

THE PREVALENCE OF POST TRAUMATIC STRESS DISORDER AND
DEPRESSION AMONG WOMEN AT EKERENYO CAMP FOR THE INTERNALLY
DISPLACED WOMEN INVOLVED IN ETHNIC VIOLENCE IN KISII DISTRICT

PROPOSAL IN PART FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF
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Declaration

I, Josephine Njoki Nyambane declare that this dissertation is my original work carried out in part fulfillment of the requirement of the degree of Masters of Science in Clinical Psychology of the University of Nairobi under the supervision and guidance of the staff of the Department of Psychiatry, University of Nairobi. I further declare that this dissertation has not been submitted for the award of any other degree or at any other university.

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And to all my colleagues and all the members of my family I say thank you and may God bless you all

DEDICATION

To my husband Peter Nyambane, sons Antony, Emanuel, Elijah, and Samuel, daughter Bosibori Nyambane for their prayers and continued support and encouragement during the two years of study.

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ABBREVIATION

1. APA American Psychiatry Association
2. A I D s Acquired immune -deficiency syndrome
3. B D I Becky's Depression Inventory
4. CORAW Coalition on Violence against Women
5. DSM IV (R) Diagnostic and Statistical Manual of mental disorder Revised
6. DALYS Disability Adjustment Life Years
7. I D P s Internally Displaced Peoples
8. I E R S ® Impact of Event Scale Revised
9. IDMC Internally Displaced Monitoring Committee
10. GBV Gender Based Violence
11. HIV Human Immune - deficiency virus
12. NGOs Non- Governmental Organization
13. PTSD Post Traumatic Stress Disorder
14. S T I s Sexually Transmitted infections
15. SPSS Statistical Package for Social Sciences
16. UNICHR United Nations Commission on Human Rights
17. UNICEF United Nation Children's Education Fund

ABSTRACT

Background

Violence is a common feature of modern life. Media presentation is filled with images of people hurting one another and although much attention is given to scenes depicting perpetrators of violence little is given to the victim's psychological problems.

Ethnic clashes have led to destruction of communities, deepening ethnic hatred, food shortages and creation of "refugee", displacement and migration with their accompanying problems. All these have specific consequences on the lives of displaced women with some of these consequences resulting in psychological problems.

Kenya has not been spared of this unpredictable ill. Recently people of different ethnic groups turned on each other, destroying property and lives of their opponent ethnic groups. Women died, others were widowed, orphaned and most of them suffered several forms of abuse both physical and psychological (emotional) especially due to sexual abuse.

Study objectives: This study aims at identify the presence of PTSD and Depression among women who are victim of ethnic violence. The specific objectives of the study is to establish the demographic profile of women who have suffered psychologically due to ethnic violence, the presence of PTSD ,and depression in these women and to document their subjective experiences

Study design. This was a descriptive and quantitative study that adopted a population survey

Setting: Ekerenyo IDP Camp in Kisii District.

Subjects: Women, who consented, were above 18 years and were in the IDP camp at the time of study or at Ngoina road area after relocation and were affected by ethnic violence after December 2007 election.

Research instrument:

1. A socio-demographic profile designed by the researcher,
2. Impact of Event Scale –Revised (for PTSD) and
3. Beck's Depression Inventory (for depression)

Result: The study shows extremely high levels of PTSD(100%) which is not surprising considering the traumatic events that occurred during the post election violence (burning of houses, murder, eviction, rape, etc) all the respondents (198) presented with PTSD with 176(89%) with moderate PTSD and 22(11%) with severe PTSD. Women with symptoms formed 94% while those with no depression were 6%. Those with moderate depression formed a bigger percentage 130 (65%) of the sample population. This was followed by 49(25%) of the women who had mild depression. Apparently only 7(4%) of the women had severe depression while 12 (6%) women had depression.

Conclusion: The study concluded that Post Traumatic Stress Disorder and Depression is present in women who have suffered ethnic violence.

CHAPTER ONE

1.0: INTRODUCTION

Violence is such a common feature of modern life. Media presentation is filled with images of people hurting one another and although much attention is given to scenes depicting perpetrators of violence little is given to the victim's psychological well being.

The total psychological impact of ethnic violence against women is literally incalculable. Ethnic clashes have led to destruction of communities, deepening ethnic hatred, food shortages and creation of "refugee", displacement and migration with their accompanying problems. All these have specific consequences on the lives of displaced women with some of these consequences resulting in psychological problems.

Ethnic violence has disrupted and destroyed hundreds of communities across the country. Distrust between the ethnic groups remains high and the charred remains of the destroyed buildings are a constant reminder of violence and the possibility of renewed violence.

Kenya has not been spared of this unpredictable ill. Recently we saw people of different ethnic groups turning on each other, destroying property and life of their opponent ethnic groups. Women died, others were widowed, orphaned and most of them suffered several forms of abuse both physical and psychological (emotional) especially due to sexual abuse. This has been going on in different parts of the country with people from Rift valley being the most adversely affected

Persistent fear and suspicion between members of the different communities living in these areas is still prevalent. Some women, when interviewed were reluctant to recount

their experiences during the ethnic clashes fearing that this would aggravate the already polarized relationships.

This fear and suspicion has affected the daily lives of many women in these communities. They are reluctant to cultivate their farms (Rift valley especially) lest there be fresh attacks by the community warriors. Similarly women are afraid of retaliatory attacks from the communities especially as they carry out their economic activities in the market places. As long as there is fear that violence could break yet again communities in these regions may not be able to resettle on their farms permanently and are living in constant fear and anxiety which in the long run has an adverse effect on their psychological health.

1.1 Background of the study

The recent post election violence resulted in more than 1,200 people dead and about 350,000 displaced. (Daily Nation, 9TH June, 2008). Most of the displaced people are now living in camps which are temporally measure residence for internally displaced people (IDPs).

There have been ethnic clashes in the past leading to deaths, maiming and displacement of people, destruction of property but the recent ethnic clashes was the worst compared to others in the past, 1992, 1997, 2002 in various parts of the country e.g., Molo, Elburgon, Burnt forest to mention but a few.)

On a visit to Limuru IDP Camp, the researcher found out that several people responded to the IDPs physical and social need but very little was done to take care of their psychological needs.

Studies done locally and elsewhere show that about 90% of people involved in disaster situation develop some form of psychological distress in the first month, 30% have persisting psychological distress within six months and 10% persist for over six months (Guiding Principle on IDPs,2006).This calls for immediate response especially psychological intervention and where necessary treatment for those in need.

Why are IDP s particularly vulnerable?

Most of the people affected by conflict and/or human rights violations suffer, displacement from one's place of residence which makes them particularly vulnerable. The following are some of the factors that are likely to increase the need for protection of women:

- Internally displaced persons may be in transit from one place to another, may be in hiding, may be forced toward unhealthy or inhospitable environments, or face other circumstances that make them especially vulnerable.
- The social organization of displaced communities may have been destroyed or damaged by the act of physical displacement; family groups may be separated or disrupted; women may be forced to assume non-traditional roles or face particular vulnerabilities.
- Internally displaced populations, and especially groups like children, the elderly, or pregnant women, may experience profound psychosocial distress related to displacement.
- Removal from sources of income and livelihood may add to physical and psychosocial vulnerability for displaced people especially women.

- Schooling for children and adolescents may be disrupted leading to additional distress to women
- . Internal displacement to areas where local inhabitants are of different groups or inhospitable may increase risk to internally displaced communities; internally displaced persons may face language barriers during displacement.
- The condition of internal displacement may raise the suspicions of or lead to abuse by armed combatants or other parties to conflict. Internally displaced persons may lack identity documents essential to receiving benefits or legal recognition; in some cases, fearing persecution, displaced persons have sometimes got rid of such documents(General Guidance on IDPs , 2006)

1.2. Statement of Research Problem

Ethnic violence is the violation of peoples rights especially women. Majority of the victims of ethnic clashes are settled in refugee camps established by church based organizations and Non –Governmental Organizations (NGOs). In most of these camps, women form a particularly vulnerable category among the displaced people. This vulnerability arises from two major factors:

-The shifting of family responsibilities

-Failure of relief agencies to provide gender sensitive programs

Long lasting psychological symptoms of PTSD, depression, other disorders (insomnia, suicide etc) have been reported in the adult female subjected to ethnic violence, however very little research has been done to quantify and qualify the psychological effect of ethnic violence against women. There is therefore,very little understanding of

the psychological effect of ethnic violence against women. Without this knowledge people will concentrate on the physical harm incurred during or after a violent act and ignore the deep seated psychological effects of the violence against women. It is therefore very difficult to design effective strategies for dealing with issues such as PTSD, depression, and other psychological disorders on victims of ethnic violence. At the same time the extent of psychological effect among the internally displaced women remain unknown leading to no psychological intervention on the affected women. This study is therefore designed to come up with the psychological effects of ethnic violence among women and to recommend ways of dealing with and managing some of the psychological problems that arise from distress caused by violent acts (for example physical abuse, rape , loss etc) during the ethnic violence .

1.3 Purpose and Justification of the Study

- 1) This kind of study has both academic and social relevance and several other implications for advocacy
- 2) Academically the study will establish the common psychological effect of ethnic violence on women. Continued education of the public on the psychological outcome of ethnic / violence victimization is critical for improving reactions to disclosure, reducing stigma, and raising awareness of available services and resources for the victims. Understanding the psychological problems in women as a result of ethnic violence will lead to a coherent and effective management of the problems.
- 3) The immediate benefit to the women IDPs cannot be underestimated as the knowledge can be used to formulate current and future techniques and

interventions on those psychologically affected by the events of ethnic violence. Psychotherapy and treatment will be given to those in need.

- 4) On social relevance the study will provide data that can be used in targeting strategies on how to manage these psychological effects after the traumatic event. Having knowledge in this area is critical for all individuals working with the survivors, including victims advocates, community health workers, and policy makers. First, it promotes continued empathy and support for survivors. Second, the knowledge may help diverse groups of service providers respond to current trends towards professionalism in the field of ethnic violence. This helps them to move away from the grassroots model to professional model which includes the use of evaluation and analytic tools and other activities
- 5) The study has several applications for advocacy groups. It may be used to advocate for the training of more providers in specialized therapeutic approaches for ethnic violence. It may also support efforts to place pressure on the formal mental health system to work collaboratively with other public systems, including medical, legal, and law enforcement systems in order to minimize the likelihood of secondary victimizations and long- term distress. Another application is to supporting reforms that help secure permanent funding for ethnic violence crisis centers and other specialized violence related services, including specific prevention and intervention programs
- 6) The psychological impact of ethnic violence is clearly a serious public health problem for women. By acquiring a common foundation of knowledge and fostering collaborations, those in the field may increase access to support and

resources, so that all women who experience the emotional aftermath of ethnic violence may follow a path of recovery that is healing and empowering. This (secondary) intervention should be done as soon as possible in order to minimize the psychological effects of the ethnic violence trauma.

- 7) Finally the results of the study will enlighten other researchers on the achievement of the outlined objectives for IDPs leading to appropriate development and implantation of proper psychological intervention for the IDPs in the country. In a similar vein the study will also form a base on which others can develop their studies.

1.4. Aim and objectives of the study

The aim of the study was to identify the prevalence of PTSD and depression amongst the internally displaced women (IDPs) at Ekerenyo IDP Camp.

Specific objective

1. To establish the demographic profile of women in the camp
2. To establish the presence of PTSD /depression in women in the IDP camp
3. To establish the relationship between the social demographic variables and other traumatic events in the development of PTSD and depression.
4. To establish the significance of different social demographic variables in the development of PTSD and depression

1.5 Study hypothesis

Alternative hypothesis

Women who are victims of ethnic violence exhibit PTSD and depression.

Null hypothesis

Women who have been victims of ethnic violence do not exhibit PTSD and depression.

1.6 .Study limitations and delimitations

Limitation

- 1) The IDP camp had few women who could neither read nor write. Since the questionnaire was self administered they were helped to participate in the study..
- 2) At the time of data collection the number had changed as the IDPs were being relocated to their former place of residence. This meant that I had to work with a smaller figure or visit them at Ngoina road shopping center where they had been relocated.

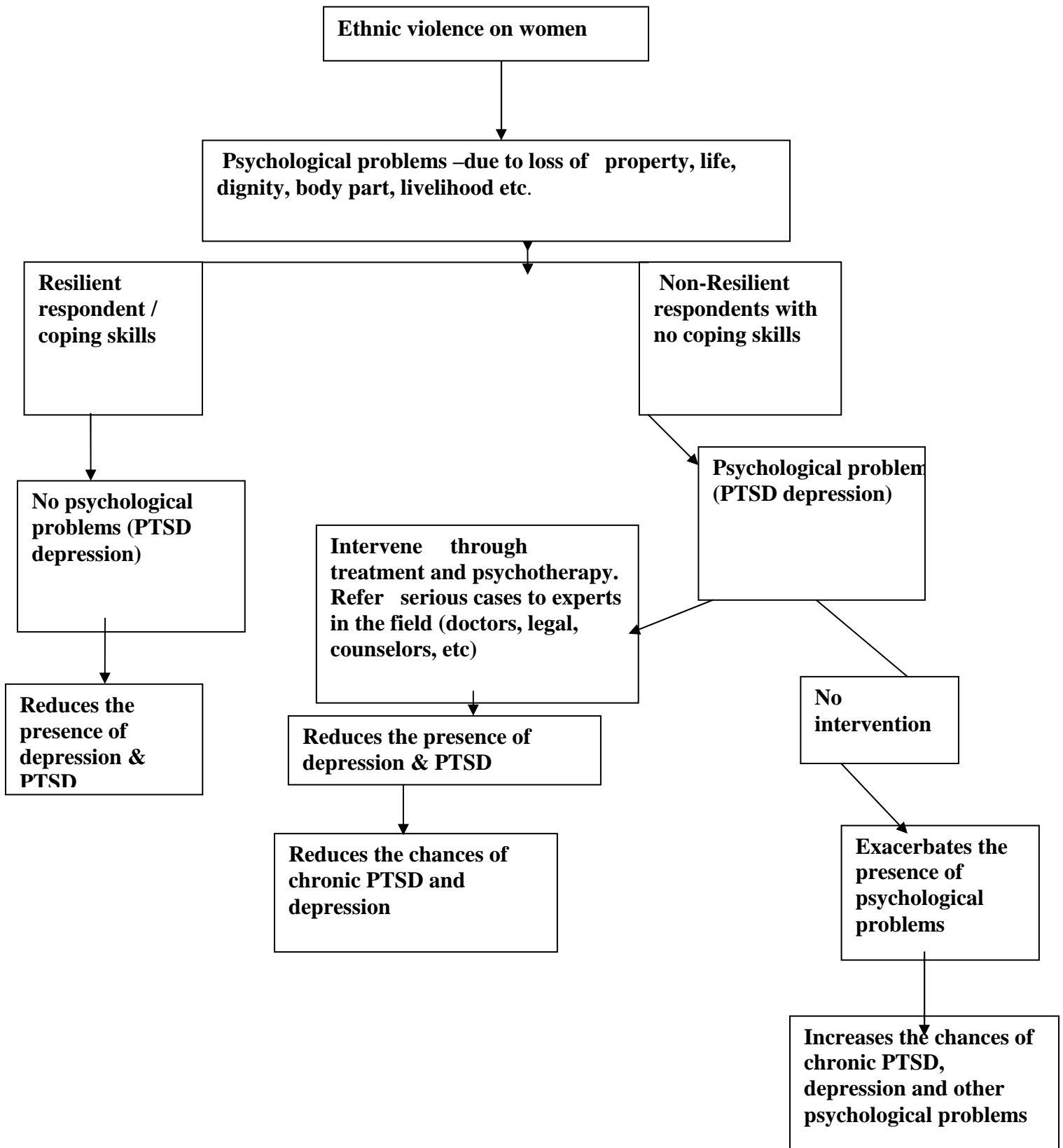
Delimitation

- 1) The study was confined to a group of women who were directly affected by the ethnic violence after December 2007 election and were at the camp during the study or at Ngoina road shopping center after relocation.
- 2) There are several factors which lead to PTSD and depression but the study focused on the impact of ethnic violence on women and its effects on the psychological health of women.

Assumption

The study approach assumed that all women in IDP camp are as a result of ethnic violence

1.7 Conceptual Frame Work of Psychological Effect of Ethnic Violence.



1.8 Definition of Terms

Ethnicity and Violence

Ethnicity (the word “ethnic comes from a Greek word meaning for “nations “) is based on cultural heritage, nationality characteristics, race religion and language. Ethnicity involves descent from common ancestors usually in a specific part of the world. Sometimes culture and ethnicity are identical. Often this term indicates different aspects of ones identity. Ethnicity is central to the development of an ethnic identity, a sense of membership based upon the shared language, religion, customs values, history and race of an ethnic group. All of us have ethnicity, but only some of us have a strong ethnic identity and use our ethnicity to define our self identity.

Ethnicity may be too ingrained in some people such that any difference may lead them on to turn on each other in a violent manner in times of conflict.

On the other hand violence involves physical force with the intent to harm another person and from an observer’s perspective, victims injuries seem best measured in terms of physical violation. Yet injury to victims of violence involves not only the physical violation but psychological violation as well .The aftermath of violence on women must be understood by considering threats not only to their bodily integrity but also to their psychological integrity.

The suffering of victims of violence varies from person to person, but it is generally far more intense than might be predicted from a simple examination of physical injury. Victims of rape, assault, sexual abuse and physical abuse often have similar responses to their victimization (Harrowitz, M., 1979, &IDCM, 2007). They frequently feel helpless,

out of control, depressed, ashamed, anxious, frightened and disorganized. Behavior reactions include sleep disturbances, uncontrollable crying, restlessness, deterioration of personal relationships and increased use of drugs (Kilpatrick D. G., et al, 1979)

The victims of ethnic violence are forced to directly confront the possible loss of physical functioning and even death. They are also forced to directly confront the possible breakdown of the cognitive structures that had been so instrumental in providing psychological stability

What is violence against women?

“Women” mean persons of female gender, including girls”. Violence against women” means all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war “Women” means persons of female gender, including girls.

The internally displaced persons (IDPs)

Internally displaced persons are "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.

The term “psychosocial “

For the purpose of this study the term “Psychosocial” refers to the dynamic relationship that exists between psychological and social effects, each continually interacting with and influencing the other

The term “psychological effects “

The “psychological effects” are those which affect different levels of functioning including cognitive (perception and memory as a basis for thoughts and learning), affective (emotions) and behavioral.

The term “Social effects”

Social effects” pertain to altered relationships, family and community networks and economic status (George S., et al, 1994)

CHAPTER TWO

2.0: REVIEW OF LITERATURE

2.1: Introduction

This chapter therefore begins by examining the risk factors that predisposes women who are victims of ethnic violence to some psychological problems.

The second section focuses on determinant diagnostic factors for PTSD, depression, and other psychological disorders.

The third section discusses previous studies that have examined the psychological effect of ethnic violence against women.

Social and psychological profile

The impacts of conflict are complex and wide ranging. They are not confined at war – they ripple outward from the initial violence, spreading from individuals and communities to countries and regions. Conflict cause insecurity due forced displacement, sudden destitution, the breakup of families and communities, collapsed social structures and the break down of the rule of law. The insecurity can persist long after the clashes have ended as internally displaced (IDP), refugees, and asylum seekers try to adjust to new circumstances around them, cope with loss and regain a sense of normalcy. Collier et al 2003, research suggests that because these adverse effects persist for a long time, much of the cost of war occur after it is over .

Over the last 30 years , over 80 million people have been forced to flee their homes , communities , or nations as result of conflict (Carballo et al ,2009) , As of the end of

2003 , there were an estimated 38 million uprooted people (13.7 million refugees and 24.5 million IDPS) almost 16 million of whom were in Africa.

In recent years 30 countries have had more than 10 percent of their population displaced through conflict. In 10 countries, displacement has been over 40 percent (Leelangi W. 2000).

Targeted killings, amputations, gender-based violence, and physical maiming, forced displacement, harassment and intimidation, conflict and relocation often have long – term psychological effects on those who have experienced or witnessed them.

Mental disorders and psychosocial consequences associated with conflicts include sleeplessness, fear, nervous, anger aggressiveness, depression, flashbacks, alcohol and substance abuse suicide and domestic and sexual violence. Following a traumatic event, a large proportion of the population may experience nightmares, anxiety, and other stress – related symptoms, although these effects usually decrease in intensity over time. For some, the hopelessness and helplessness associated with persistent insecurity, statelessness and poverty will trigger ephemeral reactions such as those mentioned above. For others, war experience may lead to post –traumatic stress Disorder (PTSD) and chronic depression. These conditions, in turn, can lead to suicide ideation and attempts, chronic alcohol and drug abuse, interpersonal violence, and other signs of social dysfunction. Studies by Mollica et al, 1999 & 2001) indicate that population affected by conflict are not only affected by mental health problems, but have associated dysfunction, which can last up five years after the conflict

The Global Burden of Disease study estimated that the burden of disease from mental and behavioral disorders such as depression, bipolar disorder, psychosis schizophrenia, and substance abuse would increase from 12 percent in 1990 (WHO,2000 1b), to close to 15 percent by 2020(UNFPA,2000). This estimate was based in part on the projection that violent conflict would shift from the 16th to 8th leading cause of disease by 2020, and violence would move from 28th to 12th, psychoses and mood disorders are widespread in conflict – affected societies (Silove D. et al, 2000). Currently, five mental disorders are among the top ten leading causes of disability, and include alcohol abuse, bipolar disorder, schizophrenia, obsessive compulsive disorder and major depression. At present, major depression is the principal cause of disability adjusted life years (DALYS) among working age population and the greatest overall source of disability in the world, (White ford H. et al ,2001)

Conflict is associated with an increase in the prevalence of mental disorders among refugees, but there are few population – based studies of adults in conflict in affected areas and low- income countries. It is estimated that acute clinical depression and post-traumatic disorders (PTSD) range between 40 and 70 percent. Epidemiological studies among IDPS and refugees on the Thai – Cambodian border, in Algeria ,Ethiopia, Gaza and Uganda indicate that 15 to 53 percent suffer from PTSD as a consequence of conflict. In Uganda 71 percent reported major depressive disorder, and in Algeria Cambodia, Ethiopia and Gaza, psychopathology prevalence was 17 percent among non –traumatized against 44 percent for those who had experienced violence. A study of Cambodian refugees by the Harvard program in refugee Trauma showed rates of acute depression and PSTD of 68 percent 37 percent respectively (Mollica et al, 1999 &

2001). This is significantly higher than those found among the general population (10 percent and 3 percent respectively). A study of Bosnia refugees in Croatia revealed similarly high rates of depression (14 to 21 percent), and PTSD (18 to 53 percent) (De Jong J., 2000).

In the case of Guatemala, large segments of the population have been displaced because of internal conflict and violence the majority of them are Maya Indians from the north and southwestern regions of the country (De Jong J., 2000).

In an attempt to find the causes of ethnic violence most scholars agree with the fact that as long as people are enslaved by their own race, ethnicity and culture, to the point of not allowing anybody or anything else to exist, ethnic violence will always be on the increase (Mc Nally R. J., 1986)

Women and young girls are exposed to sexual abuse and exploitation for two reasons, One is an increase in adolescence activity- as a result of them not attending school and at the same time the parents are too preoccupied with other problems to keep track of what the girls are doing. This leads to an increase in teenage pregnancies a problem that aggravates the psychological well being of the female parent. Secondly some of the young girls and women engage in casual commercial sex or prostitution in order for them to meet the basic needs e.g. food and clothing .Some women and girls are direct victims of physical violence and rape. This has a far reaching psychological effect on the victim. The victims are traumatized and ashamed. In the absence of counseling services in the camps most of these women are still traumatized many years latter. Young girls have witnessed their parents being killed, raped or being physically assaulted, their houses being burned down. Witnessing the death or rape of a family

member has a very traumatizing effect on a woman; the memory of the ordeal may remain with that person for many years to come if not treated. Many women fail to cope with the traumatic event and end up suffering from post traumatic stress disorder. They may therefore acquire a keen awareness of their ethnicity and that of their attackers. This causes them to live a guarded life ready to fight back in case of any repeat of ethnic violence. They are therefore in constant anxiety as it is difficult for them to predict when the enemy will attack them again. In most cases the victims of ethnic violence are caught unawares. This un-preparedness makes the situation worse for women as suddenly their loved ones are killed, their houses are burnt down, are not able to feed their children etc. This state leads to a sense of helplessness, hopelessness, and insecurity. At times the government is unable to provide adequate security to the women making them vulnerable to other ills and several forms of abuse. Women need security, affection and a sense of belonging without which their psychological health is affected (Nicole P.Y., 2006).

2.2. Post traumatic stress disorder (PTSD) determining factors

According to diagnostic and statistical manual of mental disorders fourth edition revised (APA, DSM-IV(R), 1994)

The diagnostic criteria for PTSD include:

A. The person has been exposed to a traumatic event in which both of the following were present:

The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

The person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways

Recurrent and intrusive recollections of the event, including images, thoughts, or perceptions

Recurrent distressing dreams of the events acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociate flashback episodes, including those that occur on awakening or when intoxicated)

Intense psychological distress on exposure to internal or external cues that symbolize or resemble an aspect of a traumatic event.

Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of

The following:

- Efforts to avoid thoughts, feelings, or conversation associated with the trauma
- efforts to avoid activities, places, or people that arouse recollections of the trauma
- inability to recall an important aspect of the trauma
- markedly diminished interest and participation in significant activities
- feeling of detachment or estrangement from others
- restricted range of affects (e.g. unable to have loving relationship)

-sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

-Difficulty in falling or staying asleep

-irritability or outbursts of anger

-difficulty in concentrating

-hyper vigilance

-Exaggerated startle response

Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specification will be done for acute PTSD if the duration of symptoms is less than 3 months and chronic if more than 3months.

Another specification will be done for PTSD with delayed symptoms if the onset of the symptoms is at least 6 months after the traumatic event.(DSM IV(R) 4th Edition ,1994)

PTSD disorder is apparently more severe and longer lasting when the stressor is of human design (APA, 2000).

. Victims of ethnic violence are victims of a stressor that is human induced and intended (i.e. designed) by a perpetrator. Such victims are particularly apt to experience severe psychological distress (APA, 2000).

In order to determine the effects of ethnic violence against women in this study, the above factors will be taken into consideration in order to diagnose PTSD.

2.3. Depression

Around the world depression occurs more frequently among women than among men. The female to male ratio ranges from 2:1 to 3:1 in industrialized countries (Maputo, 2003). There are three explanations for the sex differences in depression namely:

Women are more likely to seek help therefore more likely to be categorized as having depression. There exists a biological difference between females and males that predisposes females to become more depressed than males. There are also psychological factors that precipitate the conditions for example, early childhood experiences, social roles etc. Among the psychosocial factors on women's depression that were proposed by the IDCM, (2007) National task force on women and depression were the following:

Women depression is related to avoidant, passive dependent behavior patterns. It is related to focusing too much on depressive feelings instead of on action and mastery strategies. The rate of physical and sexual abuse of women is much higher during the ethnic violence and is a major factor in women's depression. Mothers of young children are especially vulnerable to stress and depression. The more the number of children in the house, the more the depression in women reported. Poverty is a pathway to depression and 3 out of 4 people in poverty are women and children. Minority of the women, elderly, and disabled are also a higher risk group for depression and merit

special attention and support. Critical in the treatment of women's depression is diagnostic assessment for women and in particular it should include;

- taking a history of sexual and physical violence

- exploring prescription drugs used

- discovering past and current medical conditions etc. Understanding the nature of women's depression is a complex issue and merits more attention. Better understanding of women's depression will reduce women's pain and suffering from depression after ethnic violence. In order to diagnose depression Becky's depression inventory instrument will be used (IRIN, 2006).

2.4. Other studies

Among the refugees, it is estimated that acute clinical depression and PTSD range between 40 and 70 percent. Epidemiological studies among IDPs and refugees on the Thai Cambodian border, in Algeria, Ethiopia, Gaza, and Uganda indicate that 15 to 53 percent suffer from PTSD as a consequence of conflict. Krupnick, J. et al (1979) showed rates of acute depression and PTSD of 68 percent and 37 percent respectively significantly higher than those found among the general population (10 percent and 13 percent respectively (Nicole P.Y., 2006). Women have been found to have significantly poorer mental health status than men. A number of studies have shown that women are two times more likely than men to experience PTSD. Studies of Bhutanese refugees in Nepal show that tortured and non tortured women had more disorders, than tortured and non tortured men (Nadelson C. C. et al, 1982). Research by Cardozo et al (2004) in Afghanistan also shows significantly poorer mental health among women than men in general.

In general women are more likely to be poor, oppressed, and forced into position of submission. These factors place them at a heightened risk for chronic emotional problems.

A study at University of Arizona on the psychological consequences of sexual trauma indicated that women who are victimized in adulthood are vulnerable to short and long term psychological consequences. Immediate distress may include shock, fear, anxiety confusion, and social withdrawal (Lazarus, R. S.1992). Survivors may also experience PTSD symptoms shortly after a violent act has occurred, such an emotional detachment, flash backs, and sleeping disorders (Nicole et al 2006). The reported rates of PTSD among rape survivors vary from approximately 30% to 65% depending on how and when the PTSD is assessed (Nicole et al 2006). The same study also reports that psychological symptoms may be overlooked in clinical practice such as depression, physical symptoms without the presence of medical conditions.

Coid et al, 2003), also indicates that some researchers have found no association between depression and adulthood sexual victimization, others have found high rates of depressive disorders among rape survivors. The study also researched on how survivors process their mental experiences of sexual trauma. In-Depth (2006) documented the influence of background characteristics on the severity of self blaming thoughts, which predicted the degree of maladaptive beliefs that the survivors used to understand and interpret the ongoing experiences. Similarly ,Calhoun K. S. et al (1982) found that survivor's perception of past, present and future control was related to post

trauma distress. Women who felt they had enough control over their recovery process reported least distress.

A study in Sri Lanka sited political violence as a leading cause for increase in violence against women (Janet A. et al, 1983) .Women living in camps after the political violence live a life of insecurity surrounded by violence. Women have been direct as well as indirect victims of armed conflict. They along with their families have been displaced; have become widowed and taken on house hold responsibility. They have been subjected to violence, detained, tortured, trafficked and raped in custody.

A study on the impact of conflict on women and girls a consultative meeting on mainstreaming gender in areas of conflict and reconstruction in Bratislava, Slovakia indicated that, women's psychological, reproductive and overall well being is compromised in times of conflict Conflict tends to increase the incidence of sexual violence; rape; sexually transmitted infections (STIs), including HIV/AIDS: and unwanted pregnancies. In addition essential social services such as medical facilities, on which women heavily depend for their well-being, are greatly disrupted by armed conflicts (.De Jong, Joop.2002)

Many wars continue to engulf Africa leaving many Africans severely traumatized. (Mollica,et al 1999&2001) .Their study reported significant physical and psychological war –related trauma inflicted to the Ugandans in their homes, in military checkpoints and in detention .The most commonly encountered mental disorders were found to be PTSD (39.9 %) , depression (52%) among others.

The prevalence of suicidal behavior was recorded as 22.7 %. These high figures were also reflected by another recent study among the IDPs in Kenya following ethnic clashes in part of the country .A prevalence of 80.2 % of the traumatized population among the heads of household had PTSD.

A study on humanitarian news and analysis Africa and Asia indicate that 40 % of the 350000 deaths in the five eastern provinces of Democratic Republic of Congo (DRC) between August 1998 and April 2001 were women (General guidance on IDPs, 2006). These figure only begins to tell the story of the effect of armed conflict on female population of war ravaged countries death, disability, were sited as the direct result of war, the break down of public health systems also has a long term impact on the population as a whole. Factoring in the impact of gender- based violence (GBV) on the war affected female population means adding a new level of war –related health issues especially the psychological problems. The report also sited PTSD, depression, suicide as the most common effects of war. The same study also researched on the woman's burden of caring for others with nobody taking care of them. They spend their time and energy trying to keep the peace in their households and lining up for hours to get food, offer sex to strangers for money in order to buy medicine. This may have a heavy toll on their psychological health (Nicole, P. Y., et al, 2006)

Kenya has not been spared of this unpredictable ill. Recently we saw people of different ethnic groups turning on each other, destroying property and life of their opponent ethnic groups. Women died, others were widowed, orphaned and most of them suffered several forms of abuse both physical and psychological (emotional) especially due to

sexual abuse. This has been going on in different parts of the country with people from Rift valley being the most adversely affected.

In December 2006, IDMC (2007) published a special report on IDPs in Kenya "I am a refugee in my own country" concerning conflict induced internally displacement in Kenya. The report documented the protracted nature of displacement as well as the continuing lack of national and international response to the IDPs in the country .Since 2007 incidents of violent clashes and conflicts have been rapidly increasing. These clashes have on numerous occasions resulted in significant internal displacement reflecting unresolved issues of land and property as well as competition for political and economic resources (IDCM, 2007).

Currently the most visible conflict in Kenya relates to the situation in Rift Valley after the December 2007 election which left many people homeless and with no property or a viable source of income. Due to the prevailing lack of security and protection of IDPs , the majority are either unwilling or unable to return back home and with continued increase of conflict taking place through out Kenya the number of IDPs has increased . IDPs in Kenya have also been caused by government initiated evictions which have been characterized by violence and human right abuses. Natural disaster such as floods, droughts also continue to cause displacement in Kenya. This may lead to inter communal conflicts over watering points and grazing areas and as a result there are increased cattle raids (IDCM, 2007).

In cases of IDPs women and girls often face gender based violence (GBV) that contribute to displacement in the first place , as well as the fact that women are also

vulnerable. This leads to physical and sexual abuse and other forms of abuse to the women in conflict areas (IDCM, 2007).

The IDMC document reported cases of sexual abuse in Mt. Elgon from 2006.

In February 2007 an inter agency mission led by UNICEF to Mount Elgon district found reports of escalating abuse and exploitation of women. They visited Cheptalis Health Center where cases of rape were reported.

Another visit to Mount Elgon in April 2007 by coalition on violence against women (CORAW) to assess the flight of women and children in the district found out that economic and sexual harassment including rape of women both by attackers and security personnel were in the rise.

The number of IDPs in Kenya has now reached 350000 situated in various parts of the country Eldoret, Nakuru, Ekerenyu, Nakuru , Naivasha etc. This call for immediate intervention in order to address the problems of women before they get to a thresh hold where it will be difficult to deal with or control the problems.

In conclusion the impact of ethnic violence on women cannot be underestimated. With the recent increase in IDPS after the last general elections there is a need for strong engagement to ensure civilians are protected and assisted .There is also need for research in order to come up with the best practice with regards to treatment and follow up of internally displaced people and formulation of policies that protects women in times of ethnic violence.

CHAPTER THREE

3.0 RESEARCH METHODS

This chapter outlines the research design to be adopted in the study. It identifies the study population and sampling procedures and discusses the data collection method. It then describes the method to be used in order to analyze data in the study.

3.1 Research Design

This was a descriptive study to establish the prevalence of PTSD and Depression amongst women who have suffered ethnic violence and are in IDP Camp. The qualitative component of design enabled one to capture the actual experiences of women in ethnic violence through interview.

3.2 Study site / scope

The study was conducted at Ekerenyio Camp for the internally displaced persons (IDPs) selected using purposive sampling. The site was chosen because the researcher expected very little resistance from the IDPs since the researcher had interacted with them earlier on before the start of this study as a volunteer (Counselor). The camp housed a large group of people (800 IDPs) majority of whom were women 480 (60%) who were affected by the recent ethnic violence after the election.

The study was conducted on two hundred (200) women but two questionnaires were not properly filled and could therefore not be used for data analysis. Majority of the

women were from Kisii district. The targeted sample were mainly women who experienced ethnic violence after the December 2007 election and were either at Ekerenyo IDP camp or within the vicinity as most of them worked in the nearby tea estate farms. The study adopted a survey study according to the inclusion criteria and included women aged 18 years and above.

The purpose of the study was to identify PTSD and depression among women who were victims of ethnic violence.

3.3 Study population and sample.

In order to determine the sample size of the internally displaced women from the target group, this study adopted a survey method.

3.4 Sampling method

All women in the IDP camp were interviewed so long as they met the given inclusion criteria. Only 200 women who met the inclusion criteria were interviewed.

Inclusion criteria

- 1) The study included every woman residing in the camp after the ethnic violence or who had been relocated to Ngoina road shopping center from Ekerenyo camp for IDPs
- 2) The study also included every woman who was over 18 years.
- 3) The study also included every woman who voluntarily agreed to participate in the study.

Exclusion criteria

- a) The study excluded every woman who did not reside in the camp after the ethnic violence and was not relocated to Ngoina road shopping center.

- b) The study also excluded every woman who was less than 18 years
- c) The study also excluded every woman who did not voluntarily agree to be interviewed

3.5. Study instruments

- 1) Social demographic questionnaire was prepared by the researcher for the purpose of this study in order to get the biographic data of the participant i.e. age, ethnicity, place of birth, the time of admission to the camp etc,

- 2) Impact of event scale Revised tool was used to measure the levels PTSD

This is a item self administered report scale designed to measure the intensity of trauma related events on two separate dimensions i.e. intrusive thoughts and avoidance behavior. The IES-R yields a total score, an intrusive sub-scale total score and an avoidance behavior sub-scale total score, with a higher scores indicating increased intensity for each category of the symptoms. The IES-R has been demonstrated to possess adequate internal reliability, test-retest reliability and sensitivity in patient and non- patient samples

The IES-R was the most efficient diagnostic measure of PTSD in a mixed military and civilian population (Neal et al., 1994). It has been described as the best PTSD measure available for assessing children exposed to traumatic events including parental murder and survivors of ship wreck 45 yielded IES-R scores comparable to adult norms (Mc.Nally, 1976, & Malquist C. P.,1986).

According to (Neal et al., 1994) the cut-off score is 35 point on IES-R total scale and the total stress score sub scale score are as follows.

- a) no symptoms 0-8
- b) mild symptoms-9-25
- c) moderate symptoms =26-43
- d) severe symptoms > 44

Another advantage in using the above selected instrument is that IES-R is self – administered and therefore less expensive and not time consuming (Harrowitz M. W. et al ,1979)

3) Beck's Depression Inventory (BDI) was used to measure depression

This is a 21 statement instrument scaled as follows

Not at all = 0, sometimes =1, most of the times =2 and all the time = 3

The total stress score is 63 points (21*3) which is the highest score in the instrument

The instrument is further sub divided into three sub division depending on the points ranging from 0 to 63

- 1) Point 0-11 represents no depression
- 2) points 12-21 represents mild depression
- 3) points 22-43 moderate depression
- 4) Points 44-63 severe depression.

Other advantages in using the above selected instrument are that BDI is self - administered instrument and is therefore less expensive and not time consuming. The

instrument has also been found to have adequate internal reliability, test -retest reliability and is sensitive to all subjects in the study.

English was the main language during the interview but the questionnaire were translated to Swahili in order to accommodate those women who did not speak English

3.6. Data collection & procedure

Data was collected using a social demographic questionnaire to capture the biographic data, problem, for PTSD Impact of Event Scale tool was used and for depression Beck's Depression Inventory (BDI) tool was used.

Each respondent was briefed on the nature of the study and clear instructions were spelt out to them on how to complete the three instruments. Those who agreed to participate in the study were given a consent form to sign before they were allowed to fill the questionnaire forms. Nobody was coerced to participate in the study

3.7Data analysis

The analysis of data was done using the Statistical Package for Social Sciences (SPSS) version 13.0. Results were considered significant when P-value was less than 0.05.

Data was summarized and presented using descriptive statistics such as percentages, graphs and pie charts

3.8. Ethical consideration

Clearance

Clearance to conduct the study was obtained from the Department of Psychiatry, University of Nairobi. Further clearance was obtained from Kenyatta National Hospital Ethical and Research committee. A research permit was obtained from the department

of science and technology, Ministry of higher Education and Ministry of Home Affairs. Permission was also secured in advance from the heads of rescue camps.

Consent

The consent form describing the nature of the study was explained to the women participants before the onset of the study. The participants were also being informed of their right to withdraw immediately if they felt that the interview was causing them distress.

Intervention and referral

Those who reacted with distress, as a result of the interview triggering or arousing emotional feelings were referred to a coordinated intervention plan of counselors and other appropriate personnel (doctors, nurses). In case of complications, the relevant cases were to be referred to the appropriate, competent expert's e.g. legal, psychiatry, gynaecologist, social groups, social workers, medical doctors etc, for further consultation and treatment.

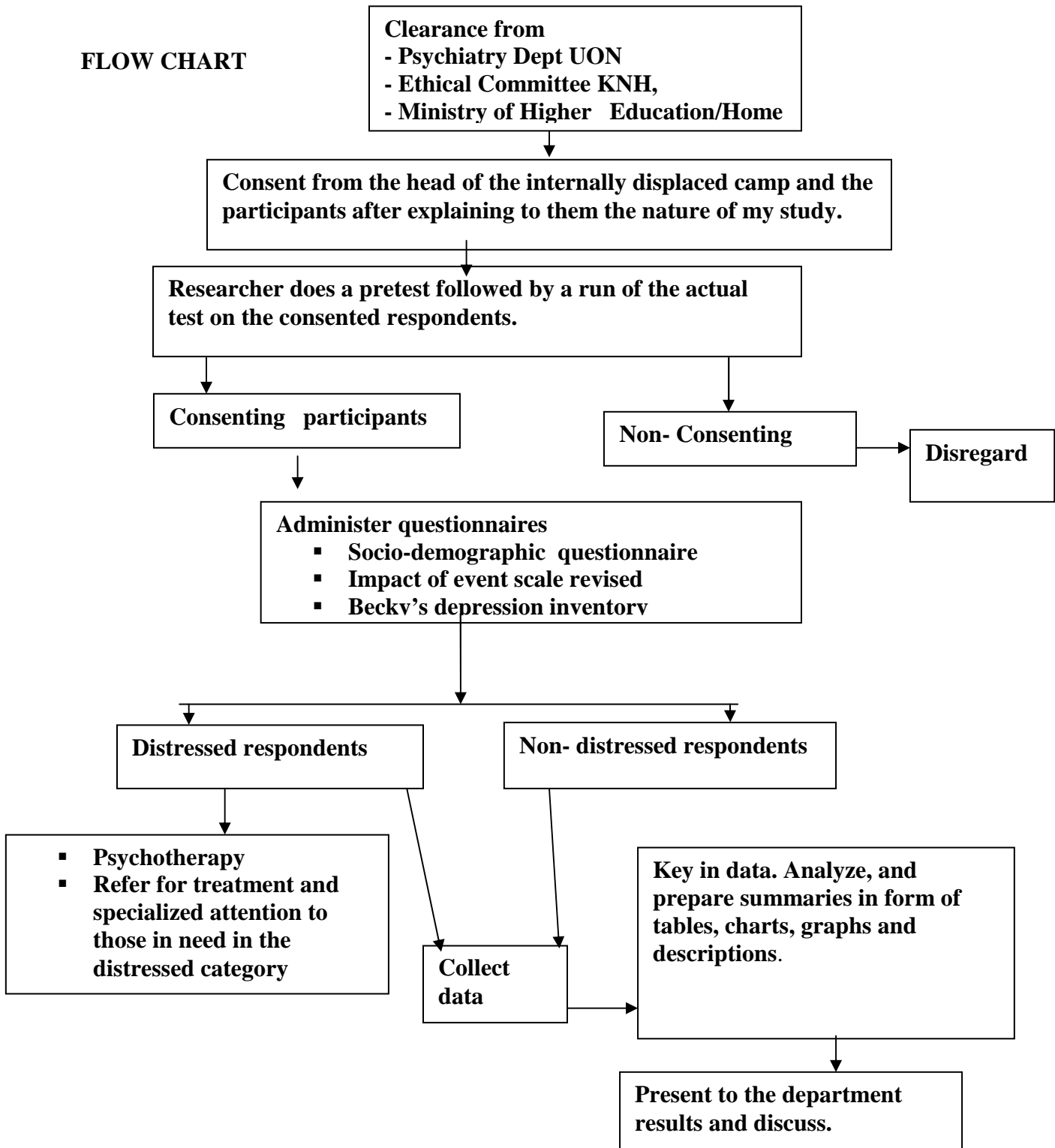
Confidentiality

The participants were assured of confidentiality of everything discussed during the interview. A breach of confidence would only have occurred if the participant was suicidal or was prepared to do harm to another person. Factors that may have necessitate a breach of confidence on matters discussed during the interview was communicated to the participants before the interview.

Direct and indirect benefits

The participants were explained the direct and indirect benefits of the study. They were also informed that there was to be no monetary compensation as a result of participation in the study

FLOW CHART



↓

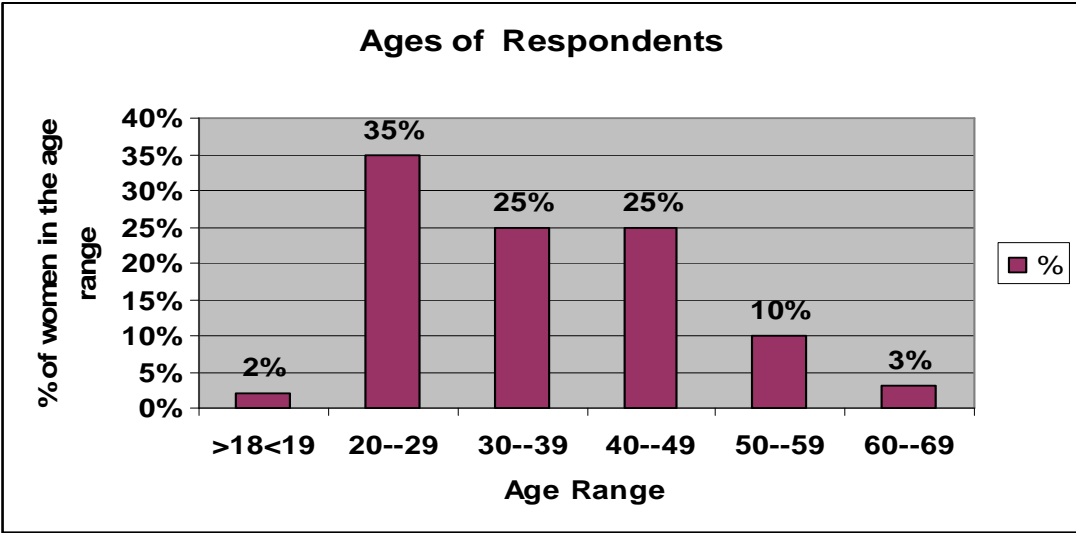
<p>After approval bind copy of the final thesis document and present to the department of psychiatry.</p>
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FREQUENCY TABLES

AGE		No	%
	Age groups		
	10--19	5	2%
	20--29	70	35%
	30--39	50	25%
	40--49	50	25%
	50--59	16	10%
	60--69	7	3%
		198	100%
Marital status		No	%
	Married	105	53%
	Single	51	26%
	Others	42	21%
		198	100%
FAMILY TYPE		No	%
	Nuclear	114	58%
	Extended	23	11%
	Others	61	31%
		198	100%
Education level		No	%
	None	23	10%
	Primary	92	47%
	Secondary	82	41%
	University	4	2%
		198	100%
Emotional expression		No	%
	Fear	103	52%
	Anger	62	31%
	Makes me want to run away	10	5%
	Makes my heart to race	23	12%
		198	100%
Other traumatic events		No	%
	Violence	121	61%
	Accident	18	9%
	National disaster	33	17%
	Sexual rape	6	3%
	Multiple trauma	20	10%
		198	100%
Ever suffered from mental illness			
	YES	4	2%

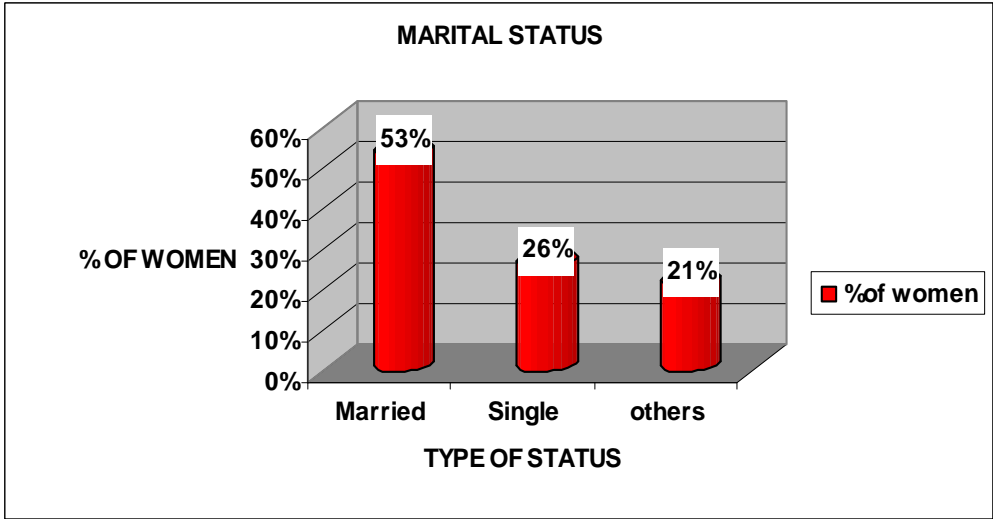
	NO	194	98%
		198	100%
Any suicidal ideations			
	YES	32	16%
	NO	166	84%
		198	100%
Insomnia symptoms			
	YES	53	27%
	NO	145	73%
		198	100%

SECONDARY UNIVERSITY	6	3	13	7	24	12	3	2	46	24	0.7600	insignificant
PTSD LEVELS TOTALS	12	6	49	25	130	65	7	4	198	100	Level of significance	insignificant
	No	%	No	%	No	%	No	%	No	%	significance	insignificant
MARITAL STATUS												
Married					95	48	10	5	105	53	0.000	significance
Single					48	24	4	2	52	26		
others					33	17	8	4	41	21		
TOTALS	0	0	0	0	176	89	22	11	198	100		
Type of family												
Nuclear					93	47	14	7	107	54	0.000	significance
Extended					31	16	0	0	31	16		
Others					52	26	8	4	60	30		
TOTALS	0	0	0	0	176	89	22	11	198	100		
EDUCATIONAL LEVEL												
NONE					20	10	2	1	22	11	0.045	significance
PRIMARY					81	41	12	6	93	47		
SECONDARY					57	29	8	4	65	33		
UNIVERSITY					18	9	0	0	18	9		
TOTALS	0	0	0	0	176	89	22	11	198	100		
DEPRESSION LEVELS												
MARITAL STATUS												
Married	4	2	34	17	62	31	3	2	103	52	0.0439	significance
Single	4	2	10	5	34	17	0	0	48	24		
others	4	2	5	3	34	17	4	2	47	24		
TOTALS	12	6	49	25	130	65	7	4	198	100		
Type of family												
Nuclear	6	3	28	14	73	37	4	2	111	56	0.0417	significance
Extended	4	2	14	7	10	5	0	0	28	14		
Others	2	1	7	4	47	23	3	2	59	30		
TOTALS	12	6	49	25	130	65	7	4	198	100		
EDUCATIONAL LEVEL												
NONE	0	0	6	3	16	8	2	1	24	12		
PRIMARY	6	3	30	15	86	43	0	0	122	61		



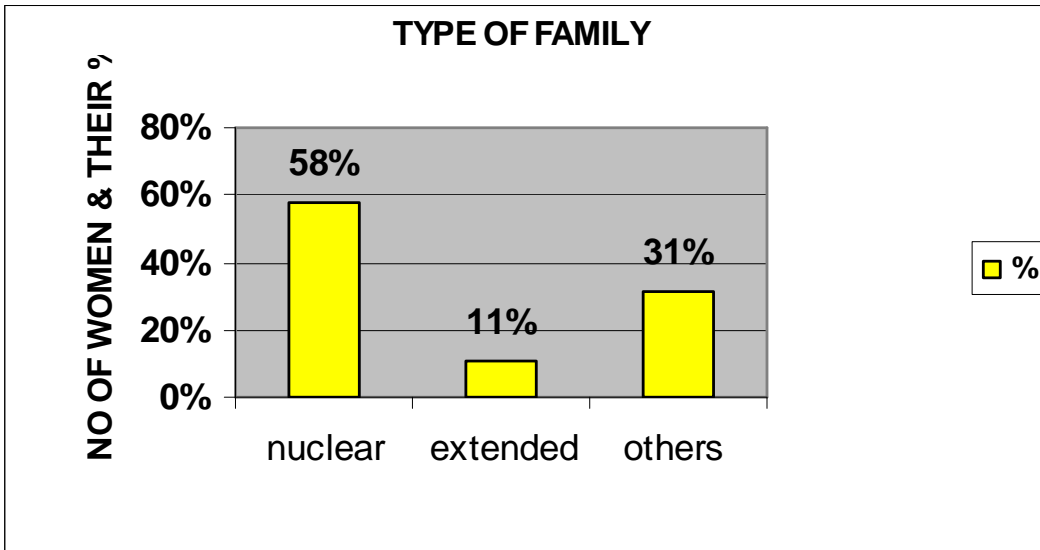
Women under age 18 but less than 19 were 2%, Age's 20-29 were 35%
 Ages 30-39 and 40-49 were both 25%, ages 50-59 were 10% and 60-69 were 3%

Figure 4.2



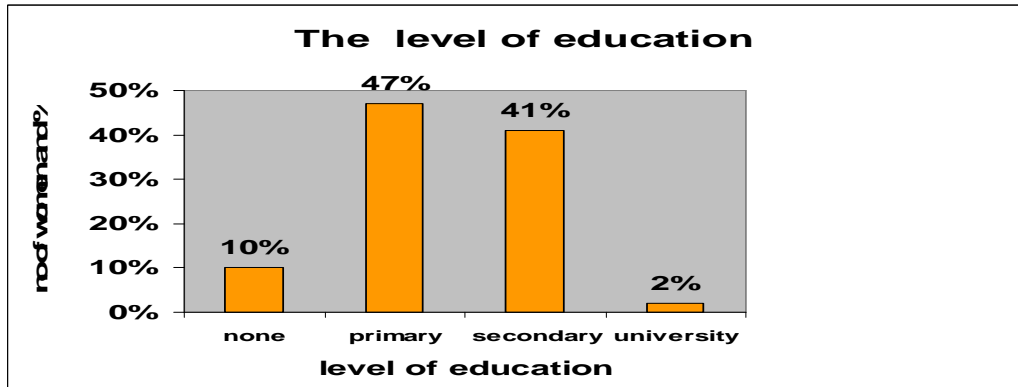
53% of respondents were married, 26% were single, and 21% were in the category others (divorced, separated).

Figure 4.3



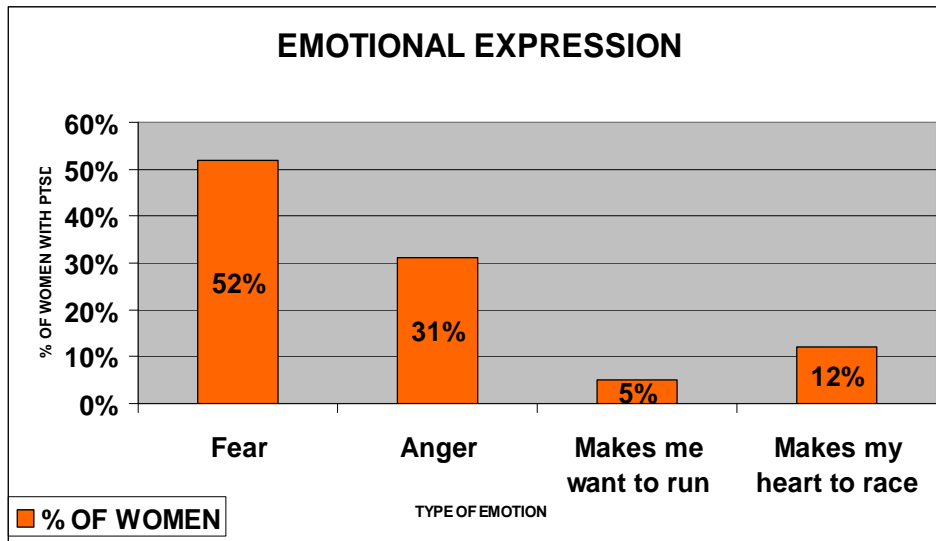
**58% of the respondents were in nuclear family,
31% were under others (divorced, separated), and
11% were in extended family.**

Figure 4.4



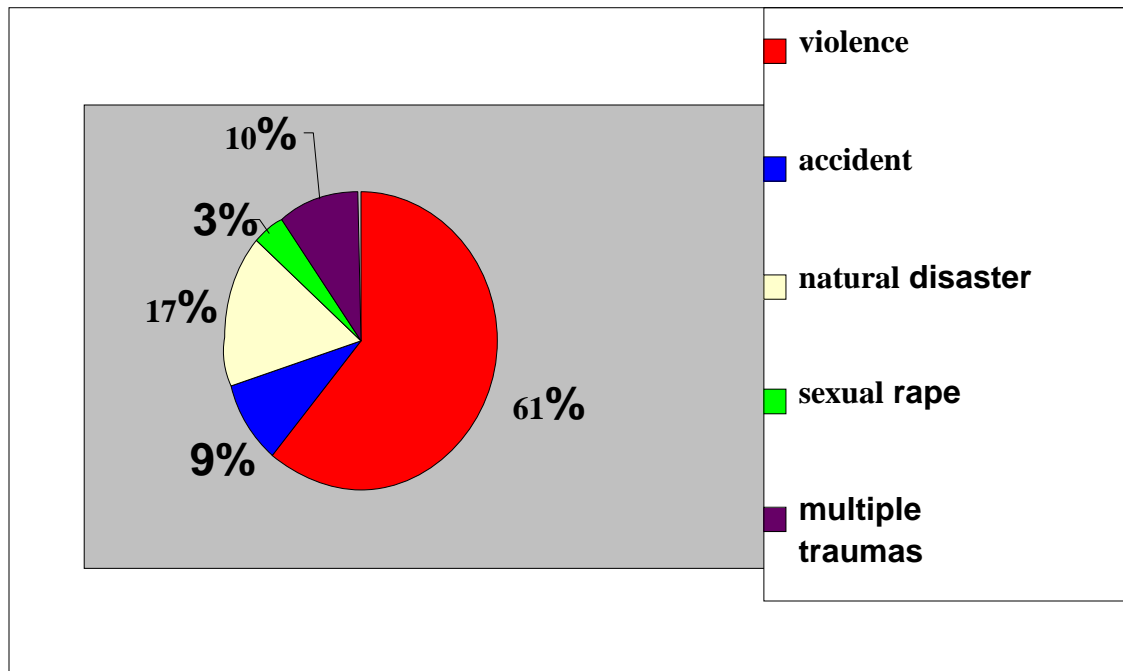
**10% had never gone to school
47% of the respondents had primary level of education
41% had secondary level of education.
and 2% had university level of education**

Figure 4.5



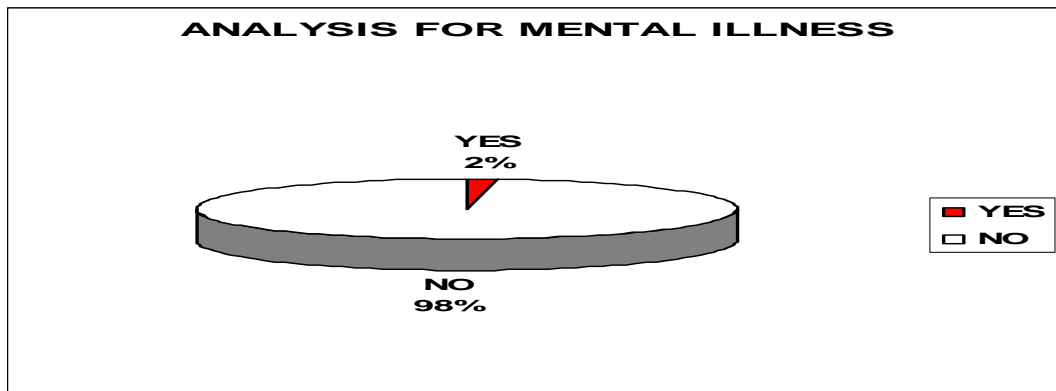
52% expressed fear, 31% anger, 5% said the memory of the violence makes them want to run away, and 12% said that the memory makes their heart race.

Figure 4.6 Other traumatic events



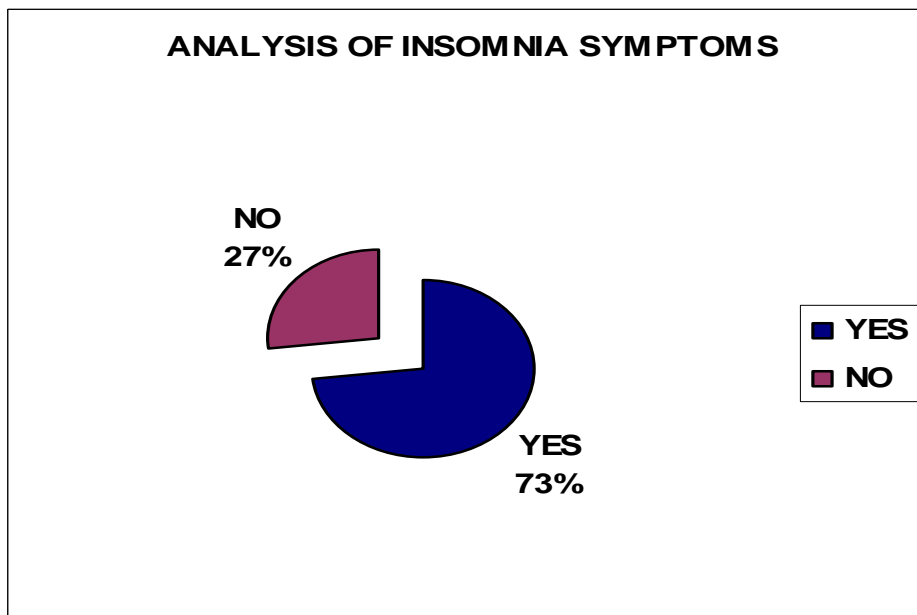
Most of the participants had suffered other traumatic experiences with the most experienced traumatic event being violence 121(61%) , followed by those who suffered natural disaster 33(17%), 20(10%) women had multiple traumas , 18 (9%) were involved in a serious accident while 6 (3%) of the women were sexually abused.

Figure 4.7



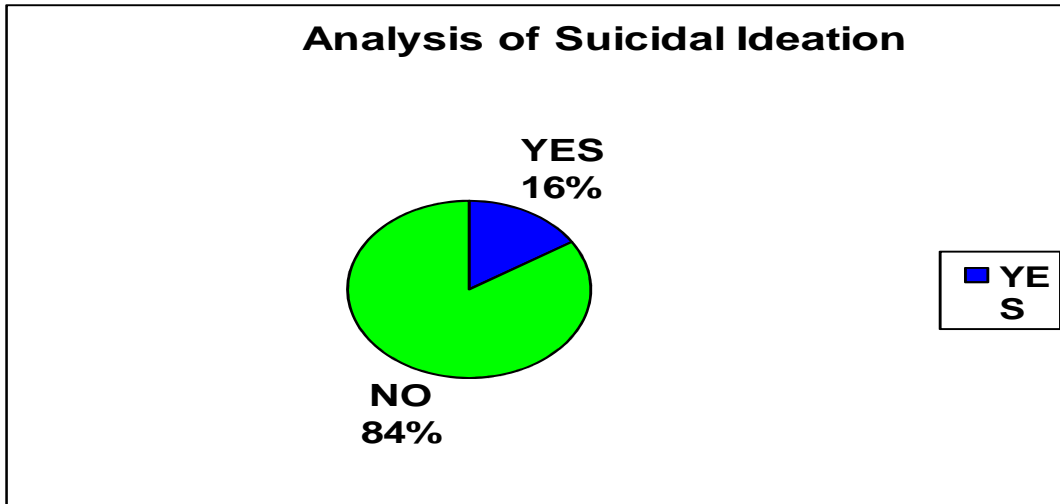
The percentage of women who said they have never been treated for mental illness were 98% while those who said they have been treated for mental illness were 2% .

Figure 4.8



The percentage of women with insomnia symptoms were 73%, and those with no insomnia symptoms were 27%.

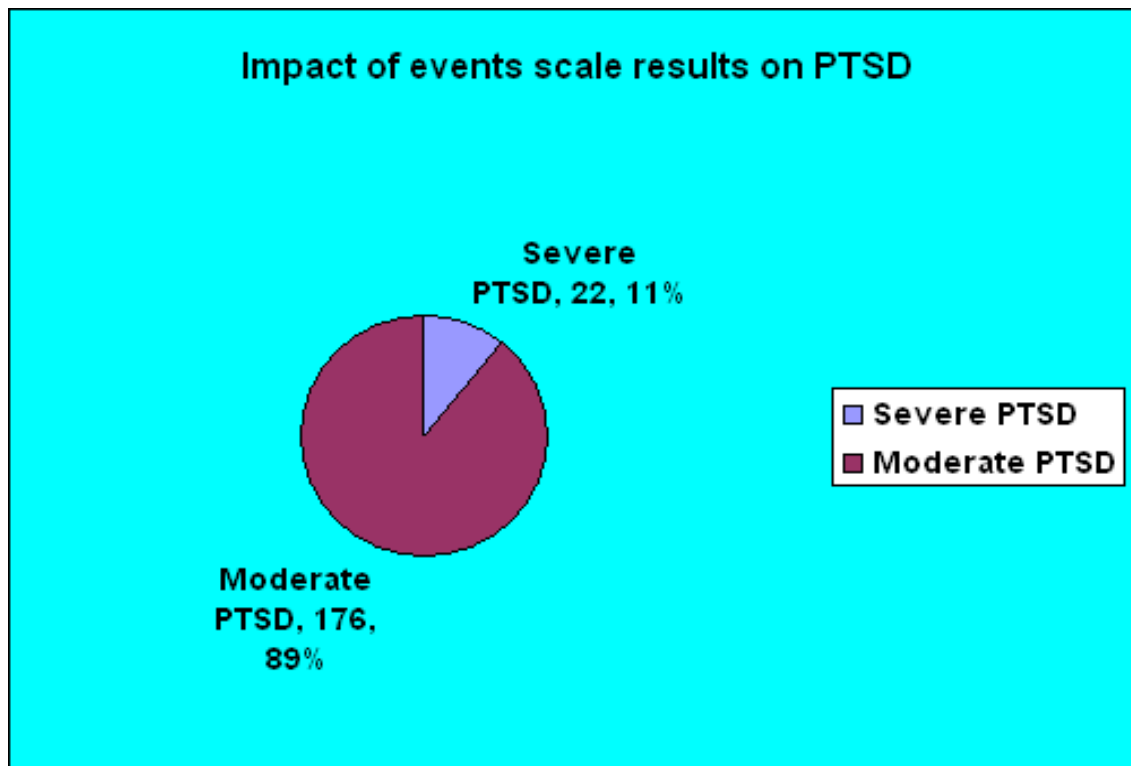
Figure 4.9



The percentage of women who said they had no suicidal ideations were 84% and those who said they have never had suicidal ideations were 16%

IMPACT OF EVENT SCALE TOOL RESULTS

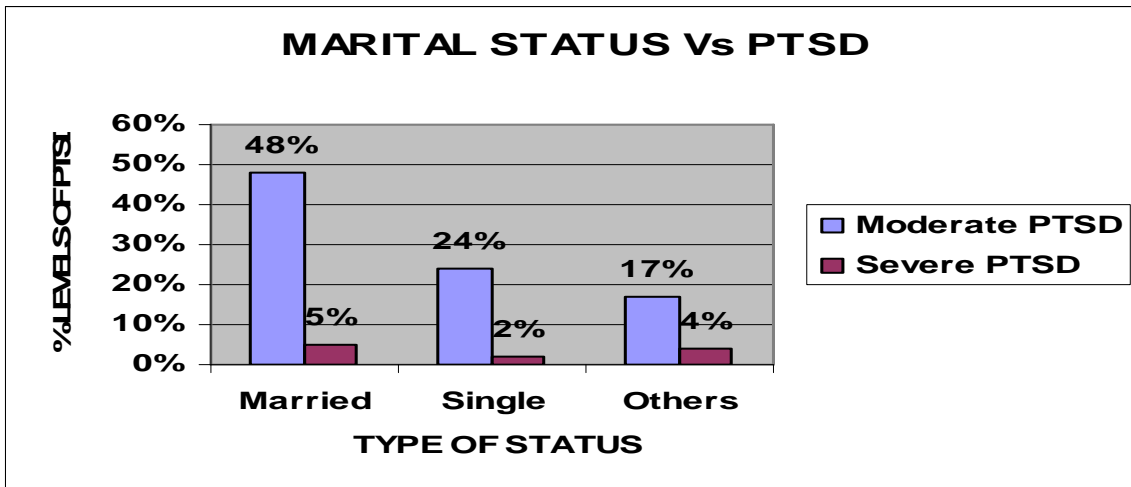
FIGURE 4.10



All the respondents (100%) had some degree of PTSD.

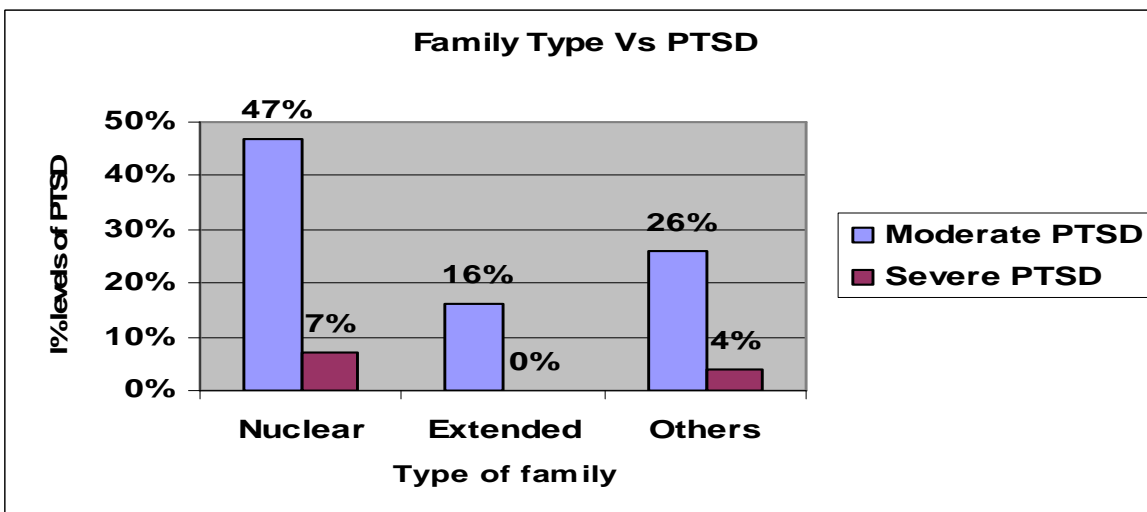
176 (89%) had moderate PTSD and 22(11%) had severe PTSD as demonstrated by the above presentation in form of a pie-chart

FIGURE 4.11



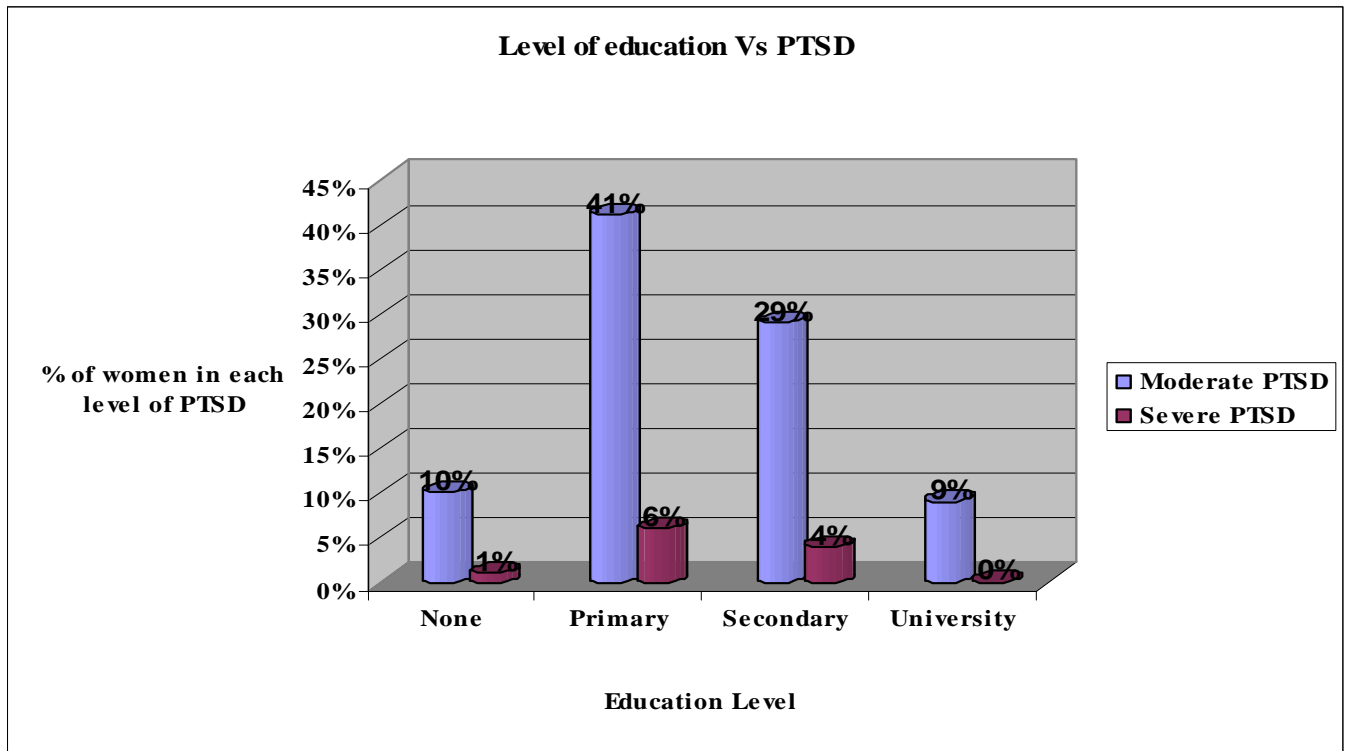
48% of married women had moderate PTSD, 5% had severe PTSD, 24% of single women had moderate PTSD, 2% had severe PTSD 17% of women in the category others (divorced, separated,) had moderate PTSD, 4% had severe PTSD.

FIGURE 4.12



47% of the women were in the nuclear family had moderate PTSD and 7% had severe PTSD, 16% of women in the extended family had moderate PTSD, none had severe PTSD 26% of women in the category others (divorced, separated,) had moderate PTSD and 4% had severe PTSD.

FIGURE 4.13



10% of women with no education had moderate PTSD and 1% had severe PTSD.

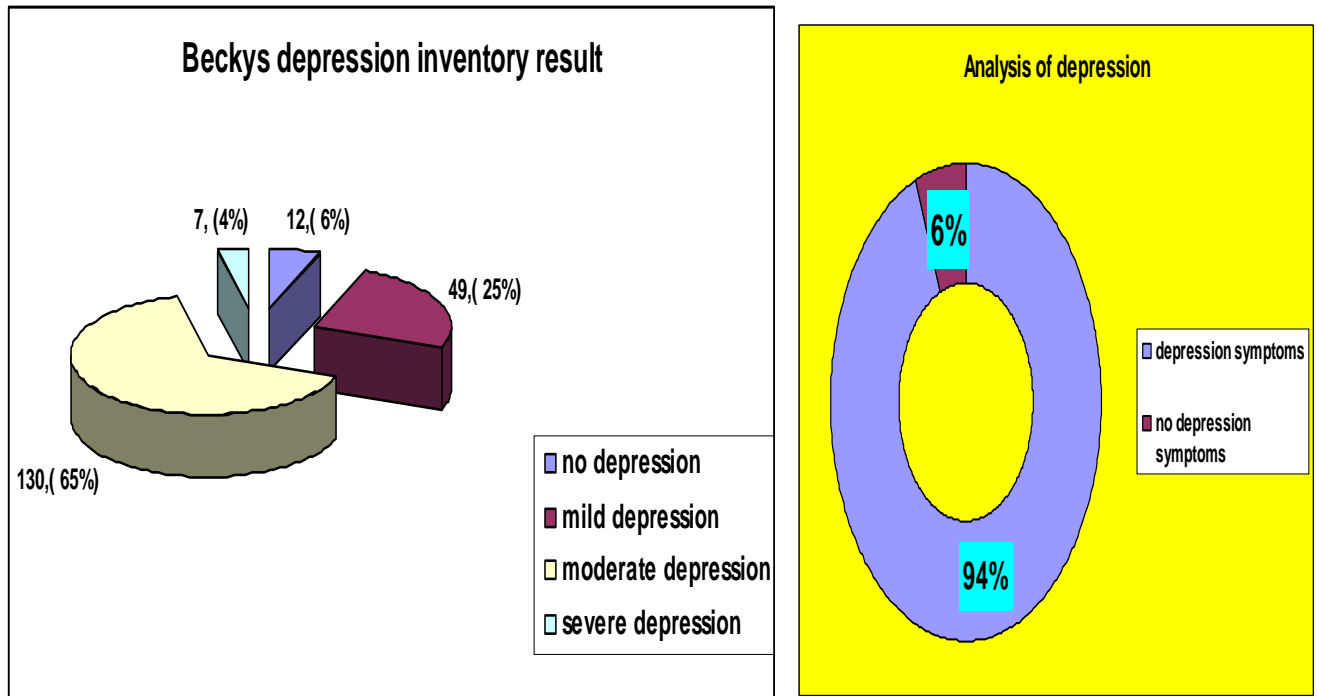
41% of women with primary level of education had moderate PTSD and 6% had severe PTSD,

29% of women with secondary level of education had moderate PTSD and 4% had severe PTSD

9% of women with university level of education had moderate PTSD and none with severe PTSD ,

BECKYS DEPRESSION INVENTORY TOOL RESULT

FIGURE 4.14



From the above presentation in form of a pie- chart 94% of respondents had depression while only 6% had no depression.

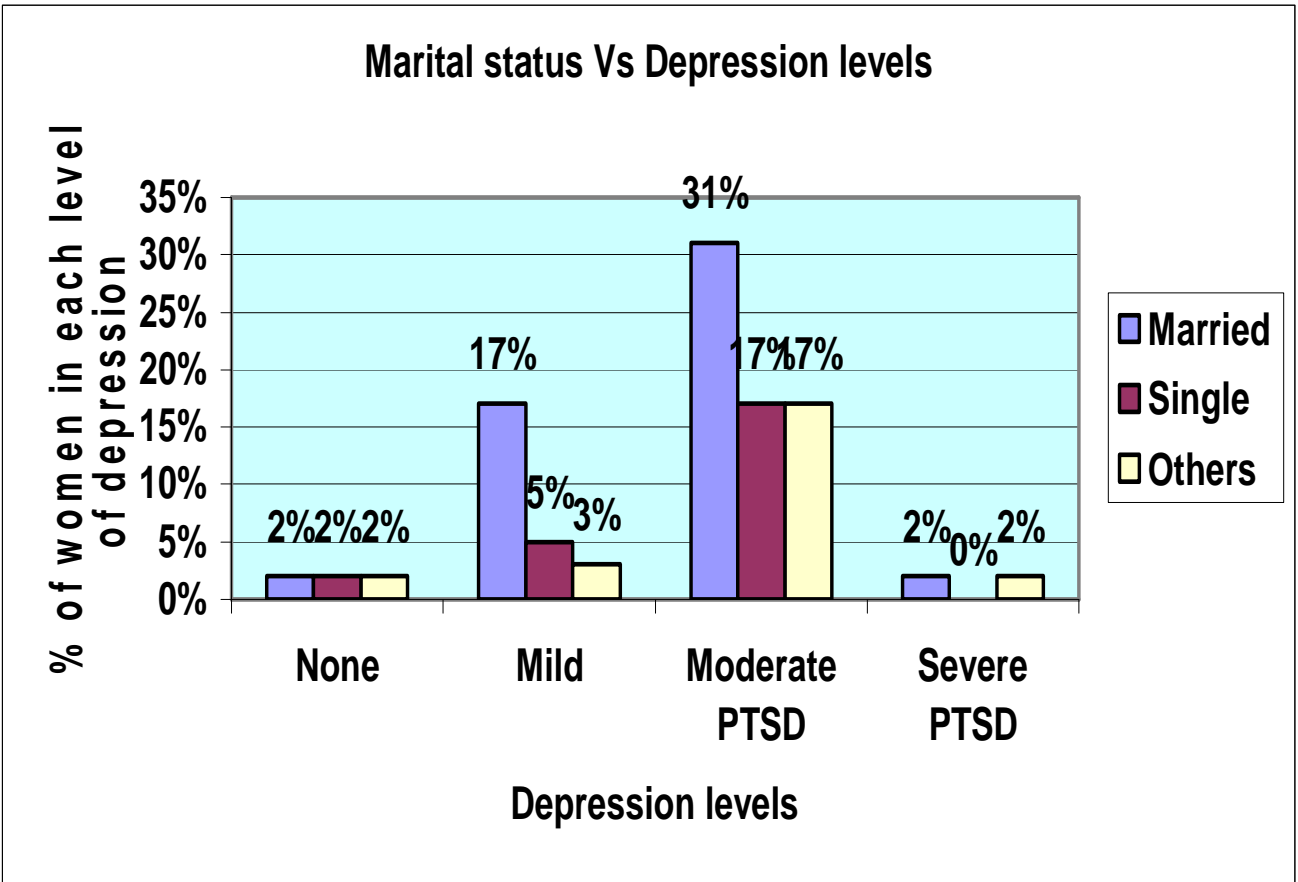
Women with moderate depression formed a bigger percentage 130 (65%) of the sample.

This was followed by 49(25%) of the women who had mild depression, and

7 (4%) of women had of severe depression.

Apparently only 12(6%) of the women had no of depression.

FIGURE 4.15

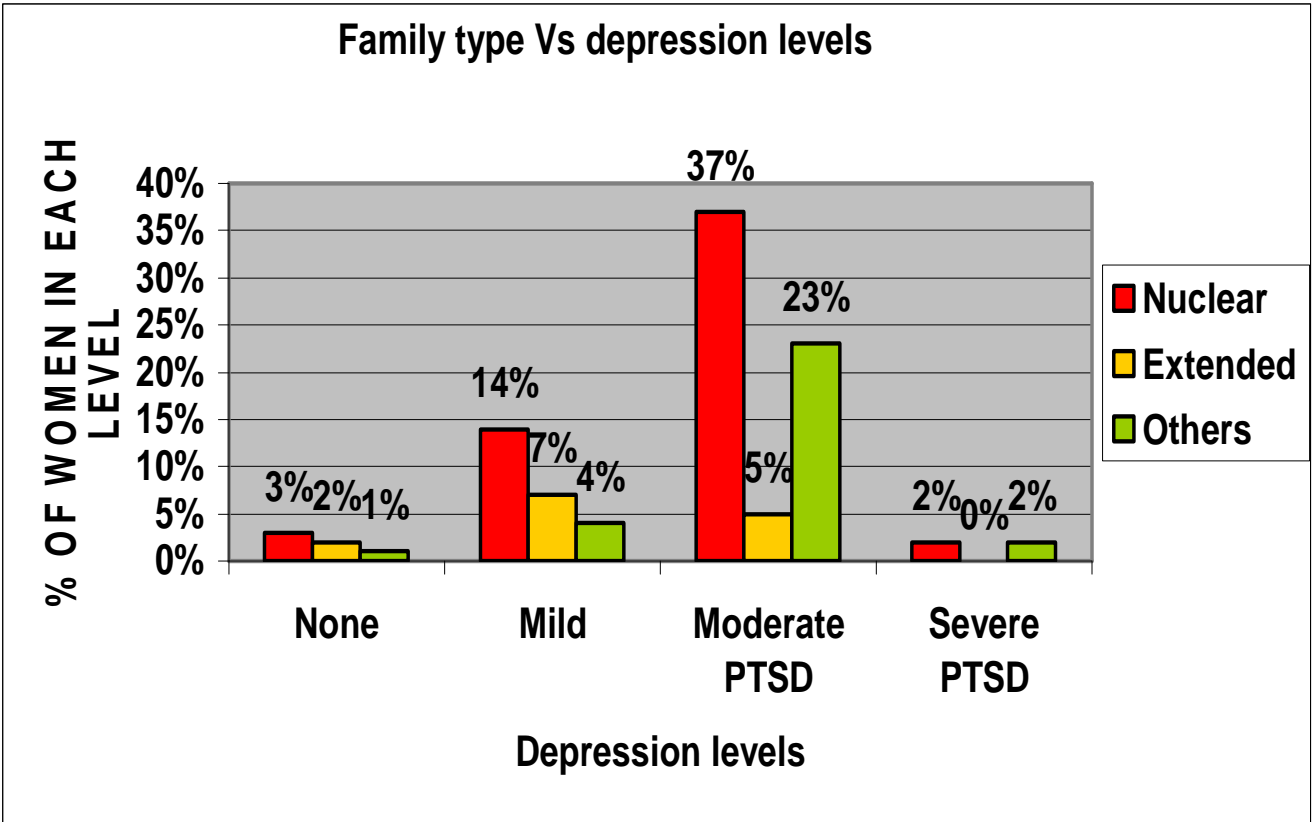


2% of married women had no depression , 17% had mild depression,31% had moderate depression and 2% had severe depression

2% of single women had no depression , 5% had mild depression,17% had moderate depression and none had severe depression

2% of women in others(divorced separated,) had no depression , 3% had mild depression,17% had moderate depression and 2% had severe depression

FIGURE 4.16

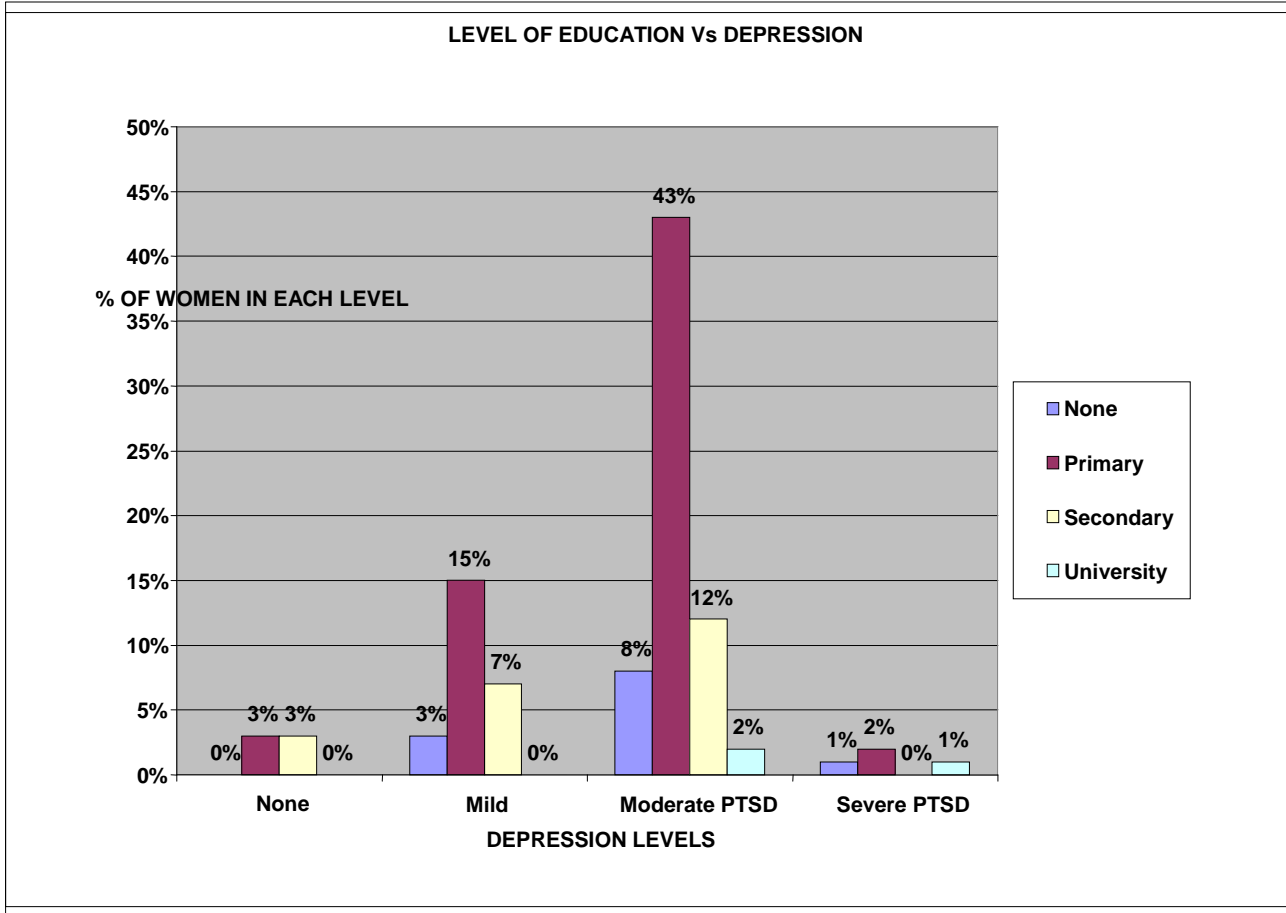


3% of women in the nuclear family had no depression , 14% had mild depression,37% had moderate depression and 2% had severe depression

2% of women in extended family had no depression , 7% had mild depression,5% had moderate depression and none had severe depression

1% of women in the category others(divorced separated,) had no depression and 4% had mild depression,23% had moderate depression and 2% had severe depression

Figure 4.17



3% of women with no education had mild depression, 8% had moderate depression and 1% had severe depression.

3% of women with primary level of education had no depression, 15% had mild depression, 43% had moderate depression and 1% had severe depression

3% of women with secondary level of education had no depression, 7% had mild depression, 12% had moderate depression and none severe depression.

2% women with university level of education had moderate depression and 1% had severe depression.

CHAPTER FIVE

DISCUSSIONS

5.1 AGE

The mean age of the women in this study was 36 years. This study did not find significant relationship between PTSD and age. The study showed that all the age range categories interviewed did develop PTSD. The findings of this study is supported by the findings of a study by Lamprecht, et al (2002) who did not find any statistical significance between age and development of PTSD though he cautions that the findings may have been attributed by the level of anxiety found in the younger subjects. The study also agrees with Ndiema's R.S.(2008) study on PTSD on girls who had undergone female genital mutilation (FGM) in Kenya where age was found to be statistically insignificant. Although the levels of PTSD tended to lower as the girls grew older, the author attributed this to the narrow range of ages. Gwanda M. (2008) study of sexually abused children and PTSD also found no significance relationship between the age of those interviewed and PTSD. According to her study, age did not have an impact on the occurrence of PTSD after exposure to traumatic event.

Other studies have suggested that young and old is a risk factor for the development of PTSD (Kessler R.C, et al,1995).The populations in these studies were however of a wider range of ages than this study. Although these studies did not find significant relationship between PTSD and age a cross- sectional cluster sample survey among Kosovo Albanians aged 15years or older found that 17.1 % reported symptoms of PTSD. There was a significant linear decrease in mental health status

and social functioning with increasing amount of traumatic events in those aged 65 year or older and internally displaced people being at increased risk of psychiatry morbidity. A study by Gwendolyn (2007) on symptoms of depression among blacks and white found age negatively correlated. This agrees with this study which found no correlation between the age of the respondent and the development of depression. It also agrees with an interview by Donald (2001-2003) of 891 of Non-Hispania women over 18 years which found none significant correlation between age and the development of depression. According to Donald studies show no increase in depressive illness among women at a later stage of life. In fact, studies show that older people feel satisfied with their lives.

This study found that exposure to traumatic events has the same distressing effects to everyone regardless of their age, and that development of PTSD and depression will depend on individuals' personal characteristics among other environmental risk factors other than age.

5.2. Family type

The type of family as a predictor of the degree of PTSD during the ethnic violence in this study was found to be significant ($P=0.000$). Women in the nuclear family reported the highest number amongst the people, who had moderate PTSD (54%), followed by those who said that they were in family type others (30%) (which includes the single, divorced, and separated) while those in extended family were (14%). The study indicates that those most affected were found to be in nuclear family type than other family type categories.

Women in the nuclear family type had the highest number of those with symptoms of depression (56%). This was followed by women who fell under the grouping others at (30%) of the sample population. Only (14%) of women under the category extended family had symptoms of depression.

The finding of this study indicates that the most affected group in the development of PTSD after the ethnic violence were women in the under the nuclear family, followed by singles and the least affected were women in the extended family. This may be attributed to the fact that the scope of support in a nuclear family is less compared to that of extended family and others. Women in extended family are bound to get support from a wider range of supporters that those in the nuclear family and family type classified as others i.e. (singles, separated, divorced).

The type of family as a predictor of depression was also found to be significant (P-value 0.0417). This agrees with a study on 84 Iraqi male refugees which found out that poor social support was a stronger predictor of depressive morbidity than trauma factors (Mc Grath et al, 1990). This study shows that increased network of social support from significant others is a shield against the development of PTSD and depression. Those who receive positive support are less likely to develop PTSD and depression at any levels. The more close-knit the family is, the more unlikely that these disorders will occur.

5.3. MARITAL STATUS

Marital status was found to be statistically significance as a predictor of both PTSD (p-value 0.000) and depression (p-value 0.439) in this study. A study by Salinas J. et al (1995) on family support and mental health in Uganda found growing evidence

between the rates of depression and marital status. Marital status was found to be a protective effect in men to the development of depression than in women. The rate of depression was found to be higher in married women than in other categories. According to the study women depend on their role as housewives for self –esteem and identity. They get frustrated due to constant routine, isolation and lack of income. Increasing devaluation of the role of housewives in modern society aggravates the situation.

A study by Neem et al (1990) identified two factors for the development of depression in women namely family conflict and marital conflict .In this study the respondents who were formally married or separated were at a greater risk in the development of depression than those not married .This does not agree with Ronald's study (2003) in which being unmarried (which includes widowhood) was a risk factor for depression .These findings do not also agree with Donald's (2001-2003) interview of 891 of Non- Hispanic women over 18 years which found none significant correlation between marital status and the development of depression. According to this study, the level of PTSD appears to decrease as women move away from married marital status to other forms of status. This may be attributed to the disintegration of family unit and the loss of social support from the members of the same family. Comparatively married women and the singles appear to be more affected by depression than those in the extended family. Members of extended family garner support from one another hence reduction of stress after a traumatic event.

5.5 Level of education

The level of education in this study was statistically significant as a predictor of development of PTSD (p-value 0.045). This agrees with the findings of Breslau et al (1991) who found that individuals with lower levels of education had a greater percentage of PTSD than those with higher levels of education. Similar findings have been found following hurricane Hugo which reported that higher education level itself may be a protective factor, besides increased age in the development of PTSD (Quota et al,2003)

A cross-sectional study by Donald (2003) of 118 Lebanese hostages of war found that psychological distress was present in 42.1% of the sample compared to 27.8% of the control group. Significant predictors for distress were the years of education and increase in religiosity after they were released.

The level of education in this study was not statistically significant in the development of depression (p-value 0.760). This agrees with findings reported in an interview of 891 of Non- Hispania women over 18 years (Donald 2001-2003) The study found none significant correlation between level of education and the development of depression.

In this study, women with primary level of education were the most affected by depression (63%). Most of them had symptoms of depression at both moderate and severe levels The author attributes this to the number of women with primary level of education in this study since they were the majority in the study. Women with secondary education followed at 22% of the sample. There were few women with

university level of education (3%) of the sample population and most of them had symptoms of depression.

5.5 History of mental illness in a family

Most of the respondents in this study reported no history of mental illness in their family or having been treated for mental illness before the traumatic event (98%).

Diema R. (2008) study also found no statistical significance between the history of mental illness and PTSD among girls who had been subjected to female genital cutting/ mutilation in Kenya. However this study contrasts a study by Lukoye, A. (2006) on mau mau survivors who found a statistical association between PTSD and the history of mental illness in the family. He however attributed this to genetic components in vulnerability to PTSD. It is also not similar to the Cambodian survey which also reported psychiatry history and current physical illness as risk factors for PTSD.

On development of depression, this study agrees with another survey of 993 adults from site 2, the largest Cambodian displaced persons camp on Thailand Cambodian border which found out that more than 82% felt depressed.

This study postulates that the fact that one has not suffered from mental illness before the event is not a good predictor for not being affected negatively by a traumatic incident. The fact that 100% of the respondents had varied degree of PTSD and 89% had depression indicates that all are vulnerable to both PTSD and depressive disorders

5.6 The highest emotional expression in response to ethnic violence

This study found out that the highest emotional expression in response to ethnic violence was fear. (52%)of the women reported that the whole ordeal left them afraid and fearful.), 31%reported emotions of anger, 12 % felt that the memory of the incident made their heart to race, 5% felt that the memory of the incident made them want to run away.

This study is similar to Diemas R S (2008) study which found a statistical significance between fear and development of PTSD. A recent epidemiological study on mental health in communities affected by war in Afghanistan in which 84% of the participants reported high feelings of fear and hatred .The same group of participants reported high prevalence of PTSD, depression and anxiety Cardozo et al, (2004) .The study also found that women had significantly poorer mental health than men as did the disabled.

In a cross sectional survey among Kosovo Albanians 90% of women expressed strong feelings of hatred towards the Serbs with 33% stating that they would act on this feelings.

One may therefore conclude that other traumatic events may precipitate the onset of PTSD. Vetting of the traumas' emotional feelings through PTSD may stop one from entering into a depressive state.

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5.7 Other traumatic events

All the participants in this study reported to have experienced one or multiple traumatic events ranging from violence, traffic accident, sexual rape, crime, natural

disaster in their life time. Those who reported violence were more than those who reported other traumatic events (61%). Those who experienced multiple traumas were (10%). This study found other traumatic events statistically significant in the development of PTSD and not statistically significant in the development of depression. Ndeti D.N et al , (2005) in their study on traumatic experiences of Kenyan secondary school students (1110 students, 629 male and 481 females) also reported a positive correlation between the number of traumatic events and the occurrence of PTSD.

Njau J.W et al.(2005) in their study on war and mental disorders in Africa also found a linear rise of psychological strain with the increasing number of traumatic events, ranging from 23% prevalence of PTSD in those who reported three or fewer pre-defined traumatizing experiences to 100% prevalence in those who reported 28 or more traumatic events.

A study by Kessler R.C (1995) on conditional risk of PTSD among trauma victims in US found out that the risk of PTSD is much greater after exposure to a traumatic event involving assaultive violence than other forms of traumatic .

Comparative studies carried out in trauma samples in other developed countries yield no systematic evidence that conditional risk of PTSD differs from the above study (Breslau N.D, et al, 1991). This is particularly likely in light of the fact that a great many people report exposure to multiple traumas over the life course (Donald et al, 2003).

The reported rates of PTSD among rape survivors vary from approximately 30% to 65% depending on how and when the PTSD symptoms are assessed .The

psychological consequences of sexual trauma among survivors have been widely studied but research investigations continue in part, because rates of violence against girls and women remain high (e.g. being treated as an outcast in the society. (Nicole P Y, 2006).

This study reported very few cases of rape during the ethnic violence 6(3%) of the sample population. The researcher attributed this to the stigma associated with sexual abuse among women in Kenya and the beliefs and cultural reprimands that goes with it. This may have stopped the raped victims from responding in affirmative during the interview.

The high level of fear in this study may be due to the fact that fear is one of the major components that an individual experiences when confronted by a traumatic event

The respondents in this study were all equally affected by the ethnic violence regardless of whether they suffered other traumatic incidents prior or during the ethnic violence. The current trauma had a stronger effect such that there was a universal presentation of PTSD 100%and 89% of depression amongst the respondent.

5.8 INSOMNIA

In order to detect insomnia symptoms in women, the questionnaire was loaded with questions with parameters to test the symptoms and they were to answer yes or no to the questions. 73% said yes to the question on difficulties in falling asleep, 74% said yes to the question on waking up early and not being able to fall asleep again,

75% reported that they were restless & helpless and 71% reported that they were not able to fall asleep at all.

The fact that most of them responded positively in the four questions may indicate that most of them had symptoms of sleep problem as they are not able to fall asleep or sleep normally.

High level of PTSD and depression in these women may have contributed to their lack of sleep. Restlessness, lack of sleep, wakefulness are symptoms of depression and in most cases stressed people find it difficult to fall asleep.

5.9 Suicidal ideation

The findings of this study showed that 16% had suicidal ideations and 84% had no suicide ideation. Out of the number interviewed (198), the feeling of worthlessness appeared to have had a slightly higher toll than any other. This may be explained by the loss that most of them felt and the timing of the study which was done almost immediately after the ethnic violence. This finding is similar to a study conducted in post –conflict Bosnia and Herzegovina which found out that over 25% of displaced adults stated that they felt that they were no longer able to play a useful role in life 16% had lost all confidence in themselves and their capacity to manage their situation and 11% of non- displaced also suffered from a lost sense of personal worth (Carballo et al ,2004)

This study found out that most of the respondents did not have suicidal ideas 93% and 75% have never attempted suicide before.

This study is in contrast to a study by Ronald et al (2003) who found out that, people with PTSD were found to be 6 times as demographically matched controls to attempt suicide. His study demonstrated that the impact of PTSD is strongest in predicting both the development of a suicide plan and the occurrence of an impulsive, unplanned attempt. Ronald's study also found that PTSD has a stronger association with suicidal ideations than any other anxiety disorder. His result is especially striking in light of the suggestion that panic disorder might be as important as depression in promoting suicidal behavior. (Ronald et al, 2003)

The low level of suicidal ideation in this study may be attributed to the fact that most this was not the first time that these women had suffered ethnic violence. There were several other times and in the process they may have acquired some skills to deal with the feelings of helplessness and hopelessness that leads to suicidal ideas.

5.11 Analysis of Prevalence of PTSD and Depression

PTSD is apparently more severe and longer lasting when the stressor is of human design. Victims of ethnic violence are victims of a stressor that is human induced and intended (i.e. designed) by a perpetrator. Such victims are particularly apt to experience severe psychological distress.

The finding in this study indicates that 89 % of the women had moderate PTSD and 11% had severe PTSD. Women with depression were 94% and 6% had no depression.

Those with moderate depression formed a bigger percentage 65% of the sample. This was followed by 25% of the women who had mild depression. Apparently only 4% of the women had severe depression while 6% women had no depression.

Among the refugees, it is estimated that acute clinical depression and PTSD range between 40 and 70 percent. Epidemiological studies among IDPs and refugees on the Thai Cambodian border, in Algeria, Ethiopia, Gaza, and Uganda indicate that 15 to 53 percent suffered from PTSD as a consequence of conflict. JANOFF-BULMAN ET AL (1983) Showed rates of acute depression and PTSD of 68 percent and 37 percent respectfully significantly higher than those found among the general population (10 percent and 13 percent respectfully). Women have been found to have significantly poorer mental health status than men 32 .The presence of PTSD (100%) and depression are far much higher than the results of the above study. The result of this study supports the hypothesis that women who are victims of ethnic violence are prone to exhibit psychological disorder PTSD and depression. This agrees with Goldman findings who reported that exposure to traumatic experiences which are beyond the limits of normal events results in PTSD and depression (Goldman. R 1997)

5.10 CONCLUSION

The analysis of ethnic violence in the development of both PTSD and depression was found to be significant p-value 0.006.

We can therefore accept the hypothesis that women who experienced ethnic violence developed both PTSD and depression and reject the alternative hypothesis that women who are experience ethnic violence do not develop PTSD and depression.

Marital status, socio-economic status, family type (due to lack of social support from significant others) emotional expressions and other traumatic events in

respondents' life played a significant role in the respondents development of both PTSD.

Type of family and marital status in respondents' life played a significant role in development of depression whereas the level of education ,family social economic status and trauma experienced before the violence had no significance role in the development of depression in women

5.12 Recommendation

- 1) There is need for psychological intervention on women who have PTSD and depression. To do this ,
 - a. Ultimate care and sensitivity must be used in all interventions designed to address mental health and psychosocial disorders to avoid stigmatizing women.
 - b. Interventions should be culturally appropriate and responsive to local, social and cultural norms.
 - c. Women must be consulted and actively participate in designing and implementing interventions.
 - d. Pre-determined approaches to meet the needs of only those belonging to our ethnic group should be avoided
- 2) A community based approach that encourages self-empowerment, and that build on local realities, culture and capacities should be adopted to help the women. It should be borne in mind that psychological well- being and the ability to generate income and satisfy basic needs are inter-related. The ability to gain employment

or to earn a reasonable income can go a long way to reducing some of the symptoms of the psychological distress. Integration of social support both psychological and material can go along way in helping the women back to the path of recovery.

- 3) Treatment periods should be used as an excellent opportunity for breaking the cycle of violence by integrating peace and reconciliation programs among the affected women.
- 4) Emphasis on mental health should be encouraged for early intervention to deal with future negative effects of both PTSD and depression in the country
- 5) Resettlement of IDPs may be very beneficial.

5.13 Further areas of study

- I. The effects of psychological and psychosocial interventions on women with depression and PTSD after a traumatic event experienced during the ethnic violence. The findings thereof may spell out the importance of this services in IDP camps.
- II. The most cost- effective mental health and psychosocial intervention that can be developed to help the women affected by ethnic violence. This will enable many IDPs to be reached by the service providers.
- III. The effect of early diagnosis of PTSD and depression in women affected by ethnic violence. The findings may prompt the government to attend to the matters of IDPs promptly.

BUDGET

	BUDGET	K.shs	Kshs
A	PROPOSAL WRITING PROPOSAL PREPARATION		
1	Proposal typing & printing	3,500	
2	photocopies	3,000	
3	KNH ethical committee	1,000	7,500
B	QUESTIONAIRES		
1	Typing, printing & photocopying	20,250	
C	SUPPORT STAFF		20,250
D	Statician TRANSPORT & COMMUNICATION	20,000	20,000
1	Proposal preparation	3,500	
2	telephone ,mail, e-mail	6,000	
3	transport & lunch for researcher (to EKERENYO for 3 days)	20,000	
4	local transport	3,000	32,500
E	DATA PROCESSING & REPORT		
1	Typing preliminary report	5,000	

2	photocopies for supervisors	3,000	
3	final draft typing	2,000	
4	photocopies for supervisors	3,000	
5	printing and binding final copy	2,000	
6	binding of ten books	10,000	25,000
	TOTAL COST		105,250
	CONTINGENCIES		10,525
GRAND TOTAL			115,775

TIME SCHEDULE

Activity	June-	July	Aug	Sep	Nov
Proposal development & Presentation to the department & Submission to research and ethic dept.					
Data collection					
Data analysis & report writing					
Results presentation and discussions, binding of final copy					

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APPENDIX 1: Consent explanation for participants in the study of the psychological effect of ethnic violence amongst women in Kenya

Introduction

My name is Josephine Nyambane from the school of medicine, department of psychiatry, University of Nairobi. I am undertaking a study on the common Psychological effects of ethnic violence amongst the internally displaced women at limuru camp in Kenyan. The information from the study will also be used for completion of master’s degree dissertation in clinical Psychology. I therefore request you to participate in the study by answering a list of questions about your personal details and your feelings about the recent ethnic violence.

Information about the risk of the interview

Some of the listed questions may arouse feelings and pain as you they may remind you of the events that took place during the ethnic violence. This is because the questions

will center on what went on during the incidents and what your emotional feelings are in relation to the incident.

Right to consent and withdraw

In the event the questions arouse painful feelings to an extent that you cannot go on with the study you have a right to withdraw from the study immediately. The study should also not go beyond the required ethical standards in regards to your physical and mental well being and should this happen you can discontinue your participation forthwith. The right to participate or not participate in the study relies entirely on you and nobody should force you to consent taking part in the study.

Benefits

As a participant you stand to benefit in that any treatment needed will be arranged during or after the study. Talking about the incident also gives you an opportunity to confront the painful feelings, fears and anxiety about the incident and to unlock the locked up emotions in a safe environment.

Confidentiality

Anything discussed between you and the interviewer will be strictly confidential .However a breach of confidence may occur incase you intend to harm yourself , another person or if with your consent you allow the interviewer to release the any information about the interview to a third party.

Feedback / referral

Any information in relation to the study or to your psychological well being will be communicated to you on request. Anything that requires further attention or referral to

an expert will be communicated to yourself and the head of the IDP camp for further consultation and treatment.

For any other issue do not hesitate to consult me on following address

Josephine Njoki Nyambane,

P.O, Box 67594- 00200, Nairobi,

or call me on Cell No. 0721-448366

APPENDIX 2 : CONSENT BYTHE HEAD OF THE INTERNALLY DISPLACED CAMP

I.....being the Head ofand having been explained the nature of study by Josephine Nyambane of, P.O Box 67594-00200, Nairobi ,

Tel 0721-448366, as detailed in a written assent, do hereby give consent for the women in this institution to participate in the study. I have also been made to understand that I can withdraw this consent any time before the data collection should I find the exercise inconsistent with the agreed terms as explained to me before the study.

Name.....

Signature.....

Date.....

Witnessed by

Name.....

Signature.....

Date.....

APPENDIX 3: CONSENT BYTHE INTERNALLY DISPLACED PARTICIPANT

I.....being a resident ofand
having been explained the nature of study by Josephine Nyambane of P.O Box 67594-
00200, Nairobi ,
Tel 0721-448366 as detailed in the assent explanation, do hereby give consent to
participate in the study. I have also been made to understand that I can withdraw this
consent any time before the data collection should I find the exercise inconsistent with
the agreed terms as explained to me before start of the study.

Name.....

Signature.....

Date.....

Witnessed by

Name.....

Signature.....

Date.....

Appendix 7 : Socio- Demographic Data Questionnaire Serial Number-----

A) Personal Background

- 1) Year of birth
- 2) Religion
- 3) Home
- 4) Highest level of education
 - None
 - Primary
 - Secondary
 - university
- 5) When did you join the camp?
 - Last three months
 - Last six months
- 6) marital status
 - married
 - single
 - divorced
 - separated
 - cohabiting

- 7) Family socioeconomic class can be described as
 - low
 - middle
 - high
- 8) My type of family can be described as

- nuclear
- extended
- other specify please explain-----

9) Have you ever experienced the following traumatic incidents during your life time?

- Serious traffic accident
- violent crime
- natural disaster
- sexual rap
- or some other unusual experience please explain-----

10) Tick the word that best describe your feelings towards ethnic violence

- Anger
- Fear
- Makes your heart race
- Makes you want to run away
- Other please specify

11) Have you ever been treated for mental illness?

- Yes
- no

12) Do you feel like life is not worthy living?

- Yes
- No

13) Do you wish you were dead and have many thoughts of possible death to self?

- Yes
- No

14) Do you have suicide ideas or gestures?

- Yes
- No

15) Have you ever attempted suicide?

- Yes
- No

16) Do you have difficulties falling asleep?

- Yes
- No

17) Do you wake up in early hours of the morning and cannot go back to sleep?

- Yes
 No
- 18) Are you restless and disturbed during the night most of the times?
- Yes
 No
- 19) Are you unable to fall asleep again if you get out of bed most of the times?
- Yes
 No

2) Impact of Events Scale Revised (I E S-R) RESPONDENT NO -----

The following is a list of difficulties people sometimes face after a stressful life event. Please read each item and indicate how distressful the event of ethnic violence has been for the last one month. If the distress did not occur within the last one month after the ethnic violence, choose "Not at all" option. The distress is scaled as follow:-

0=Not at all 1=A little bit 2= moderately 3=quite a bit 4= extremely

Please indicate inserting in the box the scale that best describe your feelings.

Swahili

Yafuatayo ni orodha ya mabo magumu ambayo watuhupitia baada ya matukeo magumu maishani. Tafadhali soma kila sehemu ambayo inaonyesha jinsi kila kitukio lilivyo kuwa gumu kwako kwa muda wa siku saba silizopita hasa ukirejelea tukio la gazia baada ya uchanguzi decemba 2007.ikiwa jawabu hiyo hukuweza kuona na kupitia sehemu hizo kwa muda wa siku saba basi utachangua sehemu ya 0="Haikuwepo Kabisa ". Weka nambari kuligana na maoni yako

1=ilikuwepo kidogo

2=ilikuwepo kwa kadiri/

kiasi

3= ilikuwepo kwa kiasi kikubwa

4= ilikuwepo saidi /sana

1	Any reminder of the incident brought back feelings about it Kitu chochote amabacho ulikiona kilileta fikira ya tukio hilo	
2	I had trouble falling asleep Nilikuwa na shida kupata ushingizi baada ya gazia	
3	Other things made me think about it Mambo mengine yalikuwa yakinifanya kufikiria kuhusu gazia	

4	I felt irritable and angry Nilijisikia nikiwa nimekerwa na kukasirika	
5	I avoided letting myself get upset when I thought or was reminded about it	
6	I thought about it when I did not mean to Nilijikuta nafikiria kuhusu gazia wakati wowote ambako sikutaka kufikiria	
7	I felt as if it had never happened to me Nilifikiria jambo hili halikuwai tendekeka kwangu	
8	Pictures about the incident kept popping into my mind Nilikuwa nikipata taswira / picha ya gazia kila wakati katika akili yangu	
9	I stayed away from the reminder about it Nilikaa mali na ukumbusho wowote kuhusu gazia	
10	I was jumpy and easily startled Nilikuwa na wasiwasi na hofu na kushtuka kwa urahisi	
11	I tried not to think about it Nilijaribu sana nisifikirie kuhusu gazia	
12	I was aware that I still had a lot of feelings about it , but did not deal with them Nilijua wazi kuwa nilikuwa bado na fikira nyingi kuhusu gazia lakini sikujishughulisha kusuluhisha	
13	Feelings about it were kind of numb Fikira huhusu gazia zilifanya mwili kuganda	
14	I found myself acting or feeling like I was back at that time Nilijikuta nikitenda na kuhisi kama wakati ule wa gazia	
15	I had trouble staying asleep Nilikuwa na shida kuendelea na ushingisi	
16	I had waves of strong feelings about it Nilikuwa na fikira na hisia nzito kuhusu tohara	
17	I tried to remove it from my memory Nilijaribu kuzitoa kwenye akili yangu	
18	I had trouble concentrating Nilikua na shida ya kufikiria	
19	Reminders of the incident caused me to have physical reactions (sweating, trouble breathing, nausea, or a pounding heart) Fikira kuhusu gazia zilifanya mwili wangu kubadilika nikatokwa na jasho , nikipata shida ya kupumuwa, nikasikia kichafu (ro kuchafuka) na moyo kupiga kwa kasi.	
20	I had dreams about it Nilikuwa na ruyia ? noto kuhusu gazia	
21	I felt watchful an on guard Nilikuwa mwagalifu na makini sana	
22	I tried not to talk about it Nilijaribu nisiongee kuhusu gazia	

3) Becky's Depression Inventory (BDI)

Respondent no -----

On this questionnaire are groups of statements. Please read each statement carefully and pick out the one statement in each group that best describe the way that you have been feeling the PAST WEEK, INCLUDING TODAY.

Please circle the number beside the statement you pick. Be sure to read the statement carefully before making your choice.

Swahili

Yafuatayo ni mafungu ya sentesi. Tafadhali soma kila fungu kwa makini . changua kutoka katika kila fungu sentesi ambayo yaeleza vyema ulivyokuwa ukihisi JUMA LILILOPITA NA UNAVYOHISI LEO ! Ashiria sentesi moja au zaidi ya moja uliyochagua katika kila fungu kwa kuweka alama ya mviringo juu ya nambari ya sentesi hiyo. Hakikisha umesoma sentesi zote katika fungu kabla ya kuchangua sentesi iliyo sambamba na unavyo hisi .

1	0	I do not feel sad	Sina huzuni
	1	I feel sad	Nina huzuni
	2	I am sad all the time and I can't snap of it	Nina huzuni wakati wote na siwezi kujiondoa
	3	I am so sad , unhappy that can't stand it	Nina huzuni sana mpaka siwezi kustahimili / kuvumilia
2	0	I am not particularly discouraged about the future	Sijafunjika moyo hasa na siku za usoni
	1	I feel discouraged about the future	Nahisi nimefunjika moyo na siku sa usoni
	2	I feel I have nothing to look forward to	Nahisi sina ninalo tarajia siku za usoni.
	3	I feel that the future is hopeless and that things	Nahisi nimekata tama a ya siku za usoni, na

		cannot improve	naona mambo hayawezi kuwa bora zaidi.
3	0	I do not feel like a failure	Sijihisi kama nimeanguka maishani.
	1	I feel I have failed more than the average person	Nahisi nimeanguka maishani zaidi ya mtu wa kawaida
	2	As I look back at my life all I can see is a lot of failure	Nikiangalia maisha yangu yaliyopita naona nimeanguka sana
	3	I feel I am a complete failure as a person	Nahisi nimeanguka kabisa maishani .
4	0	I get much satisfaction out of things as I used to	Naridhika na mambo kama ilivyo kawaida yangu
	1	I don't enjoy things the way I used to	Sifurahii mambo kama nilivyo kuwa nikifurahia
	2	I don't get real satisfaction out of anything anymore	Sitosheki tena kikamilifu na jambo lolote
	3	I am dissatisfied or bored with everything	Sitosheki wala sichangamshwi na chochote tena
5	0	I don't feel particularly guilty	Sihisi kama nina hatia fulani
	1	I feel I guilty a good part of time	Nahisi nina hatia wakati mwingine
	2	I feel guilty most of the time	Nahisi nina hatia wakati mwingi
	3	I feel guilty all the time	Nahisi nina hatia wakati wote
6	0	I don't feel I am being punished	Sihisi kama ninadhibiwa
	1	I feel I may be punished	Nahisi kama naweza kuadhibiwa
	2	I am disgusted with myself	Natarajia kuadhibiwa
	3	I hate myself	Nahisi ninadhibiwa
7	0	I don't feel disappointed in myself	Sihisi kama nimeikarisirikia nafsi yangu
	1	I am disappointed in myself	Nimeikarisikia
	2	I am disgusted with myself	Najidharau
	3	I hate myself	Najichukia
8	0	I don't feel I am any worse than anybody else	Sihisi Kama mimi ni mbaya saidi ya mtu yeyote yule
	1	I am critical of myself for my weakness or mistakes	Najisuta (kujitoa makosa) sana katika makosa yangu ama udhaifu wangu
	2	I blame myself all the time	Najilaumu wakati wowote kwa makosa yangu
	3	I blame myself all for my faults	Najilaumu kwa ovu lolote linalo tendeta
9	0	I don't have any thought of killing myself	Sina wazo lolote la kujiuwa
	1	I have thoughts of killing myself but I would not carry them out	Nina wazo la kujiuwa, lakini sijalitimiza wazo hilo
	2	I would like to kill myself	Ningetaka kujiuwa
	3	I would like to kill myself if I had the chance	Nitajiuwa nikipata nafasi
10	0	I don't cry ay more than usual	Silii siku hizi saidi ya vile ilikuwa kaida yangu
	1	I cry more now than usual	Nalia siku hizi saidi ya vile ilikuwa kawaida yangu
	2	I cry all the time	Nalia wakati wowote siku hizi
	3	I used to be able to cry, but now I cant even though I want to	Nilikua nikiweza kulia , lakini sasa hata nikitaka kulia siwezi
11	0	I am no more irritated now than ever am	Sikasirishwi kwa urahisi siku hizi kama ilivyo kuwa kawaida yangu
	1	I get annoyed or irritated more easily than I used to	Nakasirishwa kwa urahisi zaidi ya ilivyo kwaida yangu
	2	I feel irritated all the time now	Nahisi nimekasirishwa wakati wote siku hizi
	3	I don't get irritated at all by the things that used to irritate me	Sikasirishwi kamwe na mambo ambayo yalikuwa yakinikasirisha
12	0	I have lost interest in other people	Sijapoteza hamu ya kujihusisha ama kujumuika na watu
	1	I am less interested in other people than I used to	Hamu yangu ya kujihusisha na watu imepungua zaidi ya ilivyo kuwa
	2	I have lost most of my interest in other people	Nimepoteza sana hamu yangu ya kujihusisha na watu

	3	I have lost all interest in other people	Nimepoteza hamu yangu yote ya kujihusisha na watu
13	0	I make decisions about as well as I ever could	Ninafanya uamuzi kuhusu jambo lolote kama kawaida.
	1	I put off making decisions more than I used to	Ninahairisha kufanya uamuzi zaidi ya vile nilivyo kuwa nikifanya
	2	I have difficulty in making decisions than before	Nina uzito mkubwa wa kufanya uamuzi kuliko hapo awali
	3	I cant make decisions at all nay more	Siwezi tena kufanya uamuzi wa jambo lolote lile
14	0	I don't feel I look worse than I used to	Sihisi kuwa naonekana mbaya zaidi ya vile nilivyo kuwa
	1	I am worried that I am looking old or unattractive	Sina wasisi kuwa naonekana sivutii
	2	I feel that there are permanent changes in my appearance that make me look unattractive	Ninahisi kuwa kuna mabadiliko yasio ondoka kwenya umbo langu yanayofanya nisivutie
	3	I believe that I look ugly	Nina amini ya kuwa nina sura mbaya
15	0	I can work about as well as before	Naweza kufanya kazi kama vile ilivyokuwa hapo awali
	1	I can take an extra effort to get started at doing something	Nilazima nifanye bidii, ndipo nianze kufanya jambo lolote
	2	I have to push myself very hard to do anything	Inabidi nijilasimishe sana ili niweze kufanya jambo lolote
	3	I cant do any work at all	Siwezi kabisa kufanya kazi yoyote
16	0	I can sleep as well as usual	Ninalala kama kawaida yangu
	1	I don't sleep as well as usual	Silali vyema kama nilivyo kuwa nikilala hapo awali
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep	Naamka mapena kwa saa limoja au masaa mawili. ambayo sio kawaida yangu , halafu ni vigumu kupata usingizi tena
	3	I wake up several hours earlier than usual and feel it hard to go back to sleep	Naamka mapema saidi ya masaa mawili , ambayo sio kawaida yangu , halafu siwezi kupata usingizi tena
17	0	I don't get more tired than I used to	Sichoki saidi ya nilivyokuwa nikichoka hapo awali
	1	I get tired more easily than I used to	Nachoka kwa urahisi zaidi ya kawaida yangu
	2	I get tired from doing most everything	Nachoshwa (nachokeshwa),karibu na kila jambo ninalofanya
	3	I am too tired to do anything	Ninachoka sana hata siwezi kufanya lolote
18	0	My appetite in no worse than usual	Hamu yangu ya chakula sio mbaya zaidi ya vile ilivyo kuwa hapo awali
	1	My appetite is not as good as it used to be	Hamu yangu ya chakula si nzuri kama ilivyo kuwa hapo awali
	2	My appetite is much more worse	Hamu yangu ya chakula ni mbaya zaidi siku hizi
	3	I have no appetite anymore	Sina hamu ya chakula hata kidogo
19	0	I haven't lost much weight if any lately	Sijapunguza uzito wa mwili wakakuonekana hivi karibuni

	1	I have lost more than 5 pounds	Nimepunguza uzito wa mwili zaidi ya paudi tano
	2	I have lost more than 10 pounds	Nimepunguza uzito wa mwili zaidi ya paudi kumi
	3	I have lost more than 15 pounds, am purposely trying to loose weight by eating less yes or no	Nimepunguza uzito wa mwili zaidi ya paudi kumi na tano Ninakula chakula kiasi kidogo kwa kusudio la , kujaribu kupunguza uzito wa mwili ndivyo au sivyo
20	0	I am no more worried about my health than usual	Sina wasiwasi usio wa kawaida kuhusu hali yangu ya afya
	1	I am very worried about physical problems such as aches and pain or upset stomach or constipation	Nina wasiwasi kuhusu shida za mwili kama vile maumivu hapa na pale , au shida ya tumbo,au kufunga choo
	2	I am very worried about physical problems and its hard to think of much less	Nina wasiwasi sana kuhusu matatizo ya mwili mpaka inakuwa Ni vigumu kuwaza jambo lingine lolote
	3	I am very worried about physical problems that I cannot think about anything else	Nina wasiwasi sana kuhusu matatizo ya mwili mpaka siwezi kuwaza jambo lingine lolote
21	0	I have not noticed any recent change in interest in sex	Sijaono mabadiriko yoyote hivi karibuni kuhusu hamu yangu ya kufanya mapenzi
	1	I am less interested in sex than before	Hamu yangu ya kufanya mapenzi imepungua zaidi ya vile ilivyokuwa
	2	I am less interested in sex now	Hamu yangu ya kufanya mapenzi imepungua sana siku hizi
	3	I have no interested in sex completely	Nimepoteza saidi kabisa hamu yangu ya kufanya mapenzi

