MEKELLE UNIVERSITY

COLLEGE OF HEALTH SCIENCES

FACULTY OF NURSING AND MIDWIFERY

DEPARTMENT OF PSYCHIATRY

PREVALENCE AND ASSOCIATED FACTORS OF VIOLENT VICTIMIZATION AMONG ADULTS WITH SEVERE MENTAL ILLNESS RECEIVING FOLLOW-UP CARE AT PUBLIC HOSPITALS IN MEKELLE CITY, MEKELLE, TIGRAY, ETHIOPIA, 2025

PRINCIPAL INVESTIGATOR: GOITEOM ADISU GOLA

A RESEARCH THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY, FACULTY OF NURSING AND MIDWIFERY, COLLEGE OF HEALTH SCIENCES, MEKELLE UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTERS SCIENCE IN INTEGRATED CLINICAL AND COMMUNITY MENTAL HEALTH

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This is to certify that the thesis entitled **"**PREVALENCE AND ASSOCIATED FACTORS OF VIOLENT VICTIMIZATION AMONG ADULTS WITH SEVEREMENTAL ILLNESS RECEIVING FOLLOW-UP CARE AT PUBLIC HOSPITALS IN MEKELLE CITY, MEKELLE, TIGRAY, ETHIOPIA, 2025**"** is submitted to the Department of Psychiatry, College of Health Sciences, Mekelle University. The student has fulfilled the research requirements for the degree of Master in Integrated Clinical and Community Mental Health. Therefore, he is authorized to submit the proposal to the Department of Psychiatry.

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Mekelle University
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Examiners' Approval Sheet

We, the undersigned members of the Board of Examiners, have reviewed and assessed the thesis titled " PREVALENCE AND ASSOCIATED FACTORS OF VIOLENT VICTIMIZATION AMONG ADULTS WITH SEVERE MENTAL ILLNESS RECEIVING FOLLOW-UP CARE AT PUBLIC HOSPITALS IN MEKELLE CITY, MEKELLE, TIGRAY, ETHIOPIA, 2025." presented by Goiteom Adisu Gola during the final open thesis defense. We certify that the thesis has been accepted as part of the requirements for the Master's Degree in Integrated Clinical and Community Mental Health.

Name of Chairperson	Signature	Date
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Final approval and acceptance of the thesis are dependent on the submission of the final copy to the candidate's Department through the office of the Department Graduate Program Coordinator.

The thesis approved by

Graduate Program Coordinator.	Signature	Date

I hereby certify that all the corrections and recommendations suggested by the Board of Examiners are incorporated into the final thesis entitled "PREVALENCE AND ASSOCIATED FACTORS OF VIOLENT VICTIMIZATION AMONG ADULTS WITH SEVERE MENTAL ILLNESS RECEIVING FOLLOW-UP CARE AT PUBLIC HOSPITALS IN MEKELLE CITY, MEKELLE, TIGRAY, ETHIOPIA, 2025" by Goiteom Adisu Gola.

Department Head	Signature	Date

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ABBREVIATIONS AND ACRONYMS

ACSH - Ayder Comprehensive Specialized Hospital

AOR - Adjusted Odds Ratio

BPD- Borderline personality disorder

CI - Confidence Interval

COR- Crude Odds Ratio

ETB - Ethiopian Birr

GAD- Generalized anxiety disorder

ICCMH - Integrated Clinical and Community Mental Health

ICVS - International Crime Victim Survey

LMIC - Low and Middle Income Countries

MGH - Mekelle General Hospital

MUCHS - Mekelle University, College of Health Sciences

OR - Odds Ratio

PTSD- Post traumatic stress disorder

SMI - Severe Mental Illness

SPSS - Statistical Package for Social Science

UK - United Kingdom

USA - United States of America

VV - Violent Victimization

WHO - World Health Organization

Abstract

Background: Adults with severe mental illness are at increased risk of violent victimization, including physical assault, sexual violence, robbery, and threats with a weapon. These experiences can worsen psychiatric outcomes and reduce quality of life. Despite this, evidence in Ethiopia remains limited.

Objective: To assess the prevalence and associated factors of violent victimization among adults with SMI receiving follow-up care at public hospitals in Mekelle City, Tigray, Ethiopia, 2025.

Methods: An institution-based cross-sectional study was conducted among 300 adults with SMI from September 15 to October 15, 2025. A multistage sampling technique followed by systematic random sampling was used. Data were collected using an adapted and pretested International Crime Victim Survey (ICVS) questionnaire. Data were entered and analyzed using SPSS version 27. Multivariate logistic regression analysis was performed to identify factors associated with violent victimization, with statistical significance set at $p < 0.05$.

Results: The lifetime prevalence of violent victimization was 62.7% (95% CI: 56.9%–68.2%), indicating a high burden among adults with SMI. Male sex (AOR = 4.39, 95% CI: 2.08–9.27), single marital status (AOR = 5.83, 95% CI: 1.97–17.29), low educational status (AOR = 4.77, 95% CI: 1.51–15.01), and history of suicidal behavior (AOR = 6.66, 95% CI: 2.47–17.98) were significantly associated with violent victimization.

Conclusion: Violent victimization is highly prevalent among adults with SMI in this setting. Key socio-demographic and clinical factors significantly increase vulnerability. Integrating routine screening, strengthening psychosocial support, and enhancing legal protection mechanisms are essential to reduce victimization in this population.

Keywords: Violent victimization, severe mental illness, suicidal behavior, Mekelle, Ethiopia

1 Introduction

1.1 Background

Violent victimization refers to experiences of physical assault, sexual violence, robbery, threats with a weapon, or other forms of coercive force directed toward an individual, often resulting in significant physical and psychological harm. It is increasingly recognized as a major public health concern, particularly among vulnerable populations such as individuals living with severe mental illness. Severe mental illness—including schizophrenia spectrum disorders, bipolar I disorder, and major depressive disorder with psychotic feature —is often associated with functional impairment, social disadvantage, and increased exposure to unsafe environments, all of which may elevate the risk of victimization(1).

Globally, individuals with SMI face a markedly higher risk of violent victimization compared to the general population, with evidence suggesting they are approximately three to eleven times more likely to experience violence(2).

Studies conducted in high-income countries report prevalence rates ranging from 20% to over 60%, depending on methodological differences such as study design and recall period. Systematic reviews and meta-analyses consistently demonstrate elevated exposure to violence among people with mental disorders and other disabilities(3).

Recent studies further confirm that this disparity persists despite improvements in mental health services. Beyond its high prevalence, violent victimization among individuals with SMI has profound clinical and public health implications. Exposure to violence is associated with physical injury, worsening psychiatric symptoms, increased substance use, and a higher risk of suicidal behavior. It also contributes to poor treatment adherence, frequent relapse, and increased hospitalization, thereby undermining the effectiveness of mental health interventions(4, 5).

Recent evidence further highlights that victimization is strongly associated with increased mortality and long-term disability among individuals with mental disorders. At a broader level, it imposes a substantial burden on healthcare systems through increased service utilization and long-term disability, while also contributing to social exclusion and reduced quality of life(4).

The risk of violent victimization among individuals with SMI is shaped by a complex interplay of clinical, social, and economic factors. Clinical factors such as symptom severity, impaired judgment, and comorbid substance use increase vulnerability. Social determinants—including

stigma, discrimination, and social isolation—further exacerbate risk by limiting access to protective relationships and support systems. Additionally, socioeconomic disadvantage, including low educational attainment, unemployment, and poverty, has been consistently identified as a key predictor of victimization(6).

Social determinants, including stigma, discrimination, and social isolation, further exacerbate risk by limiting access to protective relationships and support systems. Socioeconomic disadvantage—manifested through low educational attainment, unemployment, and poverty—has also been consistently identified as a key predictor of victimization(7,8).

Recent studies emphasize that these factors interact cumulatively, with individuals exposed to multiple vulnerabilities facing substantially higher risks of repeated victimization(5,9).

Importantly, emerging evidence suggests that victimization is not only a consequence of vulnerability but also a factor that worsens mental health outcomes, creating a cyclical relationship. Individuals who experience violence are more likely to develop severe psychiatric symptoms, engage in risky behaviors, and experience suicidal ideation or attempts. Recent longitudinal studies have demonstrated that prior victimization significantly predicts subsequent psychiatric deterioration and suicidal behavior, reinforcing the bidirectional relationship between violence and mental illness(4,9).

Importantly, emerging evidence suggests that victimization is not only a consequence of vulnerability but also a contributing factor to worsening mental health outcomes, creating a cyclical relationship. Individuals exposed to violence are more likely to experience severe psychiatric symptoms, engage in risky behaviors, and develop suicidal ideation or attempts(4,9).

Despite substantial global evidence, most studies have been conducted in high-income countries, limiting the generalizability of findings to low- and middle-income countries (LMICs). In these settings, structural challenges such as poverty, weak legal protection systems, limited mental health services, and pervasive stigma may further increase the risk of victimization. In Ethiopia, mental health services remain underdeveloped, and individuals with SMI frequently face social exclusion, economic hardship, and inadequate protection from violence(10).

In sub-Saharan Africa, and particularly in Ethiopia, mental health services remain underdeveloped and insufficient to meet population needs. Although national policies promote the integration of mental health into primary healthcare, implementation remains inconsistent,

and community-based support systems are limited. As a result, individuals with SMI frequently face social exclusion, economic hardship, and inadequate protection from violence(11).

Existing studies in Ethiopia have reported substantial levels of victimization among people with SMI, including both direct violence and indirect forms such as neglect and exploitation. However, these studies are limited in number and scope(12).

Furthermore, evidence suggests that certain subgroups of individuals with SMI may be at particularly high risk of victimization. Sociodemographic factors such as male sex, single marital status, and low educational attainment have been associated with increased exposure to violence. Clinical factors, including suicidal behavior and comorbid psychiatric conditions, may further increase susceptibility to victimization. Recent research supports the inclusion of behavioral factors, such as suicidal behavior, as important predictors of victimization risk, highlighting the need for integrated assessment approaches(5,9).

Although some studies in Ethiopia have reported high levels of victimization among individuals with SMI, these studies are limited in number and geographic scope. Furthermore, there is insufficient evidence examining the combined influence of sociodemographic, clinical, and behavioral factors—particularly suicidal behavior—on violent victimization. Therefore, this study aims to assess the prevalence and associated factors of violent victimization among adults with SMI receiving follow-up care in Mekelle, Tigray, Ethiopia.

1.2 Statement of the problem

Severe mental illness (SMI), including schizophrenia spectrum disorders, bipolar I disorder, and major depressive disorder with psychotic features, is a major contributor to the global burden of disease and is associated with significant psychosocial and functional impairment. Individuals living with SMI often experience impaired judgment, reduced social functioning, and limited economic opportunities, which increase their exposure to adverse living conditions and reduce their ability to protect themselves from harm.(13).

Among the most serious yet under-recognized challenges faced by individuals with SMI is violent victimization. This includes physical, sexual, and psychological harm inflicted by others and represents a critical but frequently overlooked public health issue. Evidence consistently shows that individuals with SMI are disproportionately affected, experiencing significantly higher rates of victimization compared to the general population. Studies from both high- and low-income countries report substantial prevalence, with some estimates exceeding 60%, indicating that victimization is widespread rather than incidental in this population(12).

In low- and middle-income countries (LMICs), including Ethiopia, the magnitude of violent victimization may be further amplified by structural and systemic challenges such as poverty, stigma, limited access to mental health services, and weak legal and social protection systems. Although Ethiopia has made progress in integrating mental health into primary healthcare, service availability remains limited and unevenly distributed. Consequently, individuals with SMI often lack adequate care, social support, and protection, increasing their vulnerability to violence, neglect, and exploitation(11).

Empirical evidence from Ethiopia highlights the seriousness of the problem. Previous studies have reported high levels of violent victimization among individuals with SMI, including both direct physical violence and indirect forms such as neglect and social exclusion. However, these studies are limited in scope and do not adequately represent all geographic areas, particularly northern regions such as Tigray(14).

Furthermore, while several risk factors—such as substance use, unemployment, and poor social support—have been identified, there remains limited evidence examining the combined influence of sociodemographic, clinical, and behavioral factors, particularly suicidal behavior, on violent victimization in the Ethiopian context. This gap is especially important in Tigray, where

prolonged conflict and socioeconomic disruption may further increase vulnerability to violence and weaken protective systems(14).

Several factors have been identified as increasing the risk of violent victimization among individuals with SMI. These include clinical factors such as active psychotic symptoms and comorbid substance use, as well as social and economic factors such as unemployment, poor social support, and treatment non-adherence. These risk factors often coexist and interact, creating compounded vulnerability. However, the relative contribution of these factors may vary across settings, particularly in contexts affected by socioeconomic instability and limited mental health infrastructure(6,8).

Despite the presence of major psychiatric service centers in Mekelle, including Ayder Comprehensive Specialized Hospital and Mekelle General Hospital, there is currently no comprehensive evidence assessing the prevalence and determinants of violent victimization among adults with SMI receiving follow-up care in this setting.

Therefore, this study aims to address this critical gap by assessing the prevalence and associated factors of violent victimization among adults with SMI in Mekelle, Tigray. The findings will provide context-specific evidence to inform clinical practice, guide public health interventions, and support policy development aimed at protecting this vulnerable population.

1.3 Significance of the study

This study provides important evidence on the magnitude and determinants of violent victimization among adults with severe mental illness in Mekelle, Ethiopia. By generating context-specific data, it contributes to addressing a critical gap in the existing literature, particularly in northern Ethiopia and conflict-affected settings.

The findings have practical implications for clinical care by supporting the integration of routine screening for victimization and risk factors within mental health services. This can enhance early identification of high-risk individuals and improve the provision of trauma-informed care.

At the policy level, the study offers evidence to inform the development of targeted interventions and resource allocation aimed at protecting vulnerable individuals with severe mental illness. It also highlights the need for stronger collaboration between healthcare systems and legal institutions to address violence and safeguard patient rights.

Furthermore, the study serves as a foundation for future research by identifying key areas requiring further investigation, including the role of behavioral and contextual factors in shaping victimization risk. Ultimately, the findings will contribute to improving mental health outcomes, reducing exposure to violence, and promoting the well-being and social inclusion of individuals with severe mental illness.

2 Literature Review

2.1 Overview

Violent victimization among individuals with severe mental illness (SMI) has been consistently reported at significantly higher rates compared to the general population across diverse settings. Evidence from high-income countries demonstrates a clear disparity in exposure to violence. For instance, 40% of psychiatric patients experienced crime within a one-year period, compared to 14% of the general population, corresponding to nearly threefold higher odds of victimization (AOR = 2.8, 95% CI: 2.0–3.8). Moreover, the risk of violent assault was more than five times higher among patients (19% vs. 3%; AOR = 5.3, 95% CI: 3.1–8.8)(2).

Similarly, 38.9% of individuals with mental disorders experienced violent victimization, with substantial proportions exposed to completed physical assault (25.8%), threatened assault (13.6%), and attempted assault (9.5%)(15). These findings highlight both the high prevalence and the diverse forms of violence experienced by this population.

59.3% of individuals with SMI experienced at least one criminal victimization event, significantly higher than the 46.0% reported among controls ($p = 0.02$). Additionally, 52.0% of patients reported experiencing discrimination compared to 24.0% of controls ($p < 0.001$) (16). Individuals with SMI had nearly three times higher risk of violent victimization compared to the general population (RR = 2.7), with markedly elevated risks for sexual offenses and physical assault (17).Another study in the Netherlands reported that 47% of individuals with SMI experienced victimization within a one-year period, with an overall risk nearly three times higher than the general population (RR = 2.8) (17).

In low- and middle-income countries such as Ethiopia, the magnitude appears even higher. 66.7% of individuals with SMI experienced lifetime violent victimization compared to 44.0% among those without SMI, with nearly double the odds after adjustment (AOR = 1.91, 95% CI: 1.21–3.01)(14).

Similarly, a study found a prevalence of 57.4% among psychiatric outpatients, with factors such as suicide attempts (AOR = 2.14), cigarette smoking (AOR = 2.25), and prior violence (AOR = 3.71) significantly associated with victimization(19).

However, a comparatively lower prevalence of 42% in Addis Ababa (AOR = 2.3, 95% CI: 1.7–3.1), suggesting variability across settings(20).

2.2 Factors Associated with Violent Victimization

The risk of violent victimization among individuals with SMI is influenced by multiple interacting factors. Substance use as a major determinant, with individuals who use substances having more than four times higher odds of victimization (OR = 4.12, 95% CI: 1.84–9.25)(8).

Similarly, alcohol misuse and severe psychiatric symptoms significantly increase vulnerability to violence(6).

History of violence and criminal involvement further amplifies risk. Individuals with prior violent behavior were found to have more than sixfold higher odds of victimization (OR = 6.57, 95% CI: 3.51–12.28), while those with a history of violent crime had markedly increased risk

(OR = 13.71, 95% CI: 4.58–41.05)(6). These findings suggest a strong bidirectional relationship between victimization and perpetration.

Sociodemographic factors also play an important role. Males had approximately 1.5 times higher odds of experiencing victimization (OR = 1.5, 95% CI: 1.2–1.9)(21).

Socioeconomic disadvantage is another key determinant; individuals in lower income groups had significantly higher risk of violence (AOR = 1.6, 95% CI: 1.3–2.0)(11).

Environmental factors are particularly important in low-resource settings. Individuals with SMI in rural Ethiopia were nearly twice as likely to experience victimization (AOR = 1.9, 95% CI: 1.4–2.5), largely due to stigma and limited access to care (22).

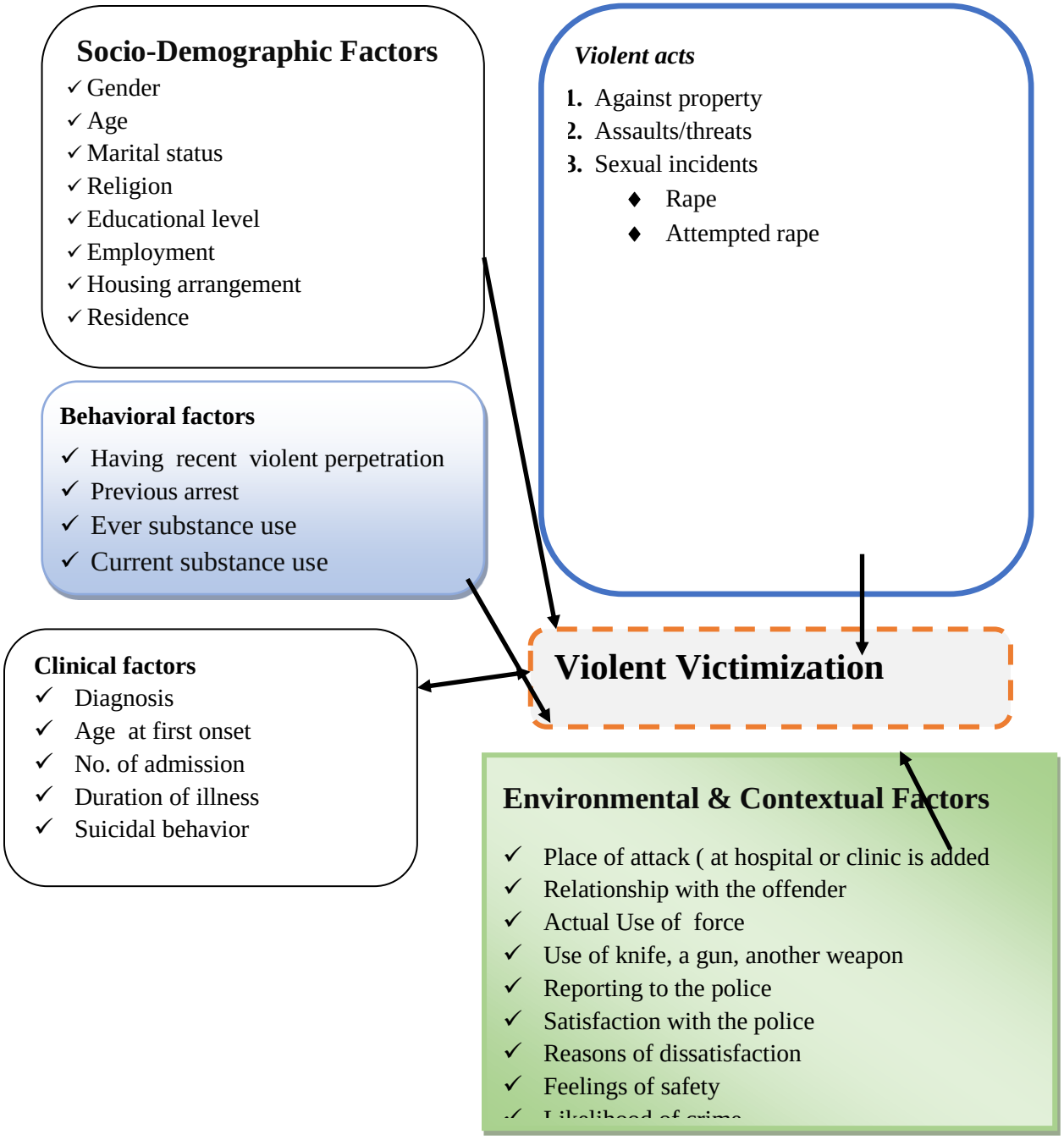
2.3 Consequences of Violent Victimization

Violent victimization has substantial clinical and psychosocial consequences for individuals with SMI. Approximately 44% of individuals with SMI who experienced violence reported severe psychiatric symptoms, indicating a strong association between victimization and symptom exacerbation(23).

Victimization is also associated with increased risk of suicidal behavior, poor treatment adherence, and higher rates of hospitalization. Individuals exposed to violence often experience worsening mental health outcomes, which in turn increase their vulnerability to further victimization, creating a cyclical pattern.

In addition, victimization contributes to social isolation, reduced quality of life, and increased substance use. These consequences are particularly severe in low- and middle-income countries, where limited mental health services and weak social support systems exacerbate the overall impact.

Conceptual framework



1. Fig 1: Conceptual framework of prevalence and associated factors of violent victimization among adults with severe mental illness receiving follow-up care at public hospitals in mekelle city, mekelle, tigray, ethiopia, 2025(24-26).

3 Objectives

3.1 General objective

- To assess the prevalence and associated factors of violent victimization among adults with severe mental illness receiving follow-up care at Public Hospitals in Mekelle City, Mekelle, Tigray, Ethiopia, 2025.

3.2 Specific objectives

- To determine the prevalence of violent victimization among adults with severe mental illness receiving follow-up care at Public Hospitals in Mekelle City, Mekelle, Tigray, Ethiopia, 2025.
- To identify factors associated with violent victimization among adults with severe mental illness receiving follow-up care at Public Hospitals in Mekelle City, Mekelle, Tigray, Ethiopia, 2025.

Methodology

3.3 Study area

The study was conducted at Ayder Comprehensive Specialized Hospital and Mekelle General Hospital, two government hospitals located in Mekelle City, Tigray Region, Northern Ethiopia, approximately 783 kilometers from Addis Ababa, the capital city of Ethiopia. Mekelle, established in 1876, serves as the administrative center of the Tigray region(27).

According to the United Nations Urbanization Prospects (2018), the estimated population of Mekelle in 2024 is 611,574. The city covers an area of approximately 259.9 square kilometers and is situated at an elevation of 2,084 meters above sea level. Administratively, Mekelle is divided into seven sub-cities, with an estimated health service coverage of approximately 90%(28).

Ayder Comprehensive Specialized Hospital provides both referral and non-referral services to an estimated population of over 8 million people from Tigray, Afar, and parts of the Amhara region. It is one of the largest hospitals in Ethiopia, with approximately 500 inpatient beds across multiple departments and specialty units. The hospital also serves as a teaching facility for the College of Health Sciences, Mekelle University. Mekelle General Hospital is another government facility providing both inpatient and outpatient services primarily to residents within the city(29).

The estimated monthly outpatient flow was approximately 700 patients at Ayder Comprehensive Specialized Hospital and 300 patients at Mekelle General Hospital.

3.4 Study period

The study was conducted from September 15 to October 15, 2025.

3.5 Study design

An institution-based cross-sectional study design was employed.

3.6 Population

3.6.1 Source population

All patients diagnosed with severe mental illness attending psychiatric follow-up services at public hospitals in Mekelle City.

3.6.2 Study population

All eligible adult patients with severe mental illness who were attending outpatient follow-up care at the selected hospitals during the data collection period.

3.7 Inclusion criteria and Exclusion criteria

3.7.1 Inclusion criteria

Adult patients (≥18 years) diagnosed with severe mental illness and attending outpatient follow-up during the study period.

3.7.2 Exclusion criteria

Patients who developed severe mental illness after experiencing victimization, those unable to communicate verbally, and those who were critically ill at the time of data collection were excluded.

3.8 Sample size determination and sampling technique

3.8.1 Sample size determination

The sample size was determined using a single population proportion formula, assuming a prevalence (p) of 57.4% based on a previous study, a 95% confidence level (Z = 1.96), and a margin of error (d) of 5%.(24).

The minimum number of sample was determined by considering the following assumptions.

$n = [(z\alpha/2)^2 \, p \, (1-p)]/d^2$

Where, 'n' is the minimum sample size required for the study

'Z' is the standard normal distribution (Z =1.96) with a confidence interval of 95% and α=0.05

'p'is the estimated prevalence of violent victimization among adults with mental illness (p) = 57.4%=0.574

'd'is an absolute precision or tolerable margin of error (d) =5%=0.05

The initial calculated sample size was: $n= [(z\alpha/2)^2 \, p \, (1-p)]/ \, d^2 = (1.96)^2 \times 0.574(1-0.574)/ (0.05)^2 = 375.7 \approx 376$

Since the source population (N = 1000) were less than 10,000, a finite population correction formula was applied, resulting in a corrected sample size of**:**

nf = n/1+(n-1)/N

nf = 376/1+(376-1)/1000 = 273.45≈ 274

After accounting for a 10 %(28) non-response rate, the final sample size was increased to 302 participants.

3.8.2 Sampling technique

A multistage sampling technique was employed. Initially, two hospitals (Ayder Comprehensive Specialized Hospital and Mekelle General Hospital) were selected from five public hospitals in

Mekelle City using a simple random sampling method (lottery method). The total sample size was proportionally allocated to each hospital based on patient flow, with 211 participants from Ayder Comprehensive Specialized Hospital and 91 from Mekelle General Hospital. Within each hospital, participants were selected using systematic random sampling. The sampling interval (K) was determined by dividing the total number of patients by the allocated sample size ($K \approx 4$). The first participant was selected randomly, and every fourth patient was subsequently included until the required sample size was achieved. This approach was chosen due to the availability of an ordered sampling frame and its effectiveness in reducing selection bias in institutional settings.

3.9 Data Collection Procedure

Data were collected using a structured, pretested, interviewer-administered questionnaire. The tool was initially prepared in English, translated into Tigrigna, and back-translated into English to ensure consistency. Data collectors provided a brief explanation of the study objectives prior to data collection. Two trained psychiatry professionals collected the data, and one mental health professional supervised the process to ensure data quality.

3.10 Data Collection Tools

Data were collected using the International Crime Victim Survey (ICVS), a standardized instrument widely used to assess victimization. The tool has demonstrated acceptable validity and reliability across different populations. For this study, the ICVS was adapted to the local context to improve relevance for individuals with severe mental illness. Minor modifications were made, including adjusting the recall period and incorporating context-specific variables(24-26).

Additional data on socio-demographic characteristics were collected using structured questions. Substance use was assessed using the ASSIST-Lite screening tool(32, 33).

3.11 Study variables

3.11.1 Dependent variable

- Violent Victimization

3.11.2 Independent variables

- ✓ **Demographic factors:** Sex, Age, Marital status, Religion, Educational level, Occupation, Housing ownership and Residence

- ✓ **Behavioral factors:** Having recent violent perpetration, Previous arrest, Substance use
- ✓ **Violent acts:** Against property, Assaults/threats, and Sexual incidents
- ✓ **Environmental & Contextual Factors :** Place of attack (at hospital or clinic is added), Relationship with the offender, Actual Use of force, Use of a (knife, a gun, or another weapon), Reporting to the police, Satisfaction with the police, and Reason of dissatisfaction, Likelihood of being a victim, feeling of safety
- ✓ **Clinical related factors:** Diagnosis, age at first onset, no. of admission, duration of illness, and suicidal behavior

3.12 Operational definitions

Violent victimization: was defined as a participant reporting at least one of the following experiences: simple assault, aggravated assault, kidnapping, rape or attempted rape, attempted robbery, personal theft, or property vandalism. These were assessed using items adapted from the Standard International Crime Victim Survey(24-26).

To improve contextual relevance for individuals with mental illness, minor modifications were made. Specifically, "lifetime prevalence" was replaced with "since the onset of mental illness," and additional context-specific categories (e.g., healthcare setting and health professional as perpetrator) were included.

The tool also captured characteristics of victimization, including timing, frequency, perpetrator relationship, location, reporting behavior, and perceived safety(24, 25).

Prevalence of violent victimization: number of persons with SMI experiencing one or more violent crimes in their life is changed to since they become mentally ill(24, 25).

Severe Mental illness*:* Severe mental illness was defined as a diagnosis of schizophrenia spectrum, bipolar I disorder, or major depressive disorder with psychotic feature, as documented in the patient's medical record.(13).

Substance use Ever use: was defined as the use of at least one psychoactive substance (e.g., alcohol, khat, or tobacco) since the onset of their mental illness, as self-reported by the participant(30, 31).

Substance use Current use: was defined as the use of at least one psychoactive substance (e.g., alcohol, khat, or tobacco) within the past 3 months, as self-reported by the participant(30, 31).

3.13 Data quality assurance

To ensure data quality, the questionnaire was pretested at Adigrat General Hospital prior to data collection. Data collectors received two days of training on the study objectives, ethical considerations, and interview techniques. The questionnaire was translated into Tigrigna and back-translated into English to maintain consistency. Daily supervision and on-site checking of completed questionnaires were conducted to ensure completeness and accuracy.

3.14 Data Processing and Analysis

Data were checked for completeness and consistency before being coded and entered into SPSS version 27 for analysis. Descriptive statistics were used to summarize the data. Binary logistic regression analysis was conducted to identify candidate variables for multivariable analysis. Variables with a p-value < 0.25 in the binary analysis were included in the multivariable logistic regression model. Statistical significance was declared at a p-value < 0.05 with a 95% confidence interval, and adjusted odds ratios were used to measure the strength of associations. Then the Data was presented using narrative, figures, and tables form the result of frequencies and cross tabulations.

3.15 Ethical Considerations

Ethical clearance was obtained from the office of the Health Research Ethics Review Committee of MUCHS (MU-IRB 2593/2025). Official permission letters were secured from the respective hospitals. Participants were informed about the purpose, procedures, risks, and benefits of the study. Participation was voluntary, and written informed consent was obtained. Confidentiality was maintained by excluding personal identifiers and securely handling all data. Participants were informed of their right to withdraw from the study at any time without any consequences.

3.16 Dissemination and utilization of the result

The study result will be presented to Mekelle University, college of health sciences, Faculty of Nursing and Midwifery, Department of Psychiatry and will also be given to respective bodies such as the study areas, Tigray Regional Health Bureau, Federal Ministry of Health, Federal Police Commission and Ethiopian Human Rights Commission in the study area. Finally the findings will be

disseminated through different meetings, workshops and publishing in the local or an international journal.

The study result will be presented to Mekelle University, college of health sciences, School of Nursing Department of Psychiatry and result documents will be disseminated to all responsible bodies in the study area. Finally the findings will be disseminated through different meetings, workshops and publishing in the local or an international journal.

4 Results

5.1 Sociodemographic characteristics of respondents

Out of the total sample size of 302, 300 participants were included in the study, yielding a response rate of 99.3%. Slightly more than half of the respondents were male 157(52.3%), indicating a relatively balanced sex distribution. The majority of participants were young adults, with 145(48.3%) aged 18–29 years and 118(39.3%) aged 30–44 years, suggesting that the study population was predominantly within the economically productive age group. Most participants resided in urban areas 221(73.7%), which reflects the hospital-based nature of the study setting. Regarding marital status, nearly half of the respondents were single 135(45.0%), which may have implications for social support and vulnerability to victimization. In terms of educational status, a substantial proportion 97(32.3%) had low educational attainment, a factor that may influence awareness, coping mechanisms, and exposure to risk. Additionally, 189(63.0%) of participants were unemployed, indicating a high level of socioeconomic vulnerability within the study population (Table 1).

Table 1: Socio-demographic characteristics of respondents at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025**(n=300).**

Characteristics	**Categories**	**N (%)**
Sex	Female	143(47.7)
	Male	157(52.3)
Age	18-29	145(48.3)
	30-44	118(39.3)
	45 and above	37(12.3)
Residence	Urban	221(73.7)
	Rural	79(26.3)
Marital Status	Single	135(45.0)

	Married	117(39.0)
	Divorced/Widowed	48(16.0)
Religion	Orthodox	238(79.3)
	Muslim	58(19.3)
	Catholic/Protestant	4(1.3)
Ethnicity	Tigray	300(100.0)
Educational level	Low education	97(32.3)
	High education	203(67.7)
Occupation	Unemployed	189(63.0)
	Employed	111(37.0)
Housing	Private	82(27.3)
	Rental	130(43.3)
	Institution/Dependent	88(29.3)

5.2 Clinical characteristics of respondents

More than half of the participants 165 (55.0%), were diagnosed with schizophrenia spectrum and other psychotic disorders, indicating that this group constituted the majority of the study population. Nearly half 145(48.3%) experienced early onset of illness, which may contribute to prolonged exposure to psychosocial challenges. The majority of participants 194(64.7%) had no history of hospital admission, suggesting that most were managed on an outpatient basis. However, 161 (53.7%) had a moderate to long duration of illness, indicating chronicity, which may increase vulnerability to adverse outcomes such as victimization (Table 2).

Table 2: Clinical characteristics of respondents at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025**(n=300).**

Variable	**Category**	**N (%)**
Diagnosis	Schizophrenia spectrum and other psychotic disorders	165(55.0)
	Bipolar and related disorders	15(5.0)
	Major depressive disorder	72(24.0)
	Other, specify(GAD, PTSD, and BPD)	48(16.0)
Age of Onset	Early onset	145(48.3)
	Middle onset	85(28.3)
	Late onset	70(23.3)
Admission History	No admission	194(64.7)
	Admission	106(35.3)
Illness Duration	Short	139(46.3)
	Moderate/Long	161(53.7)

5.3 Perception of safety and violence characteristics of respondents

Most participants 223(74.3%) perceived their likelihood of encountering risky situations as low, and 254 (84.7%) reported feeling safe walking at night. Despite these perceptions, the high prevalence of victimization observed in this study suggests a discrepancy between perceived and actual risk, highlighting potential gaps in risk awareness or environmental safety (Table 3).

Table 3: Perceptions of safety and violence characteristics of respondents at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025**(n=300).**

Variable	**Category**	**N (%)**
Perceived Risk	Unlikely	223(74.3)
	Likely	77(25.7)
Perceived Safety	Safe	254(84.7)
	Unsafe	46(15.3)

5.4 Substance use characteristics of respondents

A considerable proportion of participants 198(66.0%) reported lifetime substance use, while 33(11.0%) reported current use. This indicates that substance use is relatively common in this population and may contribute to increased vulnerability to violence (Table 4).

Table 4: Substance use characteristics of respondents at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025**(n=300).**

Variable	Category	N (%)
Ever Substance Use	No	102(34.0)
	Yes	198(66.0)
Current Substance Use	No	267(89.0)
	Yes	33(11.0)

5.5 Criminal history characteristics of respondents

Approximately one-fifth of participants 63(21.0%) reported a history of arrest and recent violent perpetration. This finding suggests a potential overlap between victimization and involvement in violence, supporting the bidirectional relationship reported in previous studies (Table 5).

Table 5: Criminal history characteristics of respondents at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025(**n=300).**

Variable	Category	N (%)
Ever Arrested	No	237(79.0)
	Yes	63(21.0)
Having recent violent perpetration	No	237(79.0)
	Yes	63(21.0)

5.6 Suicidal behavior characteristics of respondents

About 77(25.7%) of participants reported a history of suicidal behavior, indicating a significant level of psychological vulnerability within the study population.

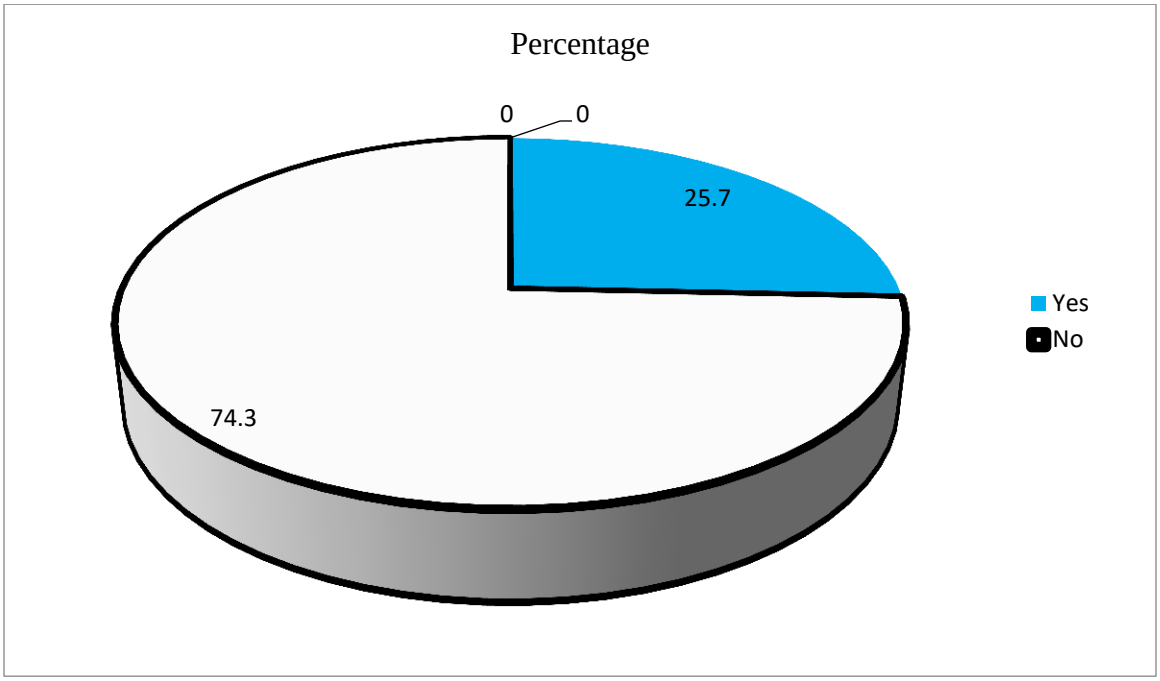


Figure 2: Suicidal behavior characteristics of respondents at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025**(n=300).**

5.7 Lifetime Prevalence of Violent victimization

The prevalence of violent victimization among adults with SMI was 62.7% (95% CI: 56.9%–68.2%), indicating that nearly two-thirds of participants had experienced at least one form of violence. This finding highlights a substantial public health burden among individuals with severe mental illness in this setting.

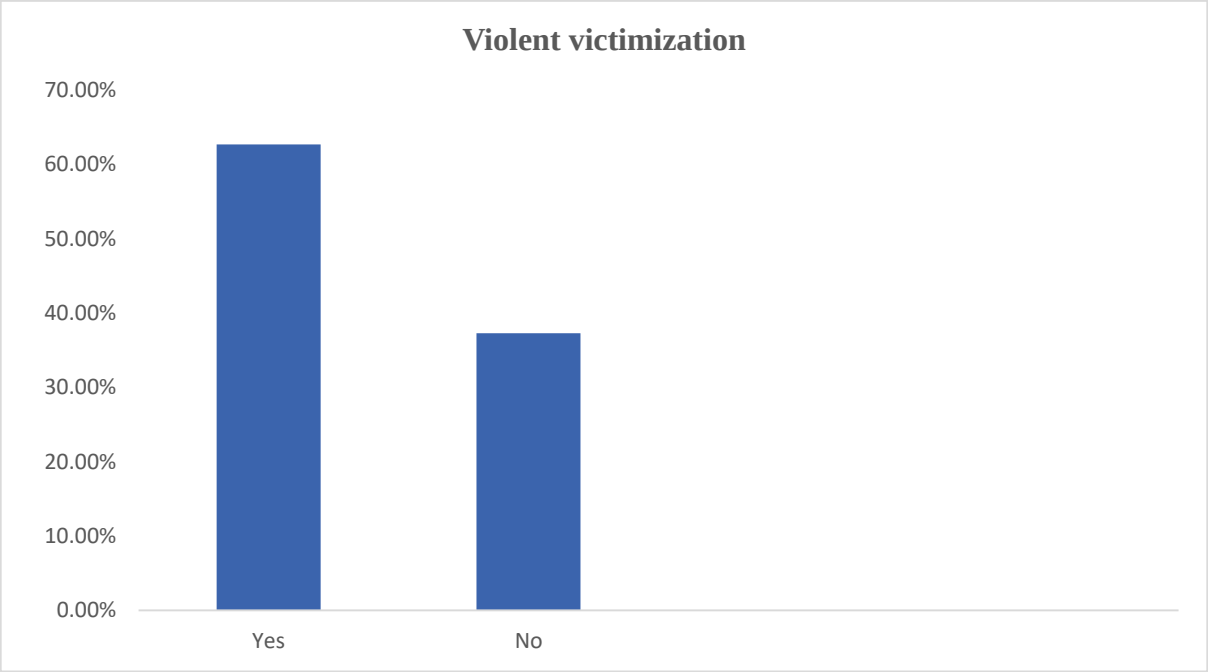


Figure 3: Prevalence of violent victimization among adults with severe mental illness at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025.

5.8 Bivariate logistic regression

Bivariate logistic regression was done to assess the relationship between each independent variables and the occurrence of violent victimization. The result is that sex, housing status, religion, educational level, occupation, residence, psychiatric diagnosis, admission history, ever using substances, suicidal behavior, history of arrest, and property-related violence were statistically significant predictors of violent victimization among participants at p-value less than 0.25.

Multivariate logistic regression analysis identified several significant predictors of violent victimization. Male participants were more than four times as likely to experience victimization compared to females (AOR = 4.39, 95% CI: 2.08–9.27), suggesting increased exposure to high-risk environments. Single individuals had significantly higher odds of victimization (AOR = 5.83, 95% CI: 1.97–17.29), which may reflect reduced social support and protection. Similarly, participants with low educational attainment were nearly five times more likely to experience violence (AOR = 4.77, 95% CI: 1.51–15.01), indicating the influence of socioeconomic disadvantage. Additionally, participants with a history of suicidal behavior had markedly increased odds of victimization (AOR = 6.66, 95% CI: 2.47–17.98), suggesting a strong link between psychological vulnerability and exposure to violence (Table 6).

Table 6: Multivariable logistic regression analysis of factors associated with violent victimization of respondents at public hospitals in Mekelle city, Mekelle, Tigray, Ethiopia, 2025**(n=300).**

Variables	Categories	Violent Victimization		COR (95% CI)	AOR (95% CI)	p-value
		Yes	No			
Sex	Male	110	47	1.95(1.21-3.13	4.39(2.08-9.27)	**0.001***
	Female	78	65	1	1	
Marital Status	Single	91	44	1.65(0.99, 2.76)	5.83 (1.97–17.29)	**0.001***
	Divorced/widowed	32	16	1.6(0.79-3.23)	0.90 (0.32–2.51)	0.834
	Married	65	52	1	1	

Housing	Private	46	36	1	1	
	Rental	75	55	1.07(0.61-1.86)	0.97 (0.40–2.31)	0.940
	Institution/Dependent	67	21	2.5(1.3-4.81)	2.70 (0.91–8.00)	0.073
Religion	Orthodox	169	69	1	**1**	
	Muslim	18	40	7.35(0.75-71.87)	15.77 (0.89–280.43)	0.060
	Catholic/Protest	1	3	1.35(0.13-13.88)	0.96 (0.05–17.20)	0.979
Educational level	Low education	69	28	1.74(1.03-2.93)	4.77 (1.51–15.01)	**0.008***
	High education	119	84	1	1	
Occupation	Unemployed	134	55	2.57(1.58-4.18)	1.84 (0.93–3.67)	0.082
	Employed	54	57	1	1	
Residence	Urban	132	89	1	1	
	Rural	56	23	1.64(0.94-2.86)	0.40 (0.15–1.09)	0.072
Diagnosis	Schizophrenia spectrum	117	48	1	1	
	Bipolar and related disorders	8	7	0.47(0.16-1.36)	1.43 (0.31–6.59)	0.648
	Major depressive disorder	39	33	0.48(0.27-0.86)	0.94 (0.27–3.27)	0.925
	Other, Specify_____	24	24	0.41(0.21-0.79)	3.89 (1.08–14.01)	**0.038***
Number of Admission	No admission	112	82	1	1	
	Admission	76	30	1.85(1.11-3.09)	2.06 (0.98–4.32)	0.055

Current substance use	No	164	103	1	1	
	Yes	24	9	1.67(0.75-3.74)	3.26 (0.90–11.90)	0.073
Ever substance use	No	54	48	1	1	
	Yes	134	64	1.86(1.14-3.04)	2.35 (0.99–5.56)	0.051
Suicidal Behavior	No	128	95	1	1	
	Yes	60	17	2.62(1.44-4.77)	6.66 (2.47–17.98)	**0.001***
History of arrest	No	44	108	1	1	
	Yes	30	220	2.0(1.07-3.73)	1.35 (0.49–3.71)	0.561
Violent acts committed (in the past 01 year)	No	141	96	1	1	
	Yes	47	16	2.0(1.07-3.73)	2.11 (0.81–5.54)	0.128

Significant Variables: Asterisks (*) indicate statistically significant variables ($p < 0.05$), References are indicated by 1.

- **df (degrees of freedom)** = 8, **Hosmer and Lemeshow Test =** 0.166
- **AOR**: Adjusted Odds Ratio, **COR**: crude Odds Ratio
- **C.I.**: Confidence Interval

6. Discussion

In the current study, 62.7% of adults living with severe mental illness (SMI) reported having experienced violent victimization (95% CI: 56.9%–68.2%), indicating that such experiences affect a substantial proportion of this population. This estimate is consistent with findings from earlier study in Ethiopia, including the Butajira study, which documented a lifetime prevalence of 66.7% among individuals with SMI (32).

Comparable rates have also been reported in European countries; for example, a study conducted in Greece found that 59.3% of people with SMI had been victims of at least one criminal incident (16).

Collectively, these results demonstrate that violent victimization among individuals with SMI is a common and serious public health issue across diverse settings.

Nevertheless, the prevalence observed in this study exceeds that reported in many high-income countries. A study from the United Kingdom indicated that only 19% of psychiatric patients experienced violent assault within the preceding year (2).

While a longitudinal study from New Zealand reported that 38.9% of individuals with any mental disorder had encountered violent victimization (15).

Likewise, research from the Netherlands has documented lower prevalence rates among people with SMI, ranging between 22.7% and 47% (17, 18).

These differences may be explained by variations in methodological approaches and operational definitions. For example, some studies employed longitudinal designs and assessed victimization within a 12-month period, whereas the present study used a cross-sectional design and measured victimization since the onset of mental illness, potentially capturing a higher cumulative prevalence. In addition, several studies defined violent victimization narrowly (e.g., physical or sexual assault only), while this study included a broader range of events such as attempted robbery, personal theft, and property vandalism.

Contextual factors may also contribute to these differences. High-income countries typically have stronger social welfare systems, better access to mental health services, and safer living environments, which may reduce exposure to violence and enhance protective mechanisms.

Moreover, the prevalence observed in the current study exceeds that reported in an earlier Ethiopian study conducted in Addis Ababa, where 42% of people with severe mental illness experienced violent victimization (11).

This variation may be attributed to methodological and population differences between the studies. The Addis Ababa research was hospital-based and involved individuals receiving specialized psychiatric services, while the present study appears to have captured participants with potentially higher social vulnerability. Variations in measurement instruments, sample characteristics, and the availability of social support may have further influenced the differences in reported prevalence.

In this study, male participants had a significantly higher risk of violent victimization compared to females (AOR = 4.39, 95% CI: 2.08–9.27). Male participants in this study had significantly higher odds of violent victimization compared to females (AOR = 4.39, 95% CI: 2.08–9.27). This finding aligns with evidence from high-income countries, although the magnitude observed here is greater. In the United States, Teplin et al. reported adjusted odds ratios between approximately 2.1 and 2.7 for male sex as a predictor of victimization (2).

Similarly, studies from the United Kingdom and the Netherlands documented effect sizes ranging from 1.6 to 2.5 (15, 17).

While the direction of association is consistent, the stronger effect in the present study may reflect contextual factors such as increased exposure of men to public environments, informal employment sectors, and limited social protection systems in northern Ethiopia. Variations in the most common forms of violence, particularly physical assaults occurring outside the home, may partly explain differences in prevalence. Although other unmeasured factors could still influence the findings, the observed associations remained statistically significant after adjusting for multiple confounders.

Marital status was also significantly associated with violent victimization. Individuals who were single had markedly increased odds of experiencing violence compared to those who were married (AOR = 5.83, 95% CI: 1.97–17.29). This finding is consistent with evidence from high-income countries indicating that unmarried individuals with severe mental illness are at elevated risk of victimization. For example, Teplin et al. reported that individuals who were not married

had approximately twofold higher odds of violent victimization compared to their married counterparts (2).

Similarly, Kamperman et al. found that absence of a partner was independently associated with increased risk of criminal victimization, with adjusted odds ratios ranging approximately between 1.7 and 2.4 depending on the model specification (17).

Although the association between single marital status and violent victimization is consistent with prior studies, the effect observed in this study was stronger(2, 3).

Single individuals may have less social support and fewer protective networks, increasing their vulnerability to violence. The association remained statistically significant after adjusting for potential confounders, indicating that being unmarried is an important social risk factor for violent victimization in this population.

Educational status showed a significant association with violent victimization in this study. Participants with lower educational attainment had nearly fivefold increased odds of experiencing violence compared to those with higher education (AOR = 4.77, 95% CI: 1.51–15.01). This finding is consistent with evidence from high-income countries demonstrating that socioeconomic disadvantage is a strong predictor of victimization among individuals with severe mental illness. For instance, de Mooij et al. reported that lower educational level was independently associated with increased odds of victimization, with adjusted odds ratios ranging approximately between 1.8 and 2.6 depending on the type of violence assessed (18).

Socioeconomic disadvantage, such as lower educational attainment and unemployment, has been linked to higher risk of violent victimization among individuals with mental disorders(7).

Although the direction of association aligns with prior research, the magnitude observed in the present study is substantially greater. Lower educational attainment was associated with increased risk of violent victimization, consistent with prior research(3, 7).

This association remained statistically significant after adjusting for potential confounders, indicating that education level is an important structural vulnerability factor in this population.

In the current study, suicidal behavior was a significant predictor of violent victimization, with participants reporting prior suicidal behavior nearly seven times more likely to experience violence (AOR = 6.66; 95 % CI: 2.47–17.98). This finding is consistent with evidence from adults with severe mental illness (SMI), who generally face elevated victimization risk compared

with the general population (2, 15). Suicidal behavior may reflect more severe psychopathology, impaired coping, and co-occurring risk factors such as substance use and social isolation, which together increase vulnerability to violence. Regarding clinical diagnosis, most categories did not show consistent associations with victimization, although participants classified under "other diagnoses" (GAD, PTSD, BPD) had significantly higher risk (AOR = 3.89; 95 % CI: 1.08–14.01), supporting literature indicating that certain diagnostic profiles, particularly personality pathology or comorbid disorders, may confer greater vulnerability (17, 18).

Contextual factors may also explain the higher prevalence observed. In low-resource settings such as Ethiopia, individuals with SMI often face socioeconomic disadvantage, stigma, and limited access to mental health services. In addition, post-conflict conditions in Tigray may have further increased exposure to violence and weakened protective social and institutional systems. Male sex was found to be a significant predictor of violent victimization, with males experiencing substantially higher risk compared to females. This finding is consistent with previous studies; however, the magnitude observed in this study is notably higher. This may be explained by increased exposure of males to public environments, informal employment, and socially risky settings where violence is more likely to occur. Marital status was also significantly associated with victimization. Single individuals were more likely to experience violence compared to married individuals. This may be due to reduced social support, lack of protective relationships, and increased social isolation, all of which can increase vulnerability. Educational status emerged as another important factor, with individuals having lower educational attainment showing significantly higher risk of victimization. This finding highlights the role of socioeconomic disadvantage in shaping vulnerability. Lower education may limit access to employment opportunities, reduce awareness of risk, and increase exposure to unsafe environments. Suicidal behavior was one of the strongest predictors identified in this study. Participants with a history of suicidal behavior had significantly higher odds of experiencing victimization. This may reflect underlying psychological vulnerability, impaired coping mechanisms, and co-occurring risk factors such as substance use and social isolation. The finding also supports the concept of a bidirectional relationship between victimization and mental health outcomes(3, 7).

Overall, the findings of this study indicate that violent victimization among individuals with SMI is influenced by a complex interaction of demographic, clinical, and socioeconomic factors. These results underscore the need for integrated approaches that address both clinical care and broader social determinants of health. Importantly, violent victimization should not be viewed solely as an individual-level issue but also as a structural problem influenced by poverty, stigma, and weak legal protection systems. Addressing these broader determinants is essential for reducing vulnerability and improving outcomes for individuals with SMI(2, 15).

7. Limitations of the study

This study has several limitations. First, the cross-sectional design limits the ability to establish causal relationships between violent victimization and associated factors. Second, recall bias may have occurred, as participants were required to report past experiences of violence. Third, social desirability bias may have influenced responses, particularly for sensitive issues such as victimization and substance use. Finally, since the study was conducted in hospital settings, the findings may not be generalizable to all individuals with severe mental illness in the community.

8. Conclusion and Recommendation

8.1 Conclusion

This study revealed that violent victimization is highly prevalent among adults with severe mental illness receiving follow-up care in Mekelle, Ethiopia, with nearly two-thirds of participants reporting at least one form of victimization. This finding indicates a substantial and often under-recognized public health problem within this vulnerable population.

The study identified several significant factors associated with violent victimization, including male sex, single marital status, low educational attainment, and a history of suicidal behavior. These findings highlight the multifactorial nature of victimization, involving demographic, clinical, and socioeconomic determinants.

Overall, the results underscore the need for integrated and context-specific interventions that address both individual vulnerabilities and broader structural factors. Without targeted efforts, individuals with SMI will continue to face a heightened risk of violence, which may further worsen their mental health outcomes and quality of life.

8.2 Recommendation

- **For Health Institutions (ACSH & MGH)**

Mental health services should integrate routine screening for violent victimization and associated risk factors into regular clinical assessments. Healthcare providers should be trained to identify, manage, and refer cases of victimization appropriately. In addition, strengthening psychosocial support services and implementing trauma-informed care approaches are essential to address the consequences of violence.

- **For Tigray Regional Health Bureau**

The regional health bureau should incorporate victimization prevention and response strategies into mental health programs. This includes developing guidelines for screening and management, improving access to mental health services, and ensuring adequate resource allocation for vulnerable populations.

- **For Federal Ministry of Health**

The Ministry of Health should strengthen national mental health policies by integrating violence prevention strategies and ensuring the protection of individuals with SMI. Expanding community-based mental health services and promoting public awareness to reduce stigma are also critical.

- **For Legal and Policy Makers**

There is a need to strengthen legal protection mechanisms for individuals with severe mental illness. Collaboration between mental health services, law enforcement agencies, and social services should be enhanced to ensure the safety, dignity, and human rights of this population. Policies aimed at preventing abuse, exploitation, and neglect should be effectively implemented and monitored.

- **For Researchers and Academic Institutions**

Further research is recommended to explore causal relationships using longitudinal study designs and to assess the impact of contextual factors such as conflict and displacement on victimization. Additionally, qualitative studies may provide deeper insights into lived experiences and coping mechanisms.

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ANNEXES

Annex -I. Participants` Information sheet

Code No: ----------

Dear Sir/Madam.

My name is ……..….am currently a data collector for a research which is conducted by a student who currently are studying at Mekelle university, college of health sciences. This information sheet and consent form is for participants who are aged 18 and older, on the study of "Prevalence And Associated Factors Of Violent Victimization Among Adults With Mental Illness Receiving Follow-Up Care At Ayder Comprehensive Specialized Hospital and Mekelle General Hospital, Mekelle, Tigray, Ethiopia, 2025"

Significance: importance of the results of this study will give a clear picture of the risk of violent victimization and its determinants among adults with mental illness, areas we need to work on. It will help policy makers identify the areas that need modification on care providing system and intervene on them.

Participants to be included: selected participants from ACSH AND MGH.

Confidentiality: all information you give will be kept confidential and your name won't be registered on the questionnaire.

Risk and benefits of the study

Risk: the study will be carried out simply by asking you with prepared and structured questions. The procedure doesn't bear any physical or psychological trauma. Those who will have met the criteria for any mental illness and were not seen by psychiatrists will be taken and linked to health facility for further investigation and treatment.

Consent: the interview will take a maximum of 30 minutes. Your participation in the study will be voluntary. You have to refuse or withdraw from participating in the study at any time before and after consent without any explanation.

Whom to contact

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Mr. Gebrewahd Bezabh (MSc, Asst. Prof.)

Annex- II. Consent form

Dear Sir/Madam;

In signing this document, I am giving my consent to participate in the study entitled "Prevalence And Associated Factors Of Violent Victimization Among Adults With Mental Illness Receiving Follow-Up Care At Ayder Comprehensive Specialized Hospital and Mekelle General Hospital, Mekelle, Tigray, Ethiopia, 2025".

I have been informed that the purpose of this research project and I understand that I am selected to participate in this study randomly. I have been informed that my participation in this study is willing full and voluntary even I have right to refuse or interrupt the filling of questionnaire and my name will not be mentioned on the questionnaire.

I have understood the purpose of the study & fully agree to participate in the study.

Signature of the participant---------- Date ----------

Thank you, have a nice day!

Interviewer: name_____ signature: _____ date: _____

Supervisor name _____ signature _____

Annex-III: English and Tigrigna Version Questionnaire

1. English Version Questionnaire

INSTRUCTION: The questionnaire has eight parts. It will take about 20 minutes to complete the interview. Please try to respond to all the questions. Thank you very much for your patience.

Part I: Socio-Demographic Information

No	Questionnaires	Alternative response
Q-1	Sex	1. Male 2. Female
Q-2	How old are you?	Age ----------
Q-3	Housing arrangement?	1. Private owned 2. Rental 3. Institution 4. Dependent (with family, friend) 5. Homeless (street)
Q-4	What is your marital status?	1. Single 2. Married 3. Separated 4. Divorced 5. Widowed
Q-5	What is your religion?	1. Orthodox 2. Muslim 3. Catholic 4. Protestant 5. Others---------
Q-6	What is your ethnicity	1. Tigray 2. Afar 3. Amhara 4. Oromo 5. Others------
Q-7	What is your level of education?	1. Illiterate 2. Primary school 3. Secondary school

		4. College and above
Q-8	What is your occupation?	1. Merchant 2. Farmer 3. Employed 4. Unemployed 5. Student 6. Daily laborer 7. Other----------
Q-9	What is your average monthly income?	_____ETB
Q-10	Residence	1. Urban 2. Rural

Part II: Questionnaire for Types of Violent Acts

Instructions: In the past years since you became mentally ill, which of the following incidents have you been victimized by? Please select your answer by placing a checkmark (✓) in the boxes provided.

No.	Types of Violent Acts	Yes (✓)	No (✓)
Q-1	Has someone taken something from you (on your person), by using force or threatening you?		
Q-2	Did anyone try to do so?		
Q-3	Has someone deliberately destroyed or damaged your home, shop, or any other property that you own?		
Q-4	Have you ever been assaulted (hit, slapped, shoved, punched, pushed, or kicked) without any weapon either inside or outside the home?		
Q-5	Have you ever been seriously assaulted with the aim to kill you? (e.g., beaten, stabbed, burnt, throttled, or otherwise attacked) with a weapon (e.g., bottle, glass, knife, club, hot liquid, rope) excluding being shot by a gun or firearm?		
Q-6	Have you ever been kidnapped (taken and held against your will)?		

7. I know this is a difficult question, so please take a moment to think about it. Have you ever experienced a sex act against your will?
    1. Attempted rape
    2. Rape
    3. I haven't experienced sexual violence
    (Please select one)
8. If you answered 'yes' to any of questions 1-7 above, when did it happen?
    1. During the previous 12 months
    2. Before one year
    3. I don't remember
    4. Didn't happen
9. How many times did you suffer from the above incidents?
    1. Once
    2. Twice
    3. Three times
    4. More than three times

10. Where did this happen?	11. Your relation with Perpetrators?	12. Who did you report this to?
1. Home	1. House Hold member	1. Police/Military
2. On street near own home	2. Other relative	2. Religious leaders/traditional leaders/elders/chiefs/ village heads
3. In a public area near a government office/building	3. Neighbor who you know	3. Government officials
4. At school	4. Close friend of you or the family	4. Women's organization
5. At work	5. Person you know by sight only	5. Local armed gangs
6. On a street/highway not near own home	6. Group of people who you know by sight only	6. Media
7. Residential institution	7. Individual stranger	7. Political party
8. Sports and athletic area	8. Group of strangers	8. Doctor, health official
9. Industrial or Construction site	9. health professional	9. Other household member
10. Farm (excluding home)	10. Other please specify	10. Other (specify)
11. Commercial area (shop, store, hotel, bar, office)	11. Did not see offender/don't know	11. Did not report it
12. Place of worship	12. Refuses to answer	12. Don't know
13. hospital		13. Refuses to answer
14. Other (specify)		
15. Unknown		

13. On the whole, were you satisfied with the way the police dealt with the matter?
    1. Yes (satisfied)

2. No (dissatisfied)
3. Don't know

Part III: Perceptions of Safety and Violence

Likelihood of being a victim: In the next 12 months, what is the likelihood that you will become a victim of one of the forms of violence mentioned above?

1. Is it more likely to be?

Violence	1 Very likely	2 Somewhat likely	3. Somewhat unlikely	4. Very unlikely
Against person				
Against property				
Both				

2. How safe do you feel walking down the street after dark in the area where you live?
    1. Very safe
    2. Moderately safe
    3. Neither safe nor unsafe
    4. Moderately unsafe
    5. Very unsafe

Part V: Clinical Factors

Q-1	**Diagnosis**	1. Schizophrenia spectrum and Otherpsychotic disorders 2. Bipolar and related disorders 3. Major depressive 4. Other, Specify_____
Q-2	Age at first onset	_____
Q-3	No. of admission	_____

Q-4	Duration of illness	_____

Substance Use Questionnaire

Instructions: Please answer the following questions regarding your substance use. Your responses are confidential and will help us understand the relationship between substance use and experiences of violence.

Q-1	Have you ever used alcoholic drinks in your life?	Yes	
		No	
Q-2	Have you used any alcoholic drinks in the last 3 months?	Yes	
		No	
Q-3	Have you ever used tobacco products?	Yes	
		No	
Q-4	Have you used any kind of tobacco products in the last 3 months?	Yes	
		No	
Q-5	Have you ever used any other substance in your life? If yes, specify it…….	Yes	
		No	
Q-6	Have you used any other substance in the last 3 months? If yes, specify it…….	Yes	
		No	

Part VII: Suicidal behavior Questionnaires

Instructions: The following questionnaire consists of 4 items. Please read each item carefully and select the one choice in each group that best describes your past suicidal ideation and planning, including today. Be sure not to choose more than one statement for any item.

Q-1	Have you ever seriously thought about committing suicide?	1.Yes 2.No
Q-2	If your answer is" yes" to Q-1 when?	Specify--------
Q-3	Have you seriously thought about committing suicide within the last 1 month?	1.Yes 2.No
Q-4	Have you ever made a plan for ommitting suicide?	1.Yes 2.No

Part VIII: Criminal History Questionnaires

Q-1	Have you ever been arrested?	1. Yes 2. No
Q-2	During past 12 months did you slap, fist, kick, attempt to kill someone or take or destroy property?	1. Yes 2. No
Q-3	During past 12 months did you performed or attempted Sexual intercourse by threatening or applying force?	1. Yes 2. No

መመላእታታት

ተወሳኺ - ፤

ናይ ሓበሬታ ወረቐትን ናይ ፍቓድ ቅጥዒን

1. **ናይ ተሳተፍቲ ሓበሬታ ወረቐት**

ኣርእስቲ እቲ ፕሮጀክት መዕናዕቲ: ኣብ ዓይደር ኩለመዳያዊ ስፔሻላይዝድ ሆስፒታል

መቐለ፣ትግራይ፣ኢትዮጵያ፣2025 ዓ/ም ኣብ ከቢድ ሕማም ኣእምሮ ዘለዎም ሰባት ዓመዕግዳይነትን ተዛመድቲ ረቓሒታትን

ስም ዋና መርማሪ፡ ጎይተኣም ኣዲሱ

ስም እቲ ትካል፡ መቐለ ዩኒቨርስቲ ኮሌጅ ጥዕና ሳይንስ ክፍሊ ስነ-ኣእምሮ

መእተዊ- እዚ መዕናዕቲ ኣብ ACSH, Mekelle, Tigray, Ethiopia, 2025 ምክትታል ኣብ ዘለዎም ከቢድ ሕማም ኣእምሮ ዘለዎም ሰባት ምስ ዓመዕ ግዳይነት ዝተኣሳሰሩ ረቓሒታት ንምግምጋም ዝዓለመ እዩ።

ኣገባብ ኣሰራርሓ፡ ኣብዚ ፕሮጀክት ክትሳተፉ እዕድመኩም።።ኣብዚፕሮጀክት ክትሳተፉ ፍቓደኛታት እንተኾይንኩም፡ ነቲ ናይ ስምምዕ ቅጥዒ ክትርድኡን ክትፍርሙን ኣለኩም። ድሕሪኡ፡እቶም መሕተቲ ጽሑፋት ክምልኡ እዮም።

ሓደጋታትን ጥቕምታትን፦ብተሳትፎ ኣብ ልዕሌኻ ዝበጽሕ ትጽቢት ዝግበረሉ ጉድኣት የለን ከምኡ'ውን ንዝሳተፍካ ቀጥታዊ ክፍሊት እውን የለን፡እንተኾነ ግን ተሳትፎኻ ነቲ ዕላማ መጽናዕቲ ንምዕዋት ክሕግዘና ተኽእሎ ኣሎ።

ምስጢራዊነት፦ ነዚ ፕሮጀክት መዕናዕቲ ዝእከብ ሓበሬታ ምስጢራዊ ክኸውንን በዚ መዕናዕቲ ዝእከብ ሓበሬታ ብዛዕባኻ ኣብ ፋይል፣ብዘይስምካ፣ግን ድማ ዝተመደበሉ ኮድ ቁዕሪ ክኽዘን እዩ። ብዘይካ ዋና መርማሪ ንማንም ኣይግለጽን ውሑስ ኮይኑ ክሕሉእዩ።

2. ቅጥዒ ፍቓድ

ዝኸበርኩም ተሳተፍቲ፡ **ቁጽሪ ኮድ፡** _____

ሰናይ ንጉሆ/ድሕሪ ቀትሪ ጎይታይ/ማዳም? ናተይ ሽመይ_____፤ብስም ጎይተኦም ኣዲሱ ኣብ ዝተዋደደ ክሊኒካውን ማሕበረሰባዊ ጥዕና ኣእምሮ ማስተርስ ዲግሪ ዝወስድ ተምሃራይ እየ። ሓደ ካብቲ ንዲግሪ ዝጠልቦ ረቓሒታት ፕሮጀክት ምርምር ምክያድ እዩ።እዚ ደብዳበ እዚ ኣብዚ መጽናዕቲ ንኽትሳተፍ ካባኻ ፍቓድ ንምሕታት የገልግል።ዕላማ ናይዚ መጽናዕቲ ኣብ ዓይደር ምክትታል ኣብ ዘለዎም SMI ዘለዎም ሰባት ምስ ዓመጽ ግዳይነት ዝተኣሳሰሩ ረቓሒታትን ምግምጋም እዩ።ኣብዚ መፅናዕቲ ዘለኩም ተሳትፎ ወለንታዊ ኮይኑ ንዕውትነት እቲ መፅናዕቲ ኣዝዩ ኣገዳሲ እዩ። ግዜ ናይ ምብኻን ሓደጋ ኣሎ ገለ ካብቲ ናይቲ መጽናዕቲ ሕቶታት ንዓኻ ዘይምቹ ክኸውን ይኽእል እዩ ንዓኻ ዘይምቹ ሕቶ ምስረኸብካ ድማ ክትዘልሎ ትኽእል ኢኻ።ኩሉ እቲ ብኣኻ ዝሃብካዮ መልስታትን ዝተረኽበ ውጽኢትን ግን ዝኾነ ሰብ መልስኻ ክረኽቦ ዘይክእል ኮዲንግ ሲስተም ተጠቒምካ ምስጢራዊ ክኸውን እዩ። ስምካ ወይ ቁጽሪ ተሌፎንካ ክትህብ ትጽቢት ኣይግበርን። ብዘይ ፍቓድ ካባኻ ንሕጋዊ ኣካልን ዝኾነ ክፋል ናይዚ መጽናዕቲ ንሳልሳይ ሰብ ኣይግለጽን እዩ።ኣብ'ዚ መጽናዕቲ 'ዚ ክትሳተፍ እንተዘይደሊኻ ናይ ምእባይን ምስሓብን ምሉእ መሰል ኣሎካ። እቲ መሕተቲ ኣስታት 30 ደቓይ ቕጥራይ ክወስድ እዩ። ኣብዚ መጽናዕቲ ክትሳተፍ ፍቓደኛ እንተኾንካ፡ነቲ ናይ ስምምዕ ቅጥዒ ክትርድኦን ክትፍርሞን ኣለካ፡ ድሕሪኡ ነቲ ክህሉ ዝኽእል መልሲ ባዕልኻ ክትምልሶ ትኽእል ወይድማ ብኣከብቲ መረዳእታ መልስኻ ክትህብ ክትሕተት ኢኻ።

ነዚ መሕተቲ ጽሑፍ ክትመልእ ፍቓደኛ ዲኻ? እወ _____ ኣይኮንኩን_____

የቐንየለይ!

ናይ ጽሑፍ ፍቓድ ቅጥዒ

ትሕዝቶ ናይዚ ሰነድን እንታይነት ናይቲ መጽናዕታዊ ፕሮጀክትን ከምዝተረዳእኩን፡ ኣብቲ መጽናዕታዊ ፕሮጀክት ብፍቓደኝነት ክሳተፍ ከም ዝሰማማዕን በዚ የረጋግጽ። ኣብ ዝኾነ እዋን ካብቲ ፕሮጀክት ክወጽእ ኣብ ርእሰ-ምሕደራ ከምዘለኹ ይርዳኣኒ።

ፈርማ ተሳታፊ _____ዕለት _____

ስምን ፈርማን ኣካቢ መረዳእታ _____ዕለት_____

ስምን ፈርማን ተቐጻጻሪ _____ዕለት_____

ብዛዕባ እዚ ፕሮጀክት ዝኾነ ስክፍታ እንተሃልዩኩም ናብ ጎይተኦም ኣዲሱ ክትድውሉ/ላ ትኽእሉ/ላ ኢኹም/ክን።
+251968903471
መምርሒ

ነቲ ዝተዋህበ ግቡእ መልሲ ከቢብካ ኣድላዩ ኣብ ዝኾነሉ ድማ ኣብቲ ዝተዋህበ ቦታታት ዘድሊ መልስታት ጽሓፍ። (ብኣከብቲ መረዳእታ ክምላእ እዩ)

ጥብቂ ሓበሬታ: እቲ ተሳታፊ መጽናዕቲ ኣብቲ መጽናዕቲ ክሳተፍ ፍቓደኛ እንተዘይኮይኑ፡ነቲ ቃለ መሕትት ደው ኣብልዎ።

ተወሳኺ-II

ናይ እንግሊዝኛን ትግርኛን ስሪት መሕተቲ ጽሑፍ

1. **ናይ ትግርኛ ስሪት መሕተቲ ጽሑፍ**

መምርሒ፡- እቲ መሕተቲ ሸሞንተ(8^{ተ}) ክፋላት ኣለዎ። ነቲ ቃለ መሕትት ንምዝዛም ኣስታት 20 ደቓይቕ ክወስድ እዩ። በይዛኹም/ክን ንኹሉ ሕቶታት መልሲ ክትህቡ/ባ ፈትኑ/ና።ስለ ቲትዕግስቲ ብጣዕሚ ነመስግን።

1^{ይ} ክፋል፡ማሕበረ- ዲሞግራፊካዊ ሓበሬታ

No.	መሕተቲ	ኣማራጺ መልሲ
ሕቶ-1	ጾታ	1. ተባዕታይ 2. ዓል ኣንስተይቲ
ሕቶ-2	ዕድሜኻ/ኽን ክንደይ እዩ?	ዕድመ ብዓመታት----------
ሕቶ-3	ሕጂ ኣበይ ኢኻ/ኺ ትነብር/ሪ ዘለኻ/ኺ?	1. ብውልቂ ዝውነን። 2. ክራይ ገዛ 3. ትካል 4. ጽግዕተኛ (ምስስድራቤት፡ዓርኪ) 5. ገዛ ዘይብሉም (ጎደና).
ሕቶ-4	ኩነታት ሓዳርኩም/ክን እንታይ እዩ?	1. ንጽል 2. በዓል ሓዳር 3. ዝተፋትሑ/ሓ 4. ዝተፈላለዩ/ያ 5. መበለት
ሕቶ-5	ሃይማኖትካ/ኪ እንታይ እዩ?	1. ኦርቶዶክሳዊ 2. ኣስላማይ 3. ካቶሊካዊ 4. ፕሮቴስታንት እዩ 5. ካልኦት---------
ሕቶ-6	ብሄርካ/ኪ እንታይ እዩ?	1. ትግራይ 2. ዓፋር 3. ኣምሓራይ 4. ኦሮሞ 5. ካልኦት------

ሕቶ-7	ደረጃ ትምህርትኻ/ኺ ክንደይ እዩ?	1. ምዕሓፍን ምንባብን ዘይኽእሉ/ላ 2. መባእታዊ ቤት ትምህርቲ 3. ካልኣይ ደረጃ ቤት ትምህርቲ 4. ኮሌጅን ልዕሊኡን
ሕቶ-8	ሞያኻ/ኺ እንታይ እዩ?	1. ነጋዳይ 2. ሓረስታይ 3. ተኞፂሩ ዝሰርሕ 4. ስራሕ ኣልቦ 5. ተማሃራይ 6. መዓልታዊ ሸቃላይ 7. ካልኢ----------
ሕቶ-9	ማእኸላይ ወርሓዊ ኣታዊኻ/ኽን ክንደይ እዩ?	_____ ብር
ሕቶ-10	Residence	1. Urban 2. Rural

2ይ ክፋል፡ መሕተቲ ንዓይነታት ዓመጽቲ ተግባራት

ኣብ ዝሓለፈ ዓመታት ከቢድ ናይ ኣእምሮ ሕማም ካብ እትሓምሙ/ማ ንደሓር፡ ካብዞም ዝስዕቡ ፍጻመታት ኣየናይ ግዳይ ኮይንካ/ክን? ኣብቲ ሳንዱቕ ብምእታው መልስኹም/ኽን ክትመርፁ/ፃ ትኽእሉ/ላ ኢኹም/ኽን።

1. ሓደ ሰብ ካባኻ/ኺ (ኣብ ልዕሊ ሰብነትካ/ኪ)፡ ሓይሊ ብምጥቃም፡ ወይ ብምፍርራሕ ገለ ነገር ወሲዱልካ?
    1. እወ
    2. ኣይፋልን
2. ከምኡ ክገብር ዝፈተነ ሰብ ኣሎ ድዩ?
    1. እወ
    2. ኣይፋልን
3. ሓደ ሰብ ኮነ ኢሉ ገዛኻ፡ ድኪንካ፡ ወይ ካልኣ ትውንኖ ንብረት ኣፅንዩ ወይ ኣበላሽዩ?

1. እወ
2. ኣይፋልን

4. ኣብ ውሽጢ ገዛ ይኹን ካብ ገዛ ወጻኢ ብዘይዝኾነ ኣጽዋር መጥቃዕቲ ፈጺምካ (ወቒዕካ፡ ጸራዕካ፡ደራእካ፡ ምጉርፋጥ፡ወይ ረጊጽካ) ትፈልጥ ዲኻ?
    1. እወ
    2. ኣይፋልን
5. ክትቀትለካዓሊምካ ብኽቢድ መጥቃዕቲ ፈጺምካ ትፈልጥዲኻ? (ብሽጉጥ ወይ ብረት ምትኳስ ዘየጠቓልል ብረት (ንኣብነት ጥርሙዝ፡ ብርጭቆ፡ ካራ፡ በትሪ፡ ውዑይ ፈሳሲ፡ ገመድ) ዝተሃርመ፡ ዝተወግአ፡ ዝተቓጸለ፡ ምትኳስ ወይ ብኻልእ መንገዲ ዝተሃርመ?
    1. እወ
    2. ኣይፋልን
6. ጨውኻ (ኣንጻር ድሌትካ ወሲድካ ተታሒዝካ) ትፈልጥዲኻ?
    1. እወ
    2. ኣይፋልን
7. እዚ ንዓኻ/ኺ ክቢድ ሕቶ ምኺኑ ይፈልጥ እየ፡ ስለዚ ንሓጺር እዋን ክትሓስበሉ/ብሉ።ኣንጻር ድሌትካ/ኪ ጾታዊ ተግባር ዘጠቓልል ኣጋጢሙካ/ኪ ድዩ? ከምኡ ንምግባር ዝግበር ፈተነታት?
    1. ፈተነ ምዕማጽ
    2. ምዕማጽ
    3. ጾታዊ ርክብ ብሓይሊ ኣይተመኮርኩን
8. ኣብ ላዕሊ ንዝርከቡ ሕቶታት 1-7 እንተወሓደ ሓደ ግዜ 'እወ' ኢልካ/ኪ እንተመሊስካ/ኪ መዓዝ እዩ ኣጋጢሙ?
    1. ኣብ ዝሓለፉ 12 ኣዋርሕ
    2. ቅድሚ ሓደ ዓመት
    3. ኣይዝክሮንየ
    4. ኣይተፈጸመን
9. በዚ ኣብ ላዕሊ ዝተጠቕሰ ፍጻመታት ክንደይ ግዜ ተሳቒኻ?
    1. ሓደ ግዜ
    2. ክልተ ግዜ
    3. ሰለስተ ግዜ
    4. ልዕሊ ሰለስተ ግዜ

10.እዚ ኣበይ እዩ ኣጋጢሙ?	11.ምስ ገበነኛታት ዘለካ ርክብ?	12.ነዚ ንመን ጸብጺብካዮ?
1. ገዛ 2. ኣብ ጎደና ጥቓ ገዛእ ገዛ 3. ኣብ ጥቓ ቤት ፅሕፈት መንግስቲ/ህንፃ ኣብ ዝርከብ ህዝባዊ ቦታ 4. ኣብ ቤት ትምህርቲ 5. ኣብ ስራሕ 6. ኣብ ጥቓ ገዛእ ርእስኻ ኣብ ዘይርከብ ጎደና/ጽርግያ 7. መንበሪ ትካል 8. ስፖርትን ኣትሌቲክስን ክባቢ 9. ናይ ኢንዱስትሪ ወይ ኮንስትራክሽን ቦታ 10. ሕርሻ (ገዛ ከይሓወሰ) 11. ንግዳዊ ቦታ (ድኳን፣ድኳን፣ሆቴል፣ባር ፣ቤትፅሕፈት) 12. ናይ ኣምልኾ ቦታ 13. ሆስፒታል 14. ካልእ (ግለጽ) . 99. . ዘይፍለጥ	1. ኣባል ሃውስ ሆልድ 2. ካልእ ዘመድ 3. እትፈልጦ ጎረቤት 4. ናይ ቀረባ ዓርኪ ወይ ናይ ስድራ ቤት 5. ብዓይኒ ጥራይ እትፈልጦ ሰብ 6. ብዓይኒ ጥራይ እትፈልጦም ጉድለ ሰባት 7. ውልቀ ጓና ሰብ 8. ጉድለ ዘይፈልጦም ሰባት 9. ካልእ በጃኹም ግለጹ 10. በዓል ሞያ ጥዕና 99. በዳሊ ኣይረኣየን/ኣይፈልጥን። 77. መልሲ ምሃብ ኣብዩ	1. ፖ*ሊስ/ወተሃደራዊ 2. መራሕቲ ሃይማኖት/ባህላዊ መራሕቲ/ሽማግለታት/ሹማምንቲ/መራሕቲ ዓዲ 3. ሰበ ስልጣን መንግስቲ 4. ውዳበ ደቂ ኣንስትዮ 5. ኣብቲ ክባቢ ዝርከቡ ፅጡቓት ጉጅለታት 6. ሚድያ 7. ፖ*ለቲካዊ ውድብ 8. ሓኪም፡ በዓል ስልጣን ጥዕና 9. ካልእ ኣባል ገዛ 10. ካልእ (ግለጽ) . 11. ኣይጸብጸበን 77. መልሲ ምሃብ ኣብዩ 99. ኣይትፈልጥን

13. ብሓፈሻ ፖ*ሊስ ነቲ ጉዳይ ብዝሓዝሉ ኣገባብ ፅጉብ ዲኻ?

1. እወ (ፅጉብ)
2. ኣይፋልን (ዘይዓገበ)
3. ኣይፈልጥን'የ

4ይ ክፋል፡ ኣረኣእያታት ድሕነትን ዓመጽን

ግዳይ ናይ ምኺን ተኽእሎ፦ ኣብዝቐጽሉ 12 ኣዋርሕ ግዳይ ናይ ሓደ ካብቶም ኣብ ላዕሊ ዝተጠቐሱ ዓይነታት ዓመጽ ናይ ምኺን ተኽእሎኻ ክንደይ ይኸውን?

1. ዝያዳ ተኽእሎ ኣሎ ድዩ?

ዓመጽ	1 ኣዝዩ ተኽእሎ	2 ብመጠኑ ተኽእሎ	3. ብመጠኑ ዘይመስል	4. ኣዝዩ ዘይተጸበናዮ
ኣንጻር ሰብ				
ኣንጻር ንብረት				
ክልቲኡ				

2. ኣብቲ እትነብረሉ ከባቢ ድሕሪ ጸልማት ኣብ ጽርግያ ክትከይድ ከለኻ ክሳብ ክንደይ ውሕስነት ይስምዓካ?
    1. ኣዝዩ ውሑስ
    2. ማእከላይ ውሑስ
    3. ውሑስ ወይ ዘይውሑስ ኣይኮነን
    4. ብማእከላይ ደረጃ ውሑስ ዘይኮነ
    5. ኣዝዩ ውሑስ ዘይኮነ

5ይ ክፋል፡ መሕተቲ ክሊኒካዊ ረቛሒታት

ሕቶ-1	መርመራ	1. ስኪዞፍረኒያን ካልኦት ስነ-ኣእምሮኣዊ ጸገማትን። 2. ምስ ባይፖላር ዝተኣሳሰሩ ጸገማት 3. ምስ ጭንቀት ዝተኣሳሰሩ ጸገማት 4. ካልእ፣ግለጽ_____
ሕቶ-2	ዕለት 1ይ ምብጻሕ	_____
ሕቶ-3	ቁጽሪ መእተዊ	_____

ክፍሊ 6ይ፡ ሕቶታት ኣጠቓቕማ ንጥረ ነገራት

ሕቶ-1	ኣብ ህይወትካ ኣልኮላዊ መስተ ተጠቒምካ ትፈልጥ ዲኻ?	እወ	

		ኣይፋ ልን	
ሕቶ-2	ኣብ ዝሓለፈ 3 ኣዋርሕ ዝኾነ ኣልኮላዊ መስተ ተጠቒምካ ዲኻ?	እወ	
		ኣይፋ ልን	
ሕቶ-3	ፍርያት ትምባኾ ተጠቒምካ ትፈልጥ ዲኻ?	እወ	
		ኣይፋ ልን	
ሕቶ-4	ኣብ ዝሓለፈ 3 ኣዋርሕ ዝኾነ ዓይነት ፍርያት ትምባኾ ተጠቒምኩም ዶ?	እወ	
		ኣይፋ ልን	
ሕቶ-5	ኣብ ህይወትካ ካልእ ንጥረ ነገር ተጠቒምካ ትፈልጥ ዲኻ? እወ እንተኾይኑ ግለጽ_____	እወ	
		ኣይፋ ልን	
ሕቶ-6	ኣብ ዝሓለፈ 3 ኣዋርሕ ካልእ ንጥረ ነገር ተጠቒምካዲ ኻ? እወ እንተኾይኑ ግለጽ_____	እወ	
		ኣይፋ ልን	

7ይ ክፋል፡ ናይ ነብሰ ቅትለት ሓሳብ ባህርያት

ሕቶታት

እዚ ዝስዕብ መሕተቲ 4 ነጥብታት ዝሓዘ እዩ።በጃኹም ነፍሲ ወከፍ ሕቶ ብጥንቃቐ ኣንብቡ ድሕሪኡ ኣብ ነፍሲ ወከፍ ጉድለ ንሕሉፍ ነብሰ ቅትለት ሓሳብ ብዝበለጸ ዝገልጽ ሓደ ምርጫ ምረጹ፣ንሎሚ ሓዊስካ መደብ። ንዝኾነ ሕቶ
ካብ ሓደ ንላዕሊ መግለጺ ከምዘይትመርጽ ኣረጋግጽ።

ሕቶ-	ብዛዕባ ነብሰ ቅትለት ብዕቱብ	1. እወ 2. ኣይፋልን

1	ሓሲብካ ትፈልጥ ዲኻ?	
ሕቶ-2	መልስኻ "እወ" እንተኾይኑ ንሕቶ-1 መዓስ?	ግለጽ---------
ሕቶ-3	ኣብ ውሽጢ ዝሓለፈ 1 ወርሒ ነብሰ ቅትለት ክትፍጽም ብዕቱብ ሓሲብካ ዲኻ?	1. እወ 2. ኣይፋልን
ሕቶ-4	መደብ ኣውጺእካ ትፈልጥ ዲኻ ንነብሰ ቅትለት ምፍጻም?	1. እወ 2. ኣይፋልን

8ይ ክፋል: መሕተቲ ታሪኽ ገበናዊ ጽሑፋት

ሕቶ-1	ተኣሲርካ ትፈልጥ ዲኻ?	1. እወ 2. ኣይፋልን
ሕቶ-2	ኣብ ዝሓለፉ 12 ኣዋርሕ ንገለ ሰብ ክትቀትል ወይ ንብረት ወሲድካ ወይ ኣጥፊእካ?	1. እወ 2. ኣይፋልን
ሕቶ-3	ኣብ ዝሓለፉ 12 ኣዋርሕ ብምፍርራሕ ወይ ሓይሊ ብምግባር ጾታዊ ርክብ ፈጺምኩም ወይ ፈቲንኩም ዶ?	1. እወ 2. ኣይፋልን

ንትሕብብሮም የመስግን!