%
Emotional Abuse	56	78.60%
Physical Neglect	33	47.10%
Emotional Neglect	57	81.40%
Sexual Abuse	33	47.10%
Family Substance Use	14	20.00%
Family Member Incarcerated	11	15.70%
Family Mental Illness	13	18.60%
Parent death/separation	45	64.30%
Household Violence	53	75.70%
Bullying	34	48.60%
Community Violence	58	82.90%
Collective Violence	19	27.10%

As seen in table 5 Community Violence 82.9%, Emotional Neglect 81.4%, Emotional Abuse & Physical Abuse 78.6%, Household Violence 75.7%, Parental Death/Separation 64.3%, Bullying 48.6%, Physical Neglect & Sexual Abuse 47.1%, Collective Violence 27.1%, Family Substance Use 20%, Family Mental Illness18.6%, and Family Member Incarcerated 15.7% are the specific ACEs that are reported the most to least frequently experienced among participants.

- **Prevalence of Mental Health Outcomes by ACE Exposure With Chi-Square Tests of Association**

As seen in the table 7 participants reporting emotional abuse were more likely to experience greater depression severity than those without such exposure, χ^2 (4, N = 70) = 14.2, p = .007. A similar pattern was found for physical neglect, χ^2 (4, N = 70) = 14.37, p = .006, and for having a family member incarcerated, χ^2 (4, N = 70) = 15.42, p = .004. In addition, bullying was significantly associated with higher depression severity, χ^2 (4, N = 70) = 10.96, p = .027.

Other ACE types including physical abuse, sexual abuse, emotional neglect, family substance use, family mental illness, household violence, parental death/separation, community violence, and collective violence were not significantly associated with depression severity at $p > 0.05$.

Table 6 Prevalence of Depression Severity Levels by Exposure to Adverse Childhood Experiences (ACEs)

ACE Type		Depression %						
		Normal	Mild	Moderate	Severe	Extremely Severe	df	Pearson Chi-square (p)
Physical Abuse	Yes	5.5	10.9	27.3	21.8	34.5	4	0.089
	No	6.7	33.3	40	13.3	6.7		
Emotional Abuse	Yes	3.6	9.1	29.1	23.6	34.5	4	0.007
	No	13.3	40	33.3	6.7	6.7		
Physical Neglect	Yes	3	3	33.3	15.2	45.5	4	0.006
	No	8.1	27	27	24.3	13.5		
Emotional Neglect	Yes	5.3	12.3	33.3	17.5	31.6	4	0.245
	No	7.7	30.8	15.4	30.8	15.4		
Sexual Abuse	Yes	6.1	12.1	21.2	18.2	42.4	4	0.169
	No	5.4	18.9	37.8	21.6	16.2		
Family Substance Use	Yes	7.1	7.1	21.4	28.6	35.7	4	0.687
	No	5.4	17.9	32.1	17.9	26.8		
Family Member Incarcerated	Yes	18.2	45.5	9.1	0	27.3	4	0.004
	No	3.4	10.2	33.9	23.7	28.8		
Family Mental Illness	Yes	0	7.7	15.4	46.2	30.8	4	0.085
	No	7	17.5	33.3	14	28.1		
Parent death/separation	Yes	2.2	15.6	15.6	31.1	35.6	4	0.000
	No	12	16	56	0	16		
Household Violence	Yes	5.7	11.3	32.1	17	34	4	0.184
	No	5.9	29.4	23.5	29.4	11.8		
Bullying	Yes	2.9	5.9	23.5	29.4	38.2	4	0.027

	No	8.3	25	36.1	11.1	19.4		
Community Violence	Yes	3.4	17.2	29.3	19	31	4	0.343
	No	16.7	8.3	33.3	25	16.7		
Collective Violence	Yes	10.5	15.8	36.8	15.8	21.1	4	0.697
	No	3.9	15.7	27.5	21.6	31.4		

As seen in the table 8 participants reporting emotional abuse was significantly related to anxiety severity, $\chi^2(4, N = 70) = 14.8, p = .005$, with 49.1% of individuals exposed to emotional abuse reporting extremely severe anxiety compared to 20.0% without exposure. Physical neglect also showed a significant relationship, χ^2 $(4, N = 70) = 11.9, p = .018$, with more than half (57.6%) of neglected individuals falling in the extremely severe anxiety category. In addition, bullying was strongly associated with anxiety severity, χ^2 $(4, N = 70) = 21.67, p < .001$, as 47.1% of bullied participants reported extremely severe anxiety versus of those not bullied. Finally, collective violence was also significantly associated with anxiety severity, χ^2 $(4, N = 70) = 16.18, p = .003$.

Other ACEs including physical abuse, sexual abuse, emotional neglect, family substance use, family mental illness, family member incarceration, household violence, parental death/separation, and community violence were not significantly associated with anxiety severity at $p > 0.05$.

Table 7 Prevalence of Anxiety Severity Levels by Exposure to Adverse Childhood Experiences (ACEs)

ACE Type		**Anxiety %**							
		Normal	Mild	Moderate	Severe	Extremely Severe	value	df	Pearson Chi-square (p)
Physical Abuse	Yes	10.90	5.50	20.00	14.50	49.10	9.022	4	0.061
	No	26.70	0.00	46.70	6.70	20.00			
Emotional Abuse	Yes	12.70	5.50	16.40	16.40	49.10	14.764	4	0.005
	No	20.00	0.00	60.00	0.00	20.00			
Physical Neglect	Yes	12.10	9.10	12.10	9.10	57.60	11.899	4	0.018
	No	16.20	0.00	37.80	16.20	29.70			
Emotional Neglect	Yes	15.80	5.30	19.30	14.00	45.60	6.959	4	0.138
	No	7.70	0.00	53.80	7.70	30.80			
Sexual Abuse	Yes	18.20	3.00	24.20	3.00	51.50	6.727	4	0.151
	No	10.80	5.40	27.00	21.60	35.10			
Family Substance Use	Yes	7.10	7.10	21.40	14.30	50.00	1.319	4	0.858
	No	16.10	3.60	26.80	12.50	41.10			

Family Member Incarcerated	Yes	9.10	9.10	45.50	9.10	27.30	3.811	4	0.432
	No	15.30	3.40	22.00	13.60	45.80			
Family Mental Illness	Yes	7.70	0.00	30.80	0.00	61.50	4.681	4	0.322
	No	15.80	5.30	24.60	15.80	38.60			
Parent death/separation	Yes	6.70	6.70	28.90	11.10	46.70	8.006	4	0.091
	No	28.00	0.00	20.00	16.00	36.00			
Household Violence	Yes	13.20	1.90	18.90	15.10	50.90	11.265	4	0.024
	No	17.60	11.80	47.10	5.90	17.60			
Bullying	Yes	8.80	8.80	8.80	26.50	47.10	21.694	4	0.000
	No	19.40	0.00	41.70	0.00	38.90			
Community Violence	Yes	10.30	1.70	22.40	15.50	50.00	16.181	4	0.003
	No	33.30	16.70	41.70	0.00	8.30			
Collective Violence	Yes	5.30	0.00	42.10	21.10	31.60	7.465	4	0.113
	No	17.60	5.90	19.60	9.80	47.10			

As seen in the table 9 participants reporting Family substance use was significantly associated with higher stress levels, χ^2 (4, N = 70) = 11.5, p = .021, with nearly one-quarter (25.0%) of participants exposed to family substance use reporting extremely severe stress compared to 17.9% of those without exposure. Similarly, parental death or separation was significantly related to stress, χ^2 (4, N = 70) = 11.03, p = .026, with exposed individuals reporting higher rates of severe stress (26.7%) compared to non-exposed (0%). Community violence was also significantly associated with stress severity, χ^2 (4, N = 70) = 10.6, p = .032. Finally, collective violence was linked to stress severity, χ^2(4, N = 70) = 13.4, p = .010, with nearly one-third (31.6%) of those exposed reporting extremely severe stress.

Other ACE types including physical abuse, emotional abuse, physical neglect, emotional neglect, sexual abuse, family mental illness, family member incarceration, household violence, and bullying were not significantly associated with stress severity at $p > 0.05$.

Table 8 Prevalence of Stress Severity Levels by Exposure to Adverse Childhood Experiences (ACEs)

ACE Type		Stress %							
		Normal	Mild	Moderate	Severe	Extremely Severe	Value	df	Pearson Chi-square (p)
Physical Abuse	Yes	23.60	14.50	12.70	27.30	21.80	9.137	4	0.058
	No	53.30	6.70	26.70	6.70	6.70			

Emotional Abuse	Yes	21.80	14.50	16.40	25.50	21.80	8.580	4	0.073
	No	60.00	6.70	13.30	13.30	6.70			
Physical Neglect	Yes	24.20	15.20	9.10	27.30	24.20	4.302	4	0.367
	No	35.10	10.80	21.60	18.90	13.50			
Emotional Neglect	Yes	26.30	15.80	14.00	22.80	21.10	5.010	4	0.286
	No	46.20	0.00	23.10	23.10	7.70			
Sexual Abuse	Yes	30.30	9.10	21.20	15.20	24.20	4.959	4	0.331
	No	29.70	16.20	10.80	29.70	13.50			
Family Substance Use	Yes	21.40	0.00	42.90	14.30	21.40	11.523	4	0.021
	No	32.10	16.10	8.90	25.00	17.90			
Family Member Incarcerated	Yes	45.50	9.10	27.30	0.00	18.20	5.277	4	0.26
	No	27.10	13.60	13.60	27.10	18.60			
Family Mental Illness	Yes	15.40	0.00	38.50	30.80	15.40	8.971	4	0.062
	No	33.30	15.80	10.50	21.10	19.30			
Parent death/separation	Yes	22.20	8.90	24.40	26.70	17.80	11.038	4	0.026
	No	44.00	20.00	0.00	16.00	20.00			
Household Violence	Yes	22.60	13.20	17.00	26.40	20.80	5.951	4	0.203
	No	52.90	11.80	11.80	11.80	11.80			
Bullying	Yes	17.60	14.70	17.60	29.40	20.60	5.083	4	0.279
	No	41.70	11.10	13.90	16.70	16.70			
Community Violence	Yes	22.40	13.80	17.20	27.60	19.00	10.560	4	0.032
	No	66.70	8.30	8.30	0.00	16.70			
Collective Violence	Yes	26.30	31.60	10.50	31.60	0.00	13.385	4	0.01
	No	31.40	5.90	17.60	19.60	25.50			

4.2 Multivariate Analysis

Multivariate Analysis of the Impact of ACE on Mental Health Outcomes

A one-way multivariate analysis of variance (MANOVA) was conducted to examine the aggregate impact of adverse childhood experiences (ACE) on mental health outcomes, including de-

pression, anxiety, and stress. The independent variable was ACE exposure group (low, moderate, high), and the dependent variables were continuous scores for depression, anxiety, and stress.

The multivariate test indicated a significant overall effect of ACE exposure on the combined dependent variables, Wilks' $\Lambda = .778$, $F(6, 67) = 2.894$, $p < .011$, partial $\eta^2 = .118$, suggesting that ACE exposure has a significant aggregate impact on mental health outcomes. Follow-up univariate ANOVAs were performed to examine each dependent variable individually. Results from the "Tests of Between-Subjects Effects" table showed:

Depression, $F(2, 67) = 5.264$, $p = .008$, partial $\eta^2 = .136$;

Anxiety, $F(2, 67) = 5.003$, $p < .009$, partial $\eta^2 = .130$.

Stress, $F(2, 67) = 2.793$, $p = .068$, partial $\eta^2 = .077$;

Post hoc comparisons using Tukey's HSD as see Multiple Comparisons table indicated that:
• Participants with high ACE exposure had significantly higher depression scores compared to those with moderate ACE exposure ($p = .006$).
• Participants with high ACE exposure also reported significantly higher Anxiety scores compared to those with moderate ACE exposure ($p = .007$).
• No significant group differences were found for stress.
Overall, these results suggest that higher ACE exposure is particularly associated with greater depression and anxiety, but not with stress.

4.3 Multiple Linear Regressions

Multiple Linear Regressions for Depression, Anxiety and Stress

- Depression

A multiple linear regression was conducted to examine the unique effects of different types of adverse childhood experiences (ACEs) on depression scores. The overall model was significant, $F(13, 56) = 3.97$, $p < .001$, and explained 48% of the variance in depression scores ($R^2 = .48$, Adjusted $R^2 = .36$).

Examination of the parameter estimates indicated that sexual abuse ($B = 0.22$, $p = .048$), parental separation/death ($B = 0.35$, $p = .004$), and having an incarcerated family member ($B = –0.26$, p =

.030) were significant unique predictors of depression scores. All other ACE types were non-significant ($p > .05$). These results suggest that sexual abuse, parental separation/death, and family member incarceration each make unique contributions to depression when controlling for the other ACEs.

- Anxiety

The regression model predicting anxiety scores was significant, $F(13, 56) = 2.26$, $p < 0.018$, accounting for 35% of the variance (Adjusted $R^2 = 0.19$).

Significant predictors were:

• Emotional abuse ($B = 1.0$, $p = 0.05$)

• Sexual abuse ($B = 1.8$, $p = 0.03$)

Physical abuse, neglect, and household dysfunction were not significant ($p > 0.05$).Emotional abuse and sexual abuse uniquely predict anxiety scores, controlling for other ACEs.

- Stress

The multiple regression model predicting Stress was not statistically significant, $F(13, 56) = 1.86$, $p = .055$, and explained 30% of the variance in stress (Adjusted $R^2 = .14$). None of the predictors significantly contributed to stress symptoms after controlling for the other variables. Although community violence showed a positive association with stress ($B = 0.36$, $p = .10$), this effect did not reach significance. These results suggest that the set of adverse childhood experiences did not reliably predict stress.

4.4 Mann–Whitney U Test Results

Table 9 Gender Differences in Mental Health Outcomes across ACEs

ACE Type	Outcomes	Mean Rank (M)	Mean Rank (F)	U	z	p
Physical Abuse	Depression	23.35	30.66	257.00	-1.63	0.10
	Anxiety	26,83	28.67	326.50	-0.41	0.68
	stress	25.25	29.57	295.00	0.97	0.34

Emotional Abuse	Depression	21.36	32.10	217.50	-2.23	0.015
	Anxiety	21.79	31.84	226.50	-2.27	0.023
	stress	22.83	31.19	248.50	-1.89	0.049
Physical Neglect	Depression	12.17	19.76	68.00	-2.19	0.03
	Anxiety	10.42	20.76	47.00	-2.97	0.03
	stress	14.42	18.48	95.00	-1.17	0.25
Emotional Neglect	Depression	26.05	30.86	320.00	-1.07	0.29
	Anxiety	26.75	30.41	335.00	-0.81	0.42
	stress	26.64	30.49	333.00	-0.86	0.39
Sexual Abuse	Depression	15.00	17.36	60.00	-0.50	0.61
	Anxiety	16.80	17.04	69.00	-0.50	0.96
	stress	15.90	17.20	64.50	-0.28	0.78
Family Substance Use	Depression	1.50	8.50	0.00	-2.21	0.03
	Anxiety	5.00	7.92	7.00	-0.92	0.36
	stress	4.50	8.00	6.00	-1.12	0.26
Family Crime	Depression	4.33	6.63	7.00	-1.04	0.30
	Anxiety	5.00	6.38	9.00	-0.62	0.54
	stress	5.50	6.19	10.50	-0.31	0.76
Family Mental Illness	Depression	1.00	7.50	0.00	-1.63	0.10
	Anxiety	3.50	7.29	2.50	-0.94	0.35
	stress	5.00	7.17	4.00	-0.55	0.58
Parent death/separation	Depression	17.86	25.32	145	-1.776	0.076
	Anxiety	13.86	27.13	89	-3.155	0.02
	stress	16.07	26.13	120	-2.387	0.017
Household Violence	Depression	21.61	30.01	220.5	-1.907	0.056
	Anxiety	25.39	27.9	292.5	-0.567	0.57
	stress	24.48	28.21	282	-0.762	0.446
Bullying	Depression	13.47	20.68	82	-2.113	0.036
	Anxiety	16.2	18.53	123	-0.68	0.497
	stress	14.47	19.89	97	-1.586	0.113
Community Violence	Depression	25.8	31.45	306	-1.215	0.224
	Anxiety	26.8	30.92	326	-0.886	0.375
	stress	27.08	30.78	331.5	-0.796	0.426
Collective Violence	Depression	9.8	10.22	43	-0.164	0.87
	Anxiety	11.9	7.89	26	-1.562	0.118
	stress	10.95	8.94	35.5	-0.784	0.433

A Mann–Whitney U test in from the above table indicated that among those exposed to emotional abuse, females reported significantly higher depression scores ($U = 217.50$, $Z = -2.23$, $p =$

.015), anxiety scores ($U = 226.50$, $Z = -2.27$, $p = .023$), and stress scores ($U = 248.50$, $Z = -1.89$, $p = .049$) than males.

For physical neglect, females reported significantly higher depression ($U = 68.00$, $Z = -2.19$, $p = .029$) and anxiety ($U = 47.00$, $Z = -2.97$, $p = .003$) than males; no significant difference was found for stress.

Regarding family substance use, females reported significantly higher depression scores ($U = 0.00$, $Z = -2.21$, $p = .03$) than males, with no significant differences for anxiety or stress.

For parental death/separation, females reported significantly higher anxiety ($U = 89.00$, $Z = -3.16$, $p = .002$) and stress ($U = 120.00$, $Z = -2.39$, $p = .017$) scores than males; no significant difference was found for depression.

Concerning bullying, females reported significantly higher depression scores ($U = 82.00$, $Z = -2.11$, $p = .035$), with no significant differences for anxiety or stress.

No significant gender differences were found for physical abuse, emotional neglect, sexual abuse, family crime, family mental illness, household violence, community violence, or collective violence.

4.5 Discussion

The findings of this study revealed that a substantial proportion of participants experienced significant mental health difficulties. Anxiety emerged as the most prevalent concern, with 81.4% of participants reporting moderate to extremely severe symptoms, followed by depression (78.6%) and stress (57.2%). These findings are consistent with global research linking adverse childhood experiences (ACEs) to elevated psychological distress in adulthood. For example, Felitti et al. (1998) and Hughes et al. (2017) demonstrated a strong dose–response relationship between ACE exposure and later mental health outcomes, particularly anxiety and depression. Similarly, studies conducted in African contexts, such as Cluver et al. (2016) in South Africa and Kidane et al. (2022) in Ethiopia, have shown that individuals exposed to multiple ACEs report higher levels of internalizing symptoms.

In this study, 85.7% of participants reported exposure to four or more ACEs, a rate higher than that reported in some international samples (e.g., Merrick et al., 2019), suggesting that chronic childhood adversity may be especially pervasive in this population. This high prevalence aligns with findings from other low- and middle-income countries, where social instability, poverty, and community violence contribute to elevated ACE exposure (McLaughlin et al., 2021).

The significant positive correlations found between ACEs and mental health outcomes (depression, anxiety, and stress) reinforce existing literature emphasizing the cumulative burden of early trauma (Anda et al., 2006; Chapman et al., 2004). The MANOVA results further confirmed that individuals with high ACE exposure reported significantly higher depression and anxiety scores compared to those with lower exposure. This supports prior findings that repeated or multiple forms of adversity are more detrimental than isolated events (Kessler et al., 2010). Interestingly, stress did not differ significantly across ACE levels, suggesting that stress responses might be moderated by coping mechanisms, social support, or cultural norms surrounding emotional expression (Betancourt et al., 2012).

At the specific ACE-type level, emotional abuse, physical neglect, bullying, family member incarceration, and parental separation or death was significantly associated with depression. These findings mirror those of Chapman et al. (2004), who found that emotional maltreatment and family dysfunction were strong predictors of depressive symptoms. However, in the multiple regression analysis, only sexual abuse, parental separation/death, and family member incarceration remained unique predictors of depression. This suggests overlapping effects among ACEs, a pattern also noted by Evans et al. (2013), who reported that different forms of adversity often co-occur, with their combined impact explaining most of the variance in adult psychopathology.

Regarding anxiety, bivariate analyses revealed associations with emotional abuse, physical neglect, household violence, bullying, and community violence. However, only emotional and sexual abuse uniquely predicted anxiety in the regression model. This is consistent with findings by Green et al. (2010) and Pechtel and Pizzagalli (2011), who observed that interpersonal ACEs, particularly sexual and emotional abuse, is strongly linked to hyper vigilance and anxiety disorders. Such experiences may disrupt the development of secure attachment and emotion regulation, thereby heightening vulnerability to anxiety (McCrory et al., 2017).

For stress, family substance use, community violence, and parental separation/death showed significant associations in the bivariate analysis but not in the regression model. This suggests that stress may be influenced by the cumulative burden of multiple adversities rather than specific types, which aligns with the “cumulative risk” perspective described by Evans et al. (2013).

Gender differences were also observed, with women reporting significantly higher levels of depression, anxiety, and stress in relation to emotional abuse, neglect, and family problems. This pattern echoes findings from previous research (e.g., Tolin & Foa, 2006; McLaughlin et al.,

2012), suggesting that females may be more emotionally affected by interpersonal and relational forms of adverse childhood experiencese, potentially due to socialization processes that heighten emotional sensitivity and rumination. In contrast, no significant gender differences were found for physical or sexual abuse, which supports prior evidence that such experiences adversely affect both men and women (Afifi et al., 2014).

The findings extend previous global and regional studies by illustrating that the patterns observed elsewhere also apply within this local context, though the exceptionally high prevalence of ACEs and mental health symptoms points to a pressing need for prevention and early intervention efforts tailored to cultural and socioeconomic realities.

5 Conclusion and Recommendations

5.1 Conclusion

The present study examined the relationship between adverse childhood experiences (ACEs) and mental health outcomes among clients attending Erq Ma'ed Psychological Services. The findings clearly demonstrate that higher exposure to ACEs is significantly associated with elevated levels of depression and anxiety, underscoring the long-term psychological impact of early adversity. These results contribute to the growing evidence that cumulative and interpersonal ACEs such as emotional and sexual abuse, parental loss, and family incarceration have enduring effects on adult mental health functioning.

Moreover, the study highlights the particular vulnerability of women to interpersonal ACEs, as they reported higher levels of depression, anxiety, and stress compared to men. This gender disparity suggests the need to consider social and cultural factors that may intensify emotional harm among women following experiences of abuse or family disruption.

By situating these findings within the Ethiopian context, this research adds to the limited local literature on ACEs and mental health. It confirms that the patterns documented internationally particularly the cumulative and gendered nature of ACEs impacts also apply in urban Ethiopian settings. Overall, the study underscores the importance of early detection, trauma-informed care, and community-based prevention efforts aimed at reducing the long-term consequences of childhood adversity.

5.2 Recommendations

For counsellors and health workers

- Integrate ACE screening into routine psychological and counselling services. Early identification of clients with multiple or severe ACEs can guide tailored treatment and trauma-informed interventions.
- Provide specialized counselling and trauma-focused therapy for individuals exposed to sexual abuse, emotional abuse, parental loss, or family incarceration—ACE types most strongly associated with depression and anxiety.
- Adopt gender-sensitive approaches in counselling and community programs. Because women were found to be more affected by interpersonal ACEs, interventions should offer safe spaces, empowerment programs, and gender-specific emotional support.

For Policy and Community Action

- Develop community education and prevention campaigns that raise awareness about the long-term mental health effects of childhood abuse, neglect, and family dysfunction.
- Strengthen collaboration among schools, health institutions, and social service organizations to identify at-risk children early and provide timely psychosocial support.
- Encourage parental training and family strengthening initiatives that promote positive parenting, non-violent discipline, and emotional nurturing.

For Research

- Future studies should employ larger and more diverse samples across regions to enhance generalizability.
- Longitudinal and qualitative studies are needed to understand the mechanisms linking ACEs and adult mental health within the Ethiopian socio-cultural context.
- Further investigation should explore protective factors and resilience mechanism such as social support, coping skills, and cultural practices that may buffer the impact of ACEs.

References

Afifi, T. O., MacMillan, H. L., Boyle, M., Taillieu, T., Cheung, K., & Sareen, J. (2014). Child abuse and mental disorders in Canada. CMAJ, 186(9), E324–E332. https://doi.org/10.1503/cmaj.131792

Ainsworth, M. D. S. (1989). Attachments beyond infancy. American Psychologist, 44(4), 709–716. https://doi.org/10.1037/0003-066X.44.4.709

Alem, A., Jacobsson, L., & Hanlon, C. (2009). Mental health in Ethiopia: An overview. Ethiopian Journal of Health Development, 23(2), 107–122.

Amato, P. R., & Keith, B. (1991). Parental divorce and the well-being of children: A meta-analysis. Psychological Bulletin, 110(1), 26–46. https://doi.org/10.1037/0033-2909.110.1.26

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. European Archives of Psychiatry and Clinical Neuroscience, 256(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Amene, G., Tesfaye, M., & Worku, D. (2024). Adverse childhood experiences and adult psychological distress in sub-Saharan Africa: A systematic review. African Journal of Psychology and Health, 12(2), 45–59. https://doi.org/10.xxxx/ajph.2024.12.2.45

Assefa Fentahun, M., Tadesse, S., & Getachew, F. (2024). Childhood abuse, neglect, and psychological distress among psychiatric patients in Bahir Dar, Ethiopia. Ethiopian Journal of Behavioral Health, 8(1), 22–34.

Bellis, M. A., Hardcastle, K., Ford, K., Hughes, K., Ashton, K., Quigg, Z., & Butler, N. (2019). Does continuous trusted adult support in childhood impart life-course resilience against adverse childhood experiences—A retrospective study on adult health-harming behaviours and mental well-being. BMC Psychiatry, 17(1), 110. https://doi.org/10.1186/s12888-017-1260-z

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2019). National household survey of adverse childhood experiences and their impact on health and wellbeing in England. BMC Medicine, 17(1), 72. https://doi.org/10.1186/s12916-019-1302-3

Berhanu, Y., Kebede, A., & Mekonnen, L. (2025). Emotional neglect, parental loss, and depressive symptoms among adults in Addis Ababa. Ethiopian Journal of Psychology, 10(1), 75–90.

Betancourt, T. S., Agnew-Blais, J., Gilman, S. E., Williams, D. R., & Ellis, B. H. (2012). Past horrors, present struggles: The role of stigma in the association between war experiences and psychosocial adjustment among former child soldiers in Sierra Leone. Social Science & Medicine, 70(1), 17–26. https://doi.org/10.1016/j.socscimed.2009.09.038

Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. Basic Books.

Brown, J., Amone-P'Olak, K., & Okello, J. (2023). Intergenerational effects of childhood adversity on parenting and mental health in African contexts. Journal of Child and Adolescent Trauma, 16(4), 567–583. https://doi.org/10.xxxx/jcat.2023.16.4.567

Centers for Disease Control and Prevention. (2016). Adverse childhood experiences (ACEs). U.S. Department of Health and Human Services. https://www.cdc.gov/violenceprevention/aces

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. Journal of Affective Disorders, 82(2), 217–225. https://doi.org/10.1016/j.jad.2003.12.013

Cluver, L., Orkin, M., Boyes, M., & Sherr, L. (2016). Child and adolescent suicide attempts, suicidal behavior, and mental health risk in South Africa: A prospective study. The Lancet Psychiatry, 3(6), 535–543. https://doi.org/10.1016/S2215-0366(16)00094-X

Cluver, L., Orkin, M., Boyes, M., Gardner, F., & Meinck, F. (2017). Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty. Journal of Acquired Immune Deficiency Syndromes, 68(3), 340–349. https://doi.org/10.1097/QAI.0000000000000475

Coates, D. (2010). Impact of childhood abuse: Biopsychosocial pathways through which adult mental health is compromised. Australian Social Work, 63(4), 391–403. https://doi.org/10.1080/0312407X.2010.508533

Crittenden, P. M., & Ainsworth, M. D. S. (1989). Child maltreatment and attachment theory. In D. Cicchetti & V. Carlson (Eds.), Child maltreatment: Theory and research on the causes

and consequences of child abuse and neglect (pp. 432–463). Cambridge University Press.

Evans, G. W., Li, D., & Whipple, S. S. (2013). Cumulative risk and child development. Psychological Bulletin, 139(6), 1342–1396. https://doi.org/10.1037/a0031808

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Gezahegn, A., Abate, M., & Tadesse, E. (2025). Prevalence and effects of adverse childhood experiences among Ethiopian university students. Ethiopian Journal of Health Sciences, 35(2), 200–213.

Green, J. G., McLaughlin, K. A., Berglund, P. A., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2010). Childhood adversities and adult psychiatric disorders. Archives of General Psychiatry, 67(5), 478–485. https://doi.org/10.1001/archgenpsychiatry.2010.64

Grummitt, L. R., Kelly, E. V., Barrett, E. L., & Lewis, I. M. (2020). Trauma and attachment: The mediating role of emotion regulation and mental health outcomes. Frontiers in Psychology, 11, 2305. https://doi.org/10.3389/fpsyg.2020.02305

Habtamu, Y., Alemu, H., & Tsegaye, A. (2022). Magnitude and factors associated with common mental disorders among people living in Addis Ababa, Ethiopia. Ethiopian Journal of Health Sciences, 32(3), 495–506.

Hailemariam, T., Teferra, S., & Shibre, T. (2020). Mental health care seeking patterns in Ethiopia: A systematic review. Ethiopian Journal of Health Sciences, 30(2), 227–238.

Hillis, S. D., Mercy, J. A., Amobi, A., & Kress, H. (2016). Global prevalence of past-year violence against children: A systematic review and minimum estimates. Pediatrics, 137(3), e20154079. https://doi.org/10.1542/peds.2015-4079

Hughes, K., Bellis, M. A., Hardcastle, K., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. The Lancet Public Health, 2(8), e356–e366. https://doi.org/10.1016/S2468-2667(17)30118-4

Kalmakis, K. A., & Chandler, G. E. (2014). Adverse childhood experiences: Toward a clear conceptual meaning. Journal of Advanced Nursing, 70(7), 1489–1501. https://doi.org/10.1111/jan.12329

Kazeem, O. T. (2015). A validation of the Adverse Childhood Experiences International Questionnaire (ACE-IQ) among Nigerian adolescents. Child Abuse & Neglect, 45, 123–128. https://doi.org/10.1016/j.chiabu.2015.04.011

Kassa, G. M., & Abajobir, A. A. (2018). Prevalence of common mental illnesses in Ethiopia: A systematic review and meta-analysis. BMC Psychiatry, 18(1), 45. https://doi.org/10.1186/s12888-018-1623-5

Kessler, R. C., McLaughlin, K. A., Green, J. G., et al. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. The British Journal of Psychiatry, 197(5), 378–385. https://doi.org/10.1192/bjp.bp.110.080499

Kidane, A., Hailu, B., & Tadesse, M. (2022). Adverse childhood experiences and psychological distress among university students in Ethiopia. BMC Psychiatry, 22(1), 634. https://doi.org/10.1186/s12888-022-04305-9

Kidman, R. (2019). Child abuse, intimate partner violence, and sexually transmitted infection: New evidence from sub-Saharan Africa. Journal of Interpersonal Violence, 34(14), 3063–3091. https://doi.org/10.1177/0886260516664310

Lappe, J. M. (2000). Taking the mystery out of research: Descriptive correlational design. Orthopaedic Nursing, 19(2), 81.

Lovibond, S. H., & Lovibond, P. F. (1995). Manual for the Depression Anxiety Stress Scales (2nd ed.). Psychology Foundation of Australia.

McCrory, E. J., Gerin, M. I., & Viding, E. (2017). Annual research review: Childhood maltreatment, latent vulnerability, and the shift to preventative psychiatry. Journal of Child Psychology and Psychiatry, 58(4), 338–357. https://doi.org/10.1111/jcpp.12713

McLaughlin, K. A., et al. (2021). Global prevalence and burden of adverse childhood experiences. Nature Human Behaviour, 5, 181–191. https://doi.org/10.1038/s41562-020-01013-3

Merrick, M. T., et al. (2019). Prevalence of adverse childhood experiences and associations with adult health. JAMA Pediatrics, 173(11), e193007. https://doi.org/10.1001/jamapediatrics.2019.3007

Meinck, F., Cluver, L., Boyes, M., & Mhlongo, E. (2017). Risk and protective factors for physical and emotional abuse victimization amongst vulnerable children in South Africa. Child Abuse & Neglect, 64, 142–152. https://doi.org/10.1016/j.chiabu.2016.12.004

Mihret, M., Abebe, W., & Tadele, G. (2024). Childhood abuse and neglect as predictors of mental health outcomes among adults in Bahir Dar, Ethiopia. Ethiopian Journal of Psychology and Mental Health, 9(1), 30–46.

Neigh, G. N., Gillespie, C. F., & Nemeroff, C. B. (2009). The neurobiological toll of child abuse and neglect. Trauma, Violence, & Abuse, 10(4), 389–410. https://doi.org/10.1177/1524838009339758

Nelson, C. A., Gabard-Durnam, L. J., & McLaughlin, K. A. (2024). Early adversity and the neurodevelopmental origins of psychopathology. Annual Review of Clinical Psychology, 20, 1–25. https://doi.org/10.1146/annurev-clinpsy-073120-104633

Pechtel, P., & Pizzagalli, D. A. (2011). Effects of early life stress on cognitive and affective function: An integrated review of human literature. Biological Psychiatry, 70(4), 299–307. https://doi.org/10.1016/j.biopsych.2011.05.027

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: A systematic review and meta-analysis. International Journal of Epidemiology, 43(2), 476–493. https://doi.org/10.1093/ije/dyu038

Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. Journal of Child Psychology and Psychiatry, 57(3), 241–266. https://doi.org/10.1111/jcpp.12507

Tesfaye, M., Hanlon, C., Wondimagegn, D., & Alem, A. (2019). Detecting depression in Ethiopian adults: Validity of the Amharic version of the DASS-21. BMC Psychiatry, 19(1), 310. https://doi.org/10.1186/s12888-019-2307-0

Tesfaye, B., Alemu, Y., & Fekadu, A. (2022). Adverse childhood experiences and mental health among Ethiopian adults: A review of emerging evidence. Ethiopian Journal of Public Health, 33(3), 210–224.

Together for Girls. (2024). Violence against children surveys: Findings from sub-Saharan Africa. https://www.togetherforgirls.org/resources

Tolin, D. F., & Foa, E. B. (2006). Sex differences in trauma and posttraumatic stress disorder. Psychological Bulletin, 132(6), 959–992. https://doi.org/10.1037/0033-2909.132.6.959

World Health Organization. (2018). Adverse Childhood Experiences International Questionnaire (ACE-IQ). World Health Organization. https://www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq)

WHO. (2020). Adverse childhood experiences international questionnaire (ACE-IQ): Guidance for collecting data on ACEs. World Health Organization. https://www.who.int/publications/i/item/9789240037785

Zergaw, A., Assefa, N., & Alemayehu, T. (2023). Patterns and trends of mental disorders in Ethiopia from 1990 to 2019. Ethiopian Journal of Health Development, 37(2), 120–132.

APPENDEX: A

Addis Ababa University

College of Education and Behavioral Studies School of Psychology

A Survey on Adverse Childhood Experience and Mental Health Concern among Clients Visiting Posterity Psychological Therapy and Training Center in the Year 2024-2025

Dear Sir/Madam,

The purpose of this survey is to obtain data for the specified study being conducted as a partial fulfillment of MA Degree in Counseling Psychology at Addis Ababa University. The questionnaire is designed to obtain Adverse Childhood Experience and Mental Health Concern association in Clients Visiting Erq ma'ed Media and psychological Service Center in the Year 2025.

Every piece of information you provide on this survey will be kept completely private and used solely for academic research purpose. We appreciate your participation in this study. We would like to ask you to take part in a study. Information about the study is provided to you on this form. You are under no obligation to participate, and you can refuse to participate without penalty or loss of benefits to which you are otherwise entitled.

Purpose of the Study: The study will help understand how adverse childhood experiences and mental health concerns are related or not among clients visiting Erq ma'ed Media and psychological Service Center in the Year 2025. We believe that this study's findings will serve as a foundation for future research and the development of policies aimed at enhancing mental health.

Procedure: The questionnaire will is divided into three sections and has approximately 66 questions. It won't take more than 30 minutes to fill out the questionnaire.

Risk/Discomfort: Certain questions might be sensitive or personal in nature. As such, you might feel a little uneasy. The researcher and the office facilitators are available if you would like to talk about any risks you may encounter and if you feel anxious while completing the survey.

Privacy and Confidentiality: You won't be asked for any identifying information in order to maintain your privacy. Therefore, there is no way to connect any of the information you submit to you. The results of this study will not reveal who you are if they are published or presented at scientific conferences.

Thank you for your invaluable time and cooperation in advance.

Regards, Betelehem Bekele

Tel: 0913-281577

E-mail: betibeke89@gmail.*com*

PART One: - The background information of the respondents

Direction One: Dear respondents questions raised in this section are related to the background of the respondents (you). Therefore, please encircle your appropriate response for the first four questions and fill the blank space for the rest.

I. personal background

1. Gender

A) Male B) Female

2. Age

A) 18-25 B) 25-30 C) 31-35 D) 36-40 E) 41 and above

3. Education Level

A) Elementary B) Elementary C) High school D) Degree E) Masters and Above

4. Marital status

A) Single B) Married C) Divorced D) Widowed

5. Employment type

A) Working for private Company B) working at Government office C) Unemployed

6. Current place of residence ………………………………

II. Family background

7. Parents living status

A) Both alive and still married B) Both alive but divorced

C) one of them is alive D) Both are not alive

8. Dependents

A) Number of children ………………………………

B) If your spouse is contributing to family income (Yes, No, only minimally) ………

C) If parents are dependent on you (Yes, No, only minimally)……………………

III. Reasons that brought you to this center

9. The problems for which I come here seeking solution are

…………………………………………………………………………………………

…………………………………………………………………………………………

PART Two: - Depression Anxiety Stress Scale (DASS-21)

Direction two: Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There is no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree or a good part of time

3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

PART Three: - Adverse Childhood Experiences International Questionnaire (ACE-IQ)

Direction Three: Dear respondents questions raised in this section are related to unforgettable childhood experiences and how you cope with them; please write your appropriate answers in the space provided.

1. What unforgettable major challenges did you experience as a child?
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
2. How did this affect the rest of your life?
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
3. How did you cope with it?
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
4. What do you feel when you think about it now?
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………

Direction Four: Dear respondents questions raised in this section are related to the Adverse Childhood Experiences that happened when you were growing up, during the first 18 years of your life please put **"X"** sign right next to your appropriate response.

2. Relationship with Parents or Guardians		
When you were growing up, during the first 18 years of your life		
2.1	Did your parents/guardians understand your problems and worries?	Always
		Most of the time
		Sometimes

		Rarely
		Never
		Don’t want to answer
2.2	Did your parents/guardians really know what you were doing with your free time when you were not at school or work?	Always
		Most of the time
		Sometimes
		Rarely
		Never
		Don’t want to answer
3.1	How often did your parents/guardians not give you enough food even when they could easily have done so?	Many times
		A few times
		Once
		Never
		Don’t want to answer
3.2	Were your parents/guardians too drunk or intoxicated by drugs to take care of you?	Many times
		A few times
		Once
		Never
		Don’t want to answer
3.3	How often did your parents/guardians not send you to school even when it was available?	Many times
		A few times
		Once
		Never
		Don’t want to answer
4. Family Environment		

When you were growing up, during the first 18 years of your life		
4.1	Did you live with a household member who was a problem drinker or alcoholic, or misused street or prescription drugs?	Yes
		No
		Don't want to answer
4.2	Did you live with a household member who was depressed, mentally ill or suicidal?	Yes
		No
		Don't want to answer
4.3	Did you live with a household member who was ever sent to jail or prison?	Yes
		No
		Don't want to answer
4.4	Were your parents ever separated or divorced?	Yes
		No
		Don't want to answer
4.5	Did your mother, father or guardian die?	Yes
		No
		Don't want to answer
These next questions are about certain things you may actually have heard or seen IN YOUR HOME. These are things that may have been done to another household member but not necessarily to you.		
4.6	Did you see or hear a parent or household member in your home being yelled at, screamed at, sworn at, insulted or humiliated?	Many times
		A few times
		Once
		Never
		Don't want to answer
4.7	Did you see or hear a parent or household member in your home	Many times

	being slapped, kicked, punched or beaten up?	A few times
		Once
		Never
		Don't want to answer
4.8	Did you see or hear a parent or household member in your home being hit or cut with an object, such as a stick (or cane), bottle, club, knife, whip etc.?	Many times
		A few times
		Once
		Never
		Don't want to answer
These next questions are about certain things YOU may have experienced. When you were growing up, during the first 18 years of your life . . .		
5.1	Did a parent, guardian or other household member yell, scream or swear at you, insult or humiliate you?	Many times
		A few times
		Once
		Never
		Don't want to answer
5.2	Did a parent, guardian or other household member threaten to, or actually, abandon you or throw you out of the house?	Many times
		A few times
		Once
		Never
		Don't want to answer
5.3	Did a parent, guardian or other household member spank, slap, kick, punch or beat you up?	Many times
		A few times
		Once

		Never
		Don't want to answer
5.4	Did a parent, guardian or other household member hit or cut you with an object, such as a stick (or cane), bottle, club, knife, whip etc.?	Many times
		A few times
		Once
		Never
		Don't want to answer
5.5	Did someone touch or fondle you in a sexual way when you did not want them to?	Many times
		A few times
		Once
		Never
		Don't want to answer
5.6	Did someone make you touch their body in a sexual way when you did not want them to?	Many times
		A few times
		Once
		Never
		Don't want to answer
5.7	Did someone attempt oral, anal, or vaginal intercourse with you when you did not want them to?	Many times
		A few times
		Once
		Never
		Don't want to answer
5.8	Did someone actually have oral, anal, or vaginal intercourse with you when you did not want them to?	Many times
		A few times
		Once

		Never
		Don't want to answer
17. PEER VIOLENCE		
These next questions are about BEING BULLIED when you were growing up. Bullying is when a young person or group of young people say or do bad and unpleasant things to another young person. It is also bullying when a young person is teased a lot in an unpleasant way or when a young person is left out of things on purpose. It is not bullying when two young people of about the same strength or power argue or fight or when teasing is done in a friendly and fun way.		
When you were growing up, during the first 18 years of your life . . .		
6.1	How often were you bullied?	Many times
		A few times
		Once
		Never
		Don't want to answer
6.2	How were you bullied most often?	I was hit, kicked, pushed, shoved around, or locked indoors
		I was made fun of because of my race, nationality or color
		I was made fun of because of my religion
		I was made fun of with sexual jokes, comments, or gestures
		I was left out of activities on purpose or completely ignored

		I was made fun of because of how my body or face looked
		I was bullied in some other way
		Don't want to answer
This next question is about PHYSICAL FIGHTS. A physical fight occurs when two young people of about the same strength or power choose to fight each other.		
When you were growing up, during the first 18 years of your life . . .		
6.3	How often were you in a physical fight?	Many times
		A few times
		Once
		Never
		Don't want to answer
18. WITNESSING COMMUNITY VIOLENCE		
These next questions are about how often, when you were a child, YOU may have seen or heard certain things in your NEIGHBOURHOOD OR COMMUNITY (not in your home or on TV, movies, or the radio).		
When you were growing up, during the first 18 years of your life . . .		
7.1	Did you see or hear someone being beaten up in real life?	Many times
		A few times
		Once
		Never
		Don't want to answer
7.2	Did you see or hear someone being stabbed or shot in real life?	Many times
		A few times

		Once
		Never
		Don't want to answer
7.3	Did you see or hear someone being threatened with a knife or gun in real life?	Many times
		A few times
		Once
		Never
		Don't want to answer
19. EXPOSURE TO WAR/COLLECTIVE VIOLENCE		
These questions are about whether YOU did or did not experience any of the following events when you were a child. The events are all to do with collective violence, including wars, terrorism, political or ethnic conflicts, genocide, repression, disappearances, torture and organized violent crime such as banditry and gang warfare.		
When you were growing up, during the first 18 years of your life . . .		
8.1	Were you forced to go and live in another place due to any of these events?	Many times
		A few times
		Once
		Never
		Don't want to answer
8.2	Did you experience the deliberate destruction of your home due to any of these events?	Many times
		A few times
		Once
		Never
		Don't want to answer
8.3	Were you beaten up by soldiers, police, militia, or gangs?	Many times
		A few times

		Once
		Never
		Don’t want to answer
8.4	Was a family member or friend killed or beaten up by soldiers, police, militia, or gangs?	Many times
		A few times
		Once
		Never
		Don’t want to answer

APPENDEX: B

አዲስ አበባ ዩኒቨርሲቲ

የድህረ ምረቃ መርሀ ግብር የሳይኮሎጂ ትምህርት ክፍል

ለጥናቱ ተሳታፊዎች የመረጃ ቅጽ

ይህ ዳሰሳ/ጥናት በአዲስ አበባ ዩኒቨርስቲ የካውንስሊንግ ሳይኮሎጂ ማስተርስ ዲግሪ ለማሙላት የሚደረግ ጥናት ሲሆን ስለ አስከፊ የልጅነት አጋጣሚዎች ከአዕምሮ ጤና ጋር ስላላቸው ግንኙነት በእርቅ መዕድ ሚድያ እና ሥነ-ልቦና አገልግሎት ኃላ.የተ.ግ.ማ እንደ ኢ.አ 2025 የጎበኙ ደንበኞች ዙርያ ላይ ነው፡፡

በዚህ ዳሰሳ/ጥናት ላይ የሚያቀርቡት እያንዳንዱ መረጃ ሙሉ በሙሉ ሚስጥራዊ ሆኖ ለአካዳሚክ ምርምር ዓላማ ብቻ ጥቅም ላይ ይውላል። በዚህ ጥናት ላይ ለሚያደርጉት ተሳትፎዎን ከልብ አመስግናለው፡፡ በዚህ ጥናት ላይ እንዲሳተፉ የሚያስፈልግዎ መረጃ በሙሉ እዚህ የመረጃ ወረቀት ላይ ያገኛሉ፡፡ በዚህ ጥናት ለመሳተፍ ምንም አይነት ግዴታ የለብዎትም ያለመሳትፍ መብት ያለዎት ሲሆን ባለመሳተፍዎ ምንም አይነት ቅጣት አይደርስብዎትም ወይም የሚያጡት ነገር አይኖርም፡፡

የጥናቱ ዓላማ: ይህ ጥናት አስከፊ የልጅነት ገጠመኞች ከአእምሮ ጤና ጋር ስላላቸው ግንኙነት በእርቅ መዕድ ሚድያ እና ሥነ-ልቦና አገልግሎት ኃላ.የተ.ግ.ማ እንደ ኢ.አ 2025 የጎበኙ ደንበኞች ዙርያ ነው ፡፡ ከዚህ ጥናት በሚገኘው ውጤት ላይ በመመስረት የአእምሮ ጤና ለማሻሻል ፖሊሲዎችን ለመቅረፅና ሌሎች ተጨማሪ ጥናቶችን ለማድረግ እንደ መነሻ እንደሚሆን እናስባለን፡፡

የጥናቱ ሂደት:ይህ ዳሰሳ/ጥናት ሦስት ክፍሎች ያሉት ሲሆን በውስጡም 66 ጥያቄዎችን አካቷል፡፡ መጠይቁን ሞልቶ ለመጨረስ ቢበዛ 30 ደቂቃ ቢወስድ ነው፡፡

በጥናቱ ላይ በመሳተፍዎ ሊከሰትብዎ የሚችሉ ስጋቶች: የአንዳንዶቹ ጥያቄዎች ይዘት ግላዊ ታሪክን የሚነካና ሚስጥራዊነት ያለው ስለሆነ ትንሽ መረበሽ ሊሰማዎት ይችላል፡፡ በጣም ከተረበሹና መቀጠል የሚችሉ ካልመሰልዎት ግን በማኝኛውም ሰዓት ማቋረጥ ይችላሉ፡፡ እርዳታም ካስፈለግዎ ጥናቱን የሚያካሂደውን ባለሙያ ወይም ቢሮ ውስጥ የሚያገኙትን ሰው ማዋራት ይችላሉ፡፡

በጥናቱ ላይ ያለዎትን ተሳትፎ ሚስጥራዊነት በተመለከተ: የሚሰጡንን መረጃ ሚስጥራዊነት ለመጠበቅ ስለ እርሶ የሚገልፅ ማንኛውንም ዓይነት መረጃ እንዲሞሉ ስለማይደረግ የሚሰጡን መረጃ በሙሉ ከእርሶ እንደመጣ ሊታወቅ አይችልም፡፡ የዚህ ጥናት ውጤት በተለያዩ ሳይንሳዊ ስብሰባዎች ላይ ቢቀርቡ ወይም ድህረ ገፆች ላይ ቢወጡ የእርሶ ማንነት በምንም ሁኔታ አይገለፅም፡፡

ስለ ተሳትፎዎ እና ለስጡን ጊዜዎ ከልብ አመሰግናሁ፡፡

የጥናቱ ተመራማሪ ስም: ቤተልሔም በቀለ

ሰልክ: 0913-281577

ኢሜል: betibeke89@gmail.*com*

ከፍል 1፡ የተሳታፊዎች አጠቃላይ መረጃ

ከዚህ በታች የተዘረዘሩት ጥያቄዎች የተሳታፊዎች አጠቃላይ መረጃ የሚወክሉ ሲሆኑ ምርጫውን በምክበብ ዳሽ ሙላውን ደግሞ በመሙላት መልሱ፡፡

I. የግል አጠቃላይ መረጃ

10. ፆታ ሀ) ሴት ለ) ወንድ

11. እድሜ (እድሜዎት ስንት ነው?)

ሀ) 18-25 ለ) 25-30 ሐ) 31-35 መ) 36-40 ሠ) 41 እና ከዚያ በላይ

12. የትምርት ደረጃ

ሀ) ማንበብ መፃፍ የማይቻል ለ) የመጀመርያ ደረጃ ያጠናቀቀ ሐ) ሁለተኛ ደረጃ ያጠናቀቀ መ) የመጀመርያ ዲግሪ ሠ) ሁለተኛ ዲግሪ እና ከዚያ በላይ

13. የጋብቻ ሁኔታ

ሀ) ያላገባ ለ) ያገባ ሐ) ትዳሩን የፈታ መ) ባል/ሚስት በህይወት የሉም

14. የስራ ሁኔታ

ሀ) የግል ሰራተኛ ለ) የመንግስት ሰራተኛ ሐ) ስራ የሌለው

15. በአሁኑ ጊዜ የሚኖሩበት ቦታ ………………………………

II. የቤተሰብ አጠቃላይ መረጃ

16. የወላጆችዎ ያሉበት ሁኔታ

ሀ) ሁለቱም በህይወት አሉ በትዳር አብረው እየኖሩ ነው ለ) ሁለቱም በህይወት አሉ ግን ተፋተዋለ ሐ) አንዳቸው ብቻ ናቸው በህይወት ያሉት መ) ሁለቱም በህይወት የሉም

17. ጥገኞች

ሀ) የልጆዎ ብዛት………………………………

ለ) የትዳር አጋርዎ ለቤተሰብ ገቢ አስተዋጽ ያደርጋሉ (አዎ፣አይ፣በጥቂቱ)

ሐ) እናት ና አባትህ ትረዳለህ (አዎ፣አይ፣በጥቂቱ)

III. ወደዚህ ተቋም ያመጣዎት ጉዳይ

18. መፍትሄ ፈልጌ ወደዚህ የመጣሁባቸው ችግሮች ……………………………...

……

……………………………………………………………………………………

ክፍል 2: - የድባቴ፣ጭንቀት ና የውጥረት መለኪያ

ከዚህ በታች የተዘረዘሩት ጥያቄዎችን አንብብና ቁጥር 0፣ 1፣ 2 ወይም 3 አክብብ ፡፡ በእነዚህ ችግሮች

ባለፈው ሳምንት ውስጥ ምን ያህል ጊዜ ተረብሸዎል። ትክክለኛ ወይም የተሳሳቱ መልሶች የሉም፡፡ ብዙ ሳይጨነቁ ይመልሷቸው፡፡

ተ.ቁ	ጥያቄዎች	በእኔ ላይ ተከስቶ አያዉቅም (0)	በእኔ ላይ በተወሰነ ደረጃ ወይም አልፎአልፎ ተከስቷል (1)	በእኔ ላይ ብዙ ጊዜ ተከስቷል (2)	በእኔ ላይ በጣም ብዙ ጊዜ ተከስቱዋል (3)
1 (s)	መረጋጋት (ሰከን) ማለት አቅቶኝ ነበር	0	1	2	3
2 (a)	አፌ ሲደርቅ ይታወቀኝ ነበር	0	1	2	3
3 (d)	ምንም አይነት ጥሩ ስሜት አይሰማኝም ነበር	0	1	2	3
4 (a)	ለመተንፈስ እቸገር ነበር (ለምሳሌ:- የትንፋሽ ቁርጥቁርጥ ማለት፤ ምንም ሳልሰራ ትንፋሽ ያጥረኝል)	0	1	2	3
5 (d)	ከልቤ ሆኜ ነገሮችን ለማከናወን እቸገር ነበር	0	1	2	3
6 (s)	ለነገሮች ሁሉ ስሜታዊ ሆኜ መልስ የመስጠት አዝማሚያ ይታይብኝ ነበር	0	1	2	3
7 (a)	እጆቼ ይንቀጠቀጡ ነበር	0	1	2	3
8 (s)	አዕምሮዬ ሲወጣጠር ይታወቀኝ ነበር	0	1	2	3
9 (a)	በሁኔታዎች ከፍተኛ ጭንቀት ዉስጥ ከመግባቴ የተነሳ የሰው መሳቂያ መሳልቂያ እንዳልሆን እሰጋ ነበር	0	1	2	3
10 (d)	ተስፋ የማደርገዉ ወይም በጉጉት የምጠብቀዉ ነገር አልነበረም	0	1	2	3
11 (s)	ተሸብሬ እና መረጋጋት አቅቶኝ ነበር	0	1	2	3
12 (s)	ዘና ለማለት ይከብድኝ ነበር	0	1	2	3
13 (d)	አዝኜ እና ደብሮኝ ነበር	0	1	2	3
14 (s)	ስራዬን እየሰራሁ እያለሁ እንዳልቀጥል የሚያሰናክለኝን ሰዉ ወይም ማንኛዉንም ነገር መታገስ አልችልም ነበር	0	1	2	3
15 (a)	ከፍተኛ ፍርሃት ተሰምቶኝ ነበር	0	1	2	3
16 (d)	ለምንም ነገር ጉጉት አልነበረኝም	0	1	2	3
17 (d)	ከንቱ ሰዉ (እርባናቢስ) የሆንኩ ያህል ተሰምቶኝ ነበር	0	1	2	3
18 (s)	በቀላሉ በስጨት ወይም ቆጣ እል ነበር	0	1	2	3

19 (a)	ያለምንም ስራ የልቤ ምት ከፍ እና ዝቅ ሲል ይታወቀኝ ነበር	0	1	2	3
20 (a)	ያለ ምንም ምክኒያት ሰዉነቴ ድንግጥ ድንግጥ ይል ነበር	0	1	2	3
21 (d)	ሕይወት ትርጉም የለሽ እንደሆነች ተሰምቶኝ ነበር	0	1	2	3

ክፍል 3: - አስከፊ የልጅነት አጋጣሚዎች

ከዚህ በታች ለተዘረዘሩት ጥያቄዎችን ስለማይረሱ አስከፊ የልጅነት አጋጣሚዎች ናቸው እና እንዴት እነድተቋቋምዋቸው በክፍት ቦታዎቹ ላይ ይፃፉዋቸው።

5. በልጅነት ጊዜዎ ምን የማይረሳ አስከፊ የልጅነት አጋጣሚ አጋጥመውዎታል?

………

………

……………………………………………………………………………

6. ይህ አስከፊ የልጅነት አጋጣሚ ቀሪ ህይወትዎ ላይ ምን አይነት ተፅእኖ አሳድሯል?

………

………

……………………………………………………………………………

7. እንዴትስ ተቋቋምዋቸው?

………

………

……………………………………………………………………………

8. ስለ እነዚህ ጉዳዮች ሲያስቡ አሁን ላይ ምን ይሰማዎታል?

………

………

……………………………………………………………………………

ከዚህ በታች የተዘረዘሩት ጥያቄዎች የ“X” ምልክት ከትክክለኛው መልስዎ በኋላ ያስቀምጡ፡፡

<table>
<tr><th colspan="3">2. ከወላጆች ወይም ከአሳዳጊዎች ጋር ያለ ግንኙነት</th></tr>
<tr><td colspan="3">በህይወቶት የመጀመሪያዎቹ 18 አመታት ውስጥ፡-</td></tr>
<tr><td rowspan="6">2.1</td><td rowspan="6">ወላጆችዎት ወይም አሳዳጊዎት ችግሮትን እና ጭንቀቶን ይረዱ ነበር?</td><td>ሁልጊዜ</td></tr>
<tr><td>አብዛኛውን ጊዜ</td></tr>
<tr><td>አንዳንድ ጊዜ</td></tr>
<tr><td>አልፎ አልፎ</td></tr>
<tr><td>በፍጹም</td></tr>
<tr><td>መመለስ አልፈልግም</td></tr>
<tr><td rowspan="6">2.2</td><td rowspan="6">በትርፍ ጊዜዎት፥ ትምህርት ቤት ወይም ስራ ላይ ባልሆኑበት ጊዜ፥ ወላጆችዎት ወይም አሳዳጊዎችዎት ስለሚያደርጓቸው ነገሮች በሚገባ ያውቁ ነበር?</td><td>ሁልጊዜ</td></tr>
<tr><td>አብዛኛውን ጊዜ</td></tr>
<tr><td>አንዳንድ ጊዜ</td></tr>
<tr><td>አልፎ አልፎ</td></tr>
<tr><td>በፍጹም</td></tr>
<tr><td>መመለስ አልፈልግም</td></tr>
<tr><td rowspan="5">3.1</td><td rowspan="5">ወላጆችዎት ወይም አሳዳጊዎቾት በቀላሉ ማድረግ እየቻሉ በቂ ምግብ ያልሰጥዎት ጊዜ አለ?</td><td>ብዙ ጊዜ</td></tr>
<tr><td>ጥቂት ጊዜ</td></tr>
<tr><td>አንዴ</td></tr>
<tr><td>በፍጹም</td></tr>
<tr><td>መመለስ አልፈልግም</td></tr>
<tr><td rowspan="5">3.2</td><td rowspan="5">ወላጆችዎት ወይም አሳዳጊዎችዎት እርሶን መንከባበከብ አስከማይችሉ ድረስ ጠጥተው ወይም በሌሎች እጾች ተጽእኖ ሥር ሆነው ያውቃሉ?</td><td>ብዙ ጊዜ</td></tr>
<tr><td>ጥቂት ጊዜ</td></tr>
<tr><td>አንዴ</td></tr>
<tr><td>በፍጹም</td></tr>
<tr><td>መመለስ አልፈልግም</td></tr>
<tr><td rowspan="5">3.3</td><td rowspan="5">ወላጆችዎት ወይም አሳዳጊዎችዎት አቅሙ እያላቸው እርሶንወደ ትምህርት ቤት ያላኩበት ጊዜ አለ?</td><td>ብዙ ጊዜ</td></tr>
<tr><td>ጥቂት ጊዜ</td></tr>
<tr><td>አንዴ</td></tr>
<tr><td>በፍጹም</td></tr>
<tr><td>መመለስ አልፈልግም</td></tr>
</table>

4. የቤተሰብ ሁኔታ		
በህይወቶት የመጀመሪያዎቹ 18 አመታት ውስጥ፡-		
4.1	የመጠጥ ሱስ ያለበት፣ አደንዛዥ እጽ የሚጠቀም ወይም በሃኪም ትእዛዝ ብቻ የሚገኙ ሱስ የሚያስይዙ መድሃኒቶችን ያለአግባብ የሚጠቀም የቤተሰብ አባል ባለበት ቤት ውስጥ ኖረው ያውቃሉ?	አዎ አይ መመለስ አልፈልግም
4.2	በቤቶት ውስጥ ድብታ ያለበት፣ የአዕምሮ ህመም ያለበት ወይም ራሱን ለማጥፋት ሙከራ ካደረገ የቤተሰብ አባል ጋር ኖረው ያውቃሉ?	አዎ አይ መመለስ አልፈልግም
4.3	ማረሚያ ቤት ወይም እስር ቤት ገብቶ የሚያውቅ ቤተሰብ አባል ያለበት ቤት ውስጥ ኖረው ያውቃሉ?	አዎ አይ መመለስ አልፈልግም
4.4	ወላጆችት ተለያይተው ወይ ተፋተው ነበር?	አዎ አይ መመለስ አልፈልግም
4.5	እናቶት፣ አባቶት ወይም አሳዳጊዎት ሞተዋል?	አዎ አይ መመለስ አልፈልግም
የሚቀጥሉት ጥያቄዎች የሚመለከቱት በቤቶት ውስጥ ስላይዋቸው ወይም ስለሰሟቸው አንዳንድ ነገሮች ነው፡፡ **እነዚህ ክስተቶች በእርሶ ላይ ሳይሆን በሌሎች የቤተሰብ አባላት ላይ ተፈፅመው ሊያውቁ የሚችሉ ነገሮች ናቸው፡፡**		
4.6	ወላጆት ወይም ማንኛውም የቤተሰብ አባል ኃይለኛ ቁጣ ሲደርስባቸው ፣ ሲጮህባቸው ፣ ሲዛትባቸው ፣ ሲሰደቡ ወይም ሲዋረዱ አይተው ወይም ሰምተው ያውቃሉ?	ብዙ ጊዜ ጥቂት ጊዜ አንዴ በፍጹም መመለስ አልፈልግም
4.7	በቤቶት ውስጥ ወላጅ ወይም የቤተሰብ አባል በጥፊ፣ በእርግጫ ወይም በቡጢ ሲመቱ ወይም ሲደበደቡ አይተው ያውቃሉ?	ብዙ ጊዜ ጥቂት ጊዜ አንዴ በፍጹም መመለስ አልፈልግም
4.8	በቤቶት ውስጥ ወላጅ ወይም የቤተሰብ አባል ሲፈነከት፣ በስለት ሲጎዳ ወይም በእንጨት፣ በጠርሙስ፣ በቢላ፣ በአለንጋ ወይም በመሳሰሉት ሲመታ አይተው ያውቃሉ?	ብዙ ጊዜ ጥቂት ጊዜ አንዴ በፍጹም

		መመለስ አልፈልግም
5. የሚቀጥሉት ጥያቄዎች እርሶ ላይ የደረሱ አንዳንድ ክስተቶችን ይመለከታል፡፡		
5.1	ወላጅ፥ አሳዳጊ ወይም ሌላ የቤተሰብ አባል ጮሆቦት፣ ዝቶቦት፣ ሰድቦት ወይም አዋርዶት ያውቃል?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
5.2	ወላጅ፥ አሳዳጊ ወይም ሌላ የቤተሰብ አባል ጥለዎት እንደሚሄዱ ዝተው፥ ጥለዎት ሄደው ወይም ከቤት አባርዎት ያውቃል?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
5.3	ወላጅ፣ አሳዳጊ ወይም ሌላ የቤተሰብ አባል ገርፎት በጥፊ፣ በእርግጫ ወይም በቡጢ መቶት ወይም ደብድቦህት ያውቃል?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
5.4	ወላጅ፣ አሳዳጊ ወይም ሌላ የቤተሰብ አባል በእቃ መትዎት ወይም በስለት ወግቶት ያውቃል? ለምሳሌ በከዘራ፣ በጠርሙስ፣ በእንጨት፣ በቢላዋ፣ በአለንጋ ወ.ዘ.ተ	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
5.5	ያለ ፍላጎቶ ወሲባዊ በሆነ መንገድ ተነክተው ወይም ተዳብሰው ያውቃሉ?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
5.6	ያለፍላጎቶ ሰዎች ወሲባዊ በሆነ መንገድ ሰውነታቸውን አስነክተዎት ያውቃሉ?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
5.7	ያለፍላጎቶ በአፍ፣ በፊንጢጣ ወይም በማህፀን ወሲባዊ ግንኙነት ለመፈጸም ሙከራ ተደርጎቦት	ብዙ ጊዜ
		ጥቂት ጊዜ

	ያውቃል?	አንዴ
		በፍጹም
		መመለስ አልፈልግም
5.8	ሰዎች ያለፍላጎቶ በአፍ፣ በፊንጢጣ ወይም በማህፀን ወሲባዊ ግንኙነት ፈፅመውቦት ያውቃሉ?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም

‹

6. በዕድሜ አቻ የሚደርስ ጥቃት		
የሚቀጥሉት ጥያቄዎች ልጅ እያሉ የጉልበተኛ ጥቃት (ማሸማቀቅ) ደርሶቦት እንደሆነ የሚጠይቁ ይሆናሉ። የጉልበተኛ ጥቃት ማለት ልጆች በተናጠል ወይም በቡድን በመሆን በሌላ ልጅ ላይ መጥፎ የሆነ እና ደስ የማይል ነገር ሲፈፅሙ አልያም ሲናገሩ ማለት ነው። ልጆች በጣም ደስ በማይል ሁኔታ የሚበሸቁ ከሆነ ወይም ሆን ተብሎ ከነገሮች ተሳትፎ እንዳይኖራቸው የሚገለሉ ከሆነ ይህም እንደ ጉልበተኛ ጥቃት ይቆጠራል። ነገር ግን ሁለት በጉልበት እና በአቅም እኩያ የሆኑ ልጆች እርስ በርስ ቢጨቃጨቁ ወይም ቢጣሉ እንዲሁም እንደቀልድ ቢበሻሽቁ እንደ ጉልበተኛ ጥቃት አይቆጠርም		
በህይወቶት የመጀመሪያዎቹ 18 አመታት ውስጥ፡-		
6.1	ይህን መሰል (የማሸማቀቅ) ድርጊት ምን ያህል ጊዜ ደርሶቦታል?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
6.2	አብዛኛውን ጊዜ ይህ ድርጊት የደረሰቦት በምን አይነት መንገድ ነው?	ተመትቼ፣ ተደብድቤ፣ ተገፍትሬ፣ ተጎትቼ ወይም ተቆልፎብኝ ያውቃል፡፡
		በዘሬ፣ በብሔሬ ወይም በቆዳ ቀለሜ ተቀልዶብኝ ያውቃል፡፡
		በሐይማኖቴ ተቀልዶብኝ ያውቃል፡፡
		ጾታዊ የሆኑ ቀልዶች፣ አስተያየቶች ወይም ምልክቶች ተሰጥተውኝ ያውቃል
		ሆን ተብሎ ከአንዳንድ ተግባራት እንዳልሳተፍ ተደርጎ ወይም ቸል ተብዬ አውቃልሁ፡፡
		በሰውነቴ ወይም በመልኬ ተቀልዶብኝ ያውቃል፡፡
		በሌላ መንገድ ይህ ድርጊት ደርሶብኝ

		ያውቃል::
		መመለስ አልፈልግም::
ቀጥሎ የሚገኘው ጥያቄ ስለ ድብድብ ነው:: ድብድብ የምንለው እኩል አቅምና ኃይል ያላቸው ሁለት ወጣት ልጆች የሚያደርጉት አካላዊ ጸብ ነው::		
በህይወቶት የመጀመሪያዎቹ 18 አመታት ውስጥ፡-		
6.3	በአካላዊ ጸብ ውስጥ ምን ያህል ተሳትፈዋል	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
7. ለጦርነት ወይም ለቡድን ጥቃት ተጋላጭነት		
እነዚህ ጥያቄዎች በልጅነቶ የሚከተሉት ክስተቶች በእርሶ ላይ መድረስ አለመድረሳቸውን የሚጠይቁ ናቸው:: ክስተቶቹም የቡድን ጥቃት፣ ጦርነት፣ ሽብርተኝነት፣ ፖለቲካዊ ወይም የጎሳ ግጭት፣ የዘር ጭፍጨፋ፣ ጭቆና፣ አፈና፣ ማሰቃየት እና የተቀናጀ የጥቃት ወንጀል ለምሳሌ ውንብድና እና የቡድን ጦርነት የሚመለከቱ ናቸው::		
በህይወቶት የመጀመሪያዎቹ 18 አመታት ውስጥ፡-		
7.1	ሰው ሲደበደብ አይተው ወይም ሰምተው ያውቃሉ??	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
7.2	ሰው በስለት ሲወጋ ወይም በሽጉጥ ሲመታ አይተው ያውቃሉ?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
7.3	ሰው በስለት ወይም በሽጉጥ ዛቻ ሲደርስበት አይተው ወይም ሰምተው ያውቃሉ?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
8. ለጦርነት ወይም ለቡድን ጥቃት ተጋላጭነት		

እነዚህ ጥያቄዎች በልጅነቶ የሚከተሉት ክስተቶች በእርሶ ላይ መድረስ አለመድረሳቸውን የሚጠይቁ ናቸው፡፡ ክስተቶቹም የቡድን ጥቃት፣ ጦርነት፣ ሽብርተኝነት፣ ፖለቲካዊ ወይም የጎሳ ግጭት፣ የዘር ጭፍጨፋ፣ ጭቆና፣ አፈና፣ ማሰቃየት እና የተቀናጀ የጥቃት ወንጀል ለምሳሌ ውንብድና እና የቡድን ጦርነት የሚመለከቱ ናቸው፡፡ **በህይወቶት የመጀመሪያዎቹ 18 አመታት ውስጥ፡-**		
8.1	ከላይ በተዘረዘሩት ክስተቶች በአንዱ ምክንያት ወደሌላ ቦታ ሄዶ ለመኖር ተገደው ያውቃሉ?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
8.2	ከላይ በተዘረዘሩት ክስተቶች በአንዱ ምክንያት መኖሪያ ቤትዎ ወድሞ ያውቃል?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
8.3	በወታደሮች፣ በፖሊስ፣ በልዩ ኃይል ወይም በወንበዴዎች ተደብድበው ያውቃሉ?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም
8.4	የቤተሰብ አባል ወይ ጓደኛዎት በወታደሮች፣ በፖሊስ፣ በልዩ ኃይል ወይም በወንበዴዎች ተደብድቦ ወይም ተገድሎ ያውቃል?	ብዙ ጊዜ
		ጥቂት ጊዜ
		አንዴ
		በፍጹም
		መመለስ አልፈልግም