



**SAINT PAUL'S HOSPITAL MILLENNIUM MEDICAL
COLLEGE**

GRADUATE STUDY PROGRAM

**VIOLENT VICTIMIZATION AND ASSOCIATED FACTORS OF
PATIENTS WITH MENTAL ILLNESS IN ADDIS ABABA, ETHIOPIA:
A FACILITY BASED CROSS SECTIONAL STUDY**

Investigator: Dr. Eden Workalemahu

NOVEMBER, 2022

ADDIS ABABA, ETHIOPIA



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Investigator: Dr. Eden Workalemahu (Psychiatry Resident)

Advisors: Dr. Girma Mamo, Assistant Professor of Psychiatry

A RESEARCH PROPOSAL SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY
PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
SPECIALTY CERTIFICATE IN PSYCHIATRY SAINT PAUL'S HOSPITAL
MILLENNIUM MEDICAL COLLEGE

Saint Paul's Hospital Millennium Medical College

Graduate Study Program

Research Project Submission Template

Name of investigator	Dr. Eden Workalemahu
The full title of the research project	Violent victimization and associated factors of patients with mental illness in Addis Ababa, Ethiopia: A facility-based cross sectional study
Duration of the project	August to September 2022
Study area	Saint Paul's Hospital Millennium Medical College, Addis Ababa
Total Cost of the project	25,360 ETB
Source(s) of Funding	Saint Paul's Hospital Millennium Medical College
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Name of Advisor	Dr. Girma Mamo

Abstract

Background: Violence has long been the leading cause of mortality and morbidity. It has been thought that people with mental illness (PWMI) are perpetrators of violence. However, several studies have suggested that PWMI are more likely to be victims of violence than perpetrators. There are limited studies that assessed violence against PWMI in low and middle-income countries.

Objectives: This study aimed to assess violent victimization and associated factors among PWMI attending the adult outpatient psychiatry clinic at Saint Paul's Hospital Millennium Medical College (SPMMC) between August and September 2022

Methods: A facility-based cross-sectional study was conducted at the SPHMMC adult outpatient unit of the psychiatry department. The data was collected using a questionnaire administered by a trained professional. The data was analyzed using SPSS version 20. Frequency and distribution, as well as cross-tabulations with chi-square findings, are presented in graphs and tables. In addition, further analysis for associations utilized a binary logistic regression.

Result: A total of 237 patients participated, with a 99.1% response rate. Results showed that 23.7% were victims of violence, and 13.7% had perpetrated violence. Most (83.9%) reported psychological violence, followed by physical violence (60.7%). In addition, factors such as substance use (OR=0.16), violence perpetration (OR=0.21), living with family (OR=24) and employment [manual labor (OR=0.3), and government job (OR=0.25)] were found to be associated during further analysis.

Conclusion & recommendations: This study showed that a high amount of PWMI are victims of violence. This can affect quality of life of patients, treatment outcomes and overall public health. Sociodemographics and clinical factors that have been associated can be targeted to help ameliorate the high victimizations. These findings should prompt us to thoroughly assess our patients for a history of violent victimization and act accordingly.

Keywords: Violence, victimization, Mental illness, Cross-sectional study, Addis Ababa

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List of Acronyms and Abbreviations

IPV	Intimate Partner Violence
SPHMMC	Saint Paul's Hospital Millennium Medical College
OPD	Out Patient Department
PWMI	People With Mental Illness
WHO	World Health Organization
GAD	General Anxiety Disorder
MDD	Major Depressive Disorder

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Introduction

Background

Violence has been a part of human history and interaction since prehistoric times. The WHO defines violence as "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation." (1)

Violence can have many forms and is categorized in various ways as there is no universally accepted method of categorization. Some examples include; considering who inflicts violence: towards the self, another individual, or a group. Another classification method is the type of violence: Physical, Sexual, Psychological, and Neglect. A different form of categorization uses age of the victims: Child maltreatment, youth violence, intimate partner violence, abuse of the elderly, sexual violence, and homicide. Interpersonal violence is inflicted by family or intimate partners, a member of a community or neighborhood, and those not related to the victim(1).

A wide variety of catastrophic consequences follow violent victimization; for individuals, communities, nations, and international well-being at large. The impact of violence can range from minor physical injuries to severe psychological trauma and even death. A WHO report mentions that most violence results in non-fatal physical injuries, mental health problems, and sexual and reproductive health issues, which are more common among women, the elderly, and children (2).

The health consequences of violence are becoming better understood, with recent studies looking in that direction. One study has found that the health-related outcomes of violence can range from depression and Post Traumatic stress disorder to cardiovascular diseases, depending on the age and sex of the victims of violence (3). Fatal outcomes are much more common among males. The WHO reported that between 2000-2014 G.C., 6 million people

lost their lives to violence(2). In 2019 G.C. 16.2 per 100,000 deaths globally and 17.9 per 100,000 mortalities per year in Africa were due to violence (4).

When thinking of violence, specific demographics come to mind. Commonly vulnerable groups are women, children, the elderly, and patients with mental illness (PWMI). Mental health and PWMI usually associated with violence(1) . Few studies found that those with mental illness are prone to the perpetration of violence. Another couple of studies reported that when co-occurring with other comorbidities, mental illness could increase the likelihood of violence perpetration (5–8). Studies in the western setup have found that most the general public perceives that mental illness, especially schizophrenia, associates with violence (9).

However, in recent years researchers have started to explore the other side of violence; the victimization of PWMI. Studies in high- and low-income countries show that PWMI are at higher risk of being victimized than the general population (see 10 for review). Studies across nations have shown an apparent increase in violent victimization (physical, sexual, and psychological) among patients with severe mental illness. For instance, rates of victimization ranging from as low as 5.6% in Finland to 36.7% in the USA have been reported (10,11). These studies indicate that victimization in PWMI is 2-3 times higher than in the general population.

Various factors are associated with increased victimization. For example, patient and disease factors (such as severity and response to treatment) and sociodemographic factors (such as education and marital status) are important factors (12–14)ⁱ. Few studies have explored sociodemographic factors such as gender, marital status, and employment; patient/disease factors such as type of diagnosis, comorbid substance use, and prior perpetration of violence(15,16)

Statement of the problem

Violence is a global concern and has detrimental consequences, in terms of physical and mental health, to the extent of death. It also has an economic burden as well. Over 1.2 million people worldwide died due to self-inflicted, interpersonal, or collective violence in 2019, accounting for 2.3% of global mortality rates. In Africa, up to 17.9 per 100,000 deaths were associated with violence in 2019. Similarly, in Ethiopia, the crude death rate due to violence was 9.4 for males and 6.9 per 100,000 deaths (2). Despite this large number, most victims of violence sustain non-fatal physical injuries, mental health problems, or sexual and reproductive health issue (4).

Patients with severe mental illness are among the high-risk or vulnerable groups, so they are at higher risk of being victims of violence and all the consequences that come with it, including the worsening of their illness. A systemic review done from data collected from over 5000 patients across the globe showed violent victimization of PWMI to range from 4.3 to 35%. (17). One study from Egypt showed that up to 43.3 % had been victims of violence (15). Studies from Sweden found a 53% prevalence of violent victimization among patients attending psychiatric care at two hospitals (18). Another study from South Korea reported a 52% prevalence of physical or sexual violence (19). Finally, one paper in India found that up to 30% of female patients had been victims (20).

There are limited studies regarding the violent victimization of mentally ill patients in Ethiopia. A community-based study found that up to 60% had been victims of violence (lifetime prevalence), and 17% had been victimized in the past year (12). Additionally, a study done in Ammanuel Mental Specialized Hospital found that 23% of the participants had a history of violent victimization (21).

Justification of the study

Various studies across different countries show that violent victimization among patients with severe mental illness is high. Poor socioeconomic status, disease severity, and stigma significantly factor into a higher risk of victimization. Victimization has various detrimental outcomes, from minor physical injuries to psychological harm to death. Due to our nation's economic standing and the poor awareness of the general community on mental health issues, attention must be given to violence toward PWMI (9). Violence a cause of morbidity and mortality, in addition to the burden on the mental health service and public health at large. To the extent of the review for this research, limited research explores the violent victimization rates and associated factors among patients with mental illness.

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Significance of the study

The findings from this paper will help contribute to understanding the magnitude and possible associated factors of victimization of patients with severe mental illness. Showing the prevalence will help get the necessary attention and support to incite change. The psychiatry department of SPHMMC can use the findings from this study to improve patient evaluation and care in the facility. The entire hospital staff can use it to enhance and spread awareness. Additionally, it will help future studies have a baseline for understanding the magnitude of the problem, as well as further studies to ascertain causality and explore more associated factors that mental health and public health professionals can target for improvement. Finally, findings from this paper can be used by different stakeholders as a baseline for measuring the effectiveness of improvement strategies put forth at an institutional and national level.

Literature review

Most studies that deal with violence and mental illness explore the prevalence or associated factors of PWMI being perpetrators of the violence or how often people that have committed violent crimes have a mental illness(5,7–9). However, it has recently become apparent that PWMI are much more likely to become victims of violent crimes than perpetrating violence (13,22,23).

A systemic review, which included over 5000 patients across nine countries, showed that up to 34% of patients had experienced some form of violence. It found that in all countries, regardless of national violence and crime rate, levels of violent victimization were from 1.6 times to up to 50 times higher, relative to the general population . It also mentioned that this wide prevalence gap was due to factors like overall crime rates and socioeconomic status (17).

A large-scale study in the U.S that recruited over 900 patients with severe mental illness found that up to 17% had been victims of violence that was 11 times higher than the national crime victimization rate. The study recommended that these findings prompt immediate action. Furthermore, this study mentioned that the severity of symptoms, socioeconomic status, and vulnerable to substance use are some of the factors that might increase vulnerability to violent victimization (24).

Another large-scale study in the U.S. found that of 700 participants with severe mental illness, 33.4% of the women and 36.7% of the men reported sexual or physical abuse within the past year. These numbers increased as the time frame was extended further back (10). A nationwide study from Sweden, which included over 250,000 cases, found that the risk of violent victimization among those with mental illness was 6.5%, while the risk of perpetration was 7.5%. The finding showed that victimization and perpetration of violence were higher in those with mental illness than in the general population and their siblings. The study indicated that the lower rates of victimization might be because "the earlier research relied on broad and self-reported measures of subjection to violence and were based on selected sample." (23)

A systemic review stated that 20 to 34% of PWMI on outpatient follow-up were victims of violence, with 35% in studies including both out and inpatients. These numbers are up to 10 times higher than the findings for patients perpetrating violence in both inpatient and

outpatient setups. They also found that despite the risk of violence perpetration, the victimization of PWMI is a more pressing matter that needs due attention (25).

Another systemic review and meta-analysis on patients with psychosis found the three-year victimization rate to be 20%, while lifetime victimization was 66% (13). Finally, a study from the Netherlands included 153 patients with depression with a history of violent victimization over the past three years. They found that 48.7% had repeated victimization over the past year. It also found that men were more likely to be victimized by strangers (26).

A case-control study in Sweden found that up to 20% of 397 cases reported being victims of violence. Most patients were diagnosed with severe mental illness, i.e., schizophrenia spectrum and other psychotic disorders, major depressive disorder or bipolar disorder (18), and about half of them required medical attention due to the severity of their injuries. A community-based study on people with psychosis showed that the one-year prevalence of violent victimization was 16% within the past year, which is twice the general population victimization rate at the time of the study (27).

Studies have also evaluated violent victimization from the perspective of patients with psychosis. One study used a cohort study design and followed patients for three years, including 172 participants. The results showed that 38% had been victims of violence during the three years(28). Studies from Asian countries show similar findings of higher levels of victimization among PWMI. For example, studies from India showed the rate of sexual violence faced by psychiatric patients and found that up to 30% of participants reported sexual coercion. These attacks ranged from physical threats to the use of authority by the perpetrator. Twelve percent said a husband or family member had attacked them more than once (20). Similarly, in Korea, a study in a psychiatric inpatient facility found that 52% (lifetime prevalence) had a history of sexual or physical violence (19).

In Africa also assessed the magnitude and associated factors of violence against PWMI. For instance,a study in Egypt reported that. Forty-three percent reported being victimized, almost all reported emotional violence, and 64% reported physical violence (15). One small scale

study from Zambia found that of 43 PWMI, 11.6% had injuries due to violent victimizations in a one year period (29).

An Ethiopian case-control community on the prevalence of mental illness included newly identified or known PWMI and community members in the same villages or neighborhoods. There were 200 participants in the case and control groups. The study compared violent victimization and the perpetration of violence in both groups, and found that PWMI were more likely to be violence victims than perpetrators, and they were up to 2 times more likely to be victims than the control group from the same neighborhood (12). A hospital based study from Addis Ababa found that of the 629 PWMI, 57.4% had a lifetime and 27.4% had one year history of violent victimization (21).

In terms of associated factors, some studies have identified factors associated with violent victimization in PWMI. Contrary to what would be assumed, several studies have shown that overall there is a higher risk of being a victim of violent crimes and violence in males than in female patients (23,27). Yet other papers, as was found in Egypt, showed that being female is more associated with being a victim of violence (15). Another study in the United Kingdom found that men are more likely to be victims of physical violence. These findings might be due to the tendency of the male to be viewed as more threatening and likely hood of showing violent tendencies (30). One study, including 900 participants, found that being female, homeless, and having poor global functioning is associated with higher victimization rates (31). Similar studies also found that having comorbid substance use, symptom severity, and functionality relates to a higher likelihood of violent victimization (26,28,32).

A study aimed to understand the relationship between (perceived) stigma and violent victimization reported that 43% of the participants had been victims of violence from the outset, and 18% more reported violent victimization in the one-year study period. Furthermore, they found that scoring higher on the perceived stigma scale was related to a higher likelihood of being a victim of violence (those that scored over two S.D. of perceived stigma had a 50% probability of violent victimization). Additionally, this paper found that the likelihood of victimization increased with a history of victimization (33).

Another study conducted to evaluate the relationship between violence and victimization found that PWMI with a history of violence toward others were at a higher risk of being victims themselves. However, the study noted that as it was a cross-sectional study design, it would not be wise to assume causality or the direction of association between the two and recommended further studies in this area (34).

Conceptual framework

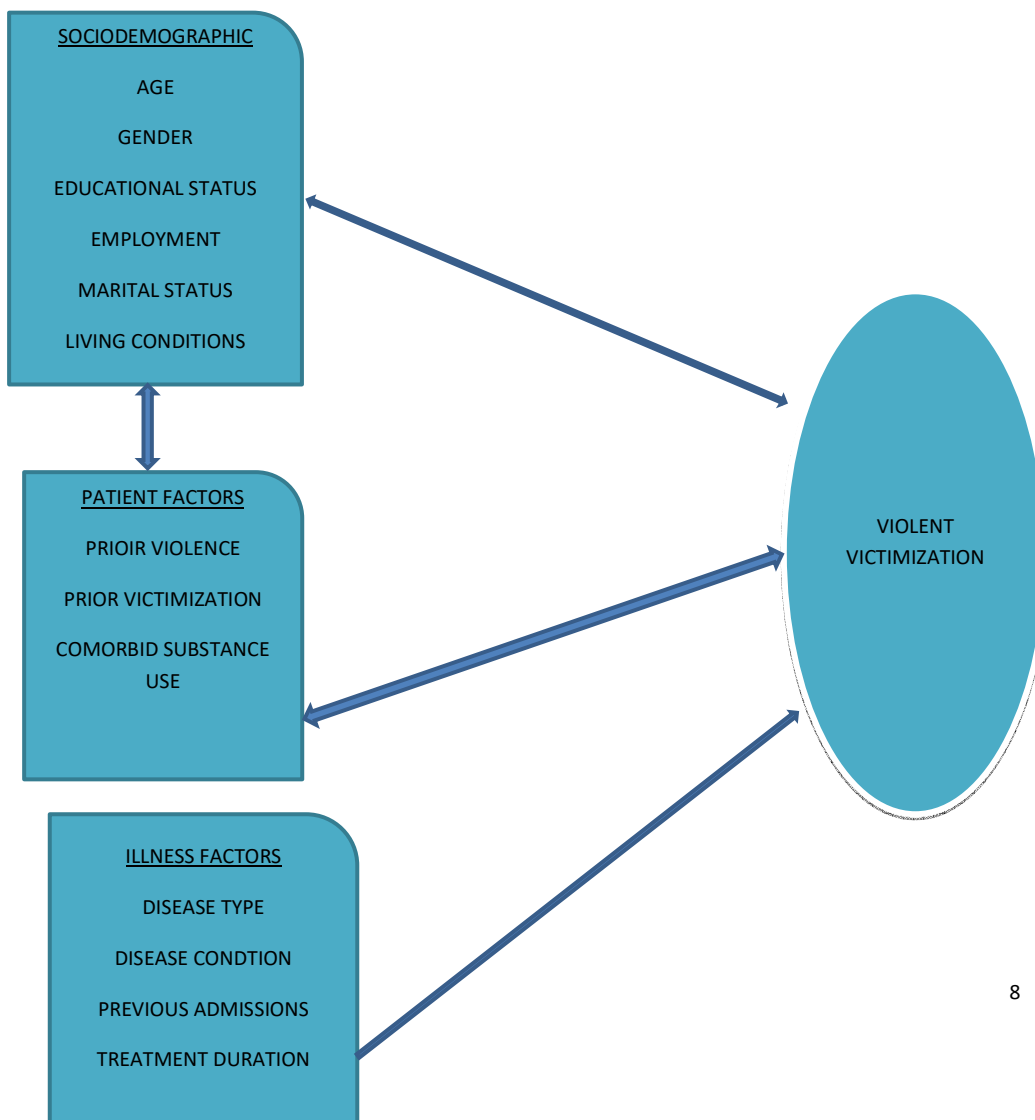


Figure 1 Conceptual framework for violent victimization of PWMI (12–14,27,30)

Objectives

General objective

- To assess the prevalence of violent victimization and associated factors in PWMI at SPHMMC, Psychiatry Department from August to September 2022

Specific objective

- To determine the prevalence of violent victimization among PWMI at SPHMMC Psychiatry (outpatient) department from August to September 2022
- To identify associated factors with violent victimization among PWMI

Methodology

Study area and period

This study was conducted among patients who had a follow-up at Saint Paul's Hospital Millennium Medical College between August and September 2022.

SPHMMC is a Tertiary level hospital located in Addis Ababa, Gulele area. The outpatient services department of psychiatry has a child and adolescent unit, adult psychiatry unit, geriatrics, and addiction clinics. An average of 70 patients are seen daily as outpatients in adult OPD, 15 in geriatrics OPD & 10 patients in child and adolescent OPD on average. In addition, it provides inpatient service with a total capacity of 23 patients, including emergency, recovery ward, and detox unit, for substance use disorder.

Study design

This study used an institution-based cross-sectional study design among patients attending adult outpatient for follow-up at the Psychiatry department, SPHMMC.

Source and study population

Source population: Patients attending SPHMMC psychiatry department outpatient unit.

Study population: Patients with outpatient follow-up attending SPHMMC that fulfill the inclusion criteria between August and September 2022.

Sample Size determination

The quantitative data's sample size was determined using a single population proportion formula. Using a sample proportion of 17%, taken from a local study from 2014 (12), with a 95% confidence interval.

- Using the single population proportion formula, with a Confidence interval of 95%, $P=0.17$, $d=0.05$

$$n = \frac{(Z_{\alpha/2})^2 \times p(1-p)}{d^2}$$

$$n = (1.96)^2 * 0.17(1-0.17) / 0.05^2$$

$$= 217$$

The corrected sample size with a 10% none response rate is 239.

Sampling Procedures

A simple random sampling method was used. Medical record numbers for the patients appointed that day are used as a sampling frame. Using the SPHMMC psychiatry outpatient appointment log, the first patient selected for that day was the first participant, after which every 5th medical record number was used to ensure equal spacing.

Eligibility criteria

Inclusion: Age over 18 years

On follow-up for at least three months

Exclusion: Severe symptoms, disorganization, or psychosis (active delusions and hallucinations) at the time of the interview

Study variables

Dependent variable: Violent victimization

Independent variables: Age, Sex, Marital status, Educational level, Employment, Living area, Type of psychiatric disorder, Duration of treatment, Substance use, Prior perpetration of violence, Number of hospitalizations, Length of admission

Operational definition

Violent victimization: if participants answer yes to any one of the following questions, which was taken from a locally adapted tool for assessing violence against women by the WHO in a cross-cultural study assessing domestic violence. [Cronbach alpha results for the subsections of physical violence (0.876); psychological violence (0.925); sexual violence (0.812)] (see annex) (35,36)

Perpetration of Violence: for this study, participants who answer yes to one or more of the questions in the section for "perpetration of violence".

Data Collection Procedures

Data were collected through a structured questionnaire. The data collection tool was adapted from a WHO Multi-country Study on Women's Health and Domestic Violence against Women(36), later validated in Ethiopia(35). The questionnaire has 43 questions, including sociodemographic and patient factors (such as type of illness and treatment duration). The questionnaire was pretested on 5% of participants to ensure clarity and ease of understanding.

Trained psychiatry clinicians collected data after one day of questionnaire training. Participants were selected after their follow-up interview and assessment for fitness

Data Management

During the data collection, data were checked for completeness and missing information at regular intervals; afterward, data cleaning was done while entering into Excel. Finally, it is exported to SPSS version 20 for analysis.

Data Analysis Procedures

Descriptive statistics are presented with frequency tables and graphs. For analysis of the association between violent victimization and the independent variables, a binary logistic regression model was used after finding the variables that show significant association (a p-value <0.25) in univariate analysis, a multivariable logistic regression model was run to get the adjusted OR, with a 95% confidence interval. The final model was checked for assumptions.

Ethical Consideration

Permission and ethical clearance were obtained from the Institutional Review Board of Saint Paul's Hospital Millennium Medical College research center and academic office, then submitted to the Department of Psychiatry. Informed written consent was taken from each

participant. Access to the collected information was limited to the principal investigator, and confidentiality was maintained throughout the project. Participants were informed that they had the right to refuse or decline to participate in the research; additionally, they were told to withdraw from participating at any time they chose. Finally, due to the safety issues associated with this research, participants were informed of options for getting help and the possible benefits and associated risks of reporting the violence they encountered.

Results

Sociodemographic

A total of 237 (99.1% response rate) participants responded to the questionnaire. Of these, 128 (54%) were men, and 109 were women. The mean age of the participants was 31.8 with (SD $\pm$ 8.8), with a minimum of 18 years and a maximum of 62 years. The majority of the participants (69.2%) were single. Regarding education, 19.4% had primary education, and 75.1% had secondary or higher education. Most participants (58.2%) were unemployed and relied on family for basic needs; 20.7% (49) worked in private businesses, while 13.9 had government jobs, and 7.2% had daily laborers. Ninety-seven point nine percent live in urban areas.

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Table 1: Sociodemographic characteristics of participants (n=237)

Sociodemographic		Violence		Frequency	Percentage	Chi-square
		Yes	No			
Gender	male	32(57.1%)	96(53%)	128	54	X ² 0.290 P=0.590
	female	24(42.9%)	85(47%)	109	46	
Age	18-25 years	18(32.1%)	53(29.3%)	71	30	X ² = 0.29 p=0.59
	26-35	19(33.9%)	75(41.4%)	94	39.7	

		)				
	Over 36 years	19(33.9%)	53(29.3%)	72	30.4	
		)				
Educational level	No formal education	3(5.4%)	10(5.5%)	13	5.5	$X^2=0.819$ $P=0.845$
	Elementary-level education	9(16.1%)	37(20.4%)	46	19.4	
	Secondary level education	21(37.5%)	70(38.7%)	91	38.4	
	Higher education	23(41.1%)	64(35.4%)	87	36.7	
Marital status	Single	39 (69.6%)	125 (69.1%)	164	69.2	$P=0.989$
	Married	10 (17.9%)	32 (17.7%)	31	17.7	
	Separated/divorced	7 (12.5%)	24 (13.3%)	42	13.1	
Living condition	Living with family/spouse	46 (82.1%)	164(90%)	210	88.6	$X^2=6.786$ $P=0.034$
	Living alone	7(12.5%)	16(8.8%)	23	9.7	
	Homeless/NGO	3(5.4%)	1 0.6%	4	1.7	
Employment	Unemployed	28 (50%)	110(60.8%)	138	58.2	$X^2=7.47$ $P=0.058$
	Government office	12(21.4%)	21(11.6%)	17	7.2	
	Manual labor	7(12.5%)	10(5.5%)	33	13.9	
	Private work	9(16.1%)	40(22.1)	49	20.7	

Patient factors

Of the 237 participants, the majority (49.1%) were diagnosed with schizophrenia spectrum and related disorders, 46 (19.7%) were diagnosed with MDD, 10(4.3%) had a primary diagnosis of a Substance use disorder, and 1.3% had other diagnoses. Of the participants with comorbidities (n=51): 13.5 percent had comorbid substance use disorder, 6.3% had comorbid major depressive disorder, and 1.3 and 1.7% each had GAD and Epilepsy.

Only 30 (12.7%) of the participants had admissions, of which 70% had one admission, and the remaining 30% had two or more admissions. For treatment duration, which was not normally distributed, the median admission was three years with 25th and 75th IQR (1, 7 years).

Table 2: Patient Factors for respondents (n=237)

Patient factors			Violence		Frequency	Percentage	Chi-square
			Yes	No	Total		
Diagnosis	Schizophrenia		25(44.6%)	87(48.1%)	115	49.1	$\chi^2 = 5.1$ p= 0.28
	MDD		11(19.6%)	37(20.4%)	46	19.7	
	Bipolar disorder		8(14.3%)	13(7.2%)	21	9.0	
	Epilepsy		12(21.4%)	36(19.9%)	39	16.7	
Substance use	No		37(66.1%)	133(73.5%)	170	71.7	$\chi^2 = 7.486$; P=0.024
	Yes	One substance	11(3.4)	13(5.5)	24	10.1	
		Two or more subs	8(14.3%)	35(19.3%)	43	18.1	
Treatment duration (in years)	Less than 3		27 (48.2%)	103 (56.9%)	130	54.9	$\chi^2 = 1.442$ p=0.486
	Between 3 and 10		16 (28.6%)	46 (25.4%)	62	26.2	
	Over 10		13 (23.2%)	32 (17.7%)	45	19	

Admission	No admission	47(83.9%)	160(88.4%)	207	87.3	Fisher exact= 3.02 p=0.19
	One admission	8(14.3%)	13(7.2%)	21	8.9	
	Two or more	1(1.8%)	8(4.4%)	9	3.8	
Perpetrated violence (past year)	Yes	17(30.4)	15(8.3)	32	13.5	X ² =17.84 P= 0.00
	No	39(69.6%)	166(91.7%)	205	86.5	

Violence

Thirteen percent of the participants stated they had perpetrated violence in the past year. Fifty-six (23.6%) have a history of at least one type of violence, of which 83.9% had reported psychological violence and 60.7% had reported physical violence (Figure 1).

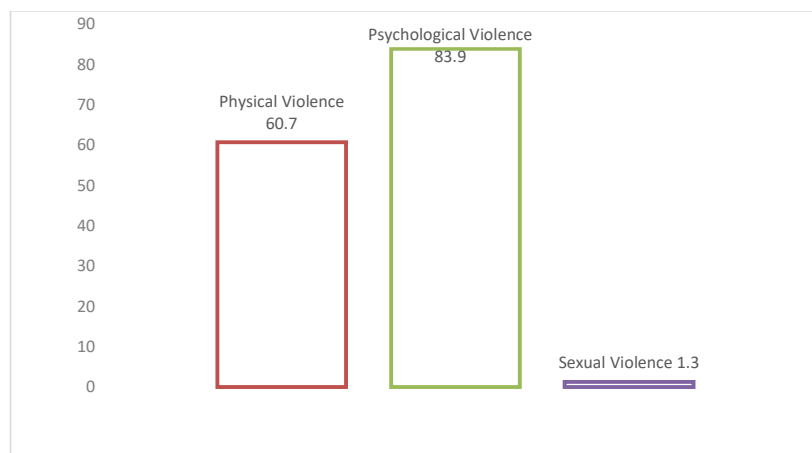


Figure 2: Violent victimization percentage distributed by type (n=56)

Of those victimized (n=56), 46.4% reported that they knew the perpetrator, while 16% stated they did not know the person that had attacked them. Most participants who knew the perpetrator said it was a family member (sibling 10.7%, parent 5.4%, relative 8.9%). Around 10 % reported it was a coworker or someone they knew from the neighborhood; the remaining did not want to specify who had perpetrated the violence. In addition, 32.1%(18/56) stated that they had suffered physical or mental health problems due to the violence, but only 6 (33%) sought medical help. Twenty-five (44%) of the victims did not tell anyone about the incident, and of the remaining 55% who had told someone, most relied on family members: with the most frequently told people being parents 17.9%, then siblings 16.1%; three (5.4%) had reported to law enforcement, and one to those working above them, two (3.8%) each had told either friends, coworkers or neighbors.

Cross-tabulations were done to assess the association between types of violence and factors. Results showed significant associations between physical violence and substance use $\chi^2=7.97$ ($p=0.019$), living conditions $\chi^2=18.724$ ($p=0.001$), and sex $\chi^2=4.39$ ($p=0.0036$). Additionally, cross tabs between psychological violence and substance use showed a statistically significant association with $\chi^2=11.65$ ($p=0.003$).

Factors associated with violent victimization

Binary logistic regression was used to analyze the findings. Univariate analysis was done to identify factors associated with overall violent victimization. Those with P-values less than 0.25 (because the independent factors are highly associated) were taken to be significant. Five factors: living conditions ($p=0.091$), employment ($p=0.067$), perpetration of violence ($p<0.001$), previous admissions ($p=0.206$), and substance use ($p=0.031$) were associated with violence. The remaining variables (i.e., treatment duration, diagnosis, marital status, age, gender, and education) did not show a significant association with the overall violent victimization ($p>0.25$).

Independent variables with a significant association were put into a multivariate analysis. Assumptions of multi-collinearity and goodness of fit were ascertained (with VIF between 1.3-1.04, Hosmer Lemeshow test with p-value > 0.05 respectively). Four of the five factors

from the initial analysis showed significant association; Perpetrated Violence (P <0.000), Living conditions (p=0.027), employment (p=0.046), and substance use (p=0.019). Respective odds ratios (crude and adjusted with 95% CI) are presented in the table below.

Table 3: Sociodemographic factors associated with violent victimization n=237)

Sociodemographic		Violence		P Value	COR[95% CI]	AOR	P Value
		Yes	No				
Gender							
	male	32(57.1%)	96(53%)	0.59	0.85 [0.46, 1.5]		
	female	24(42.9%)	85(47%)	1	1		
Age							
	18-25 years	18(32.1%)	53(29.3%)	0.887	1.06[0.49,2.23]		
	26-35	19(33.9%)	75(41.4%)	0.349	1.41[0.68,2.93]		
	Over 36 years	19(33.9%)	53(29.3%)	1	1		
Educational level							
	No formal education	3(5.4%)	10(5.5%)	0.797	1.2[0.3,4.7]		
	Elementary-level education	9(16.1%)	37(20.4%)	0.379	1.5[0.6,3.5]		
	Secondary level education	21(37.5%)	70(38.7%)	0.604	1.19[0.6,2.36]		
	Higher education	23(41.1%)	64(35.4%)	1	1		
Marital status							
	Single	39 (69.6%)	125 (69.1%)	0.99	1.002[0.5, 2.2]		
	Married	10 (17.9%)	32 (17.7%)	0.9	1.071 [0.36, 3.22]		
	Separated/divorced	7 (12.5%)	24 (13.3%)	1	1		
Living condition							
	Living with family	46 (82.1%)	164(90%)	0.042	10.7[1.1, 105.3]	0.008	24[2.3,249]

Living alone	7(12.5%)	16(8.8%)	0.121	6.9 [0.6,78]	0.024	18.6[1.5, 234]
Homeless/NGO	3 (5.4%)	1 0.6%	1	1	1	1
Employment						
Unemployed	28 (50%)	110(60.8%)	0.772	1.13[0.5,2.6]	0.5	0.7[0.3,1.8]
Manual labor	12(21.4%)	21(11.6%)	0.059	0.36[0.13,1.04]	0.07	0.3[0.07, 1.1]
Government office	7(12.5%)	10(5.5%)	0.054	0.445[0.19,1.01]	0.02	0.25[0.08, 0.8]
Private work	9(16.1%)	40(22.1)	1	1	1	1

Regarding sociodemographics, employment and living conditions showed significant association with being a victim of violence after controlling for other variables. Compared to having a private job, having a job related to manual labor is 0.3 times less likely to be a victim of violence (95% CI 0.07, 1.1). Those participants who reported living with family are 24 times(95% CI 2, 234) and those living alone are 18 (95% CI 1.5, 234) times more likely to be victims of violence, than those who were homeless or supported by an NGO.

Table 4: Patient factors associated with violent victimization (n=237)

Patient factors		Violence		P value	COR [95% CI]	P value	AOR [95% CI]
		Yes	No				
Diagnosis	Schizophrenia	25(44.6%)	87(48.1%)	0.934	0.97[0.43,2.16]		
	MDD	11(19.6%)	37(20.4%)	0.13	0.47[0.17,1.25]		
	Bipolar disorder	8(14.3%)	13(7.2%)	0.71	0.86[0.39,1.9]		
	Epilepsy	12(21.4%)	36(19.9%)	1	1		
Treatment	Less than 3	27(48.2%)	103(56.9%)	1	1		

t duration (in years)		)	)				
	Between 3 and 10	16 (28.6%)	46 (25.4%)	0.43 5	0.75[0.37,1.5]		
	Over 10	13 (23.2%)	32 (17.7%)	0.26 6	0.645[0.298,1.39 6]		
Admission	No admission	47(83.9%))	160(88.4%))	0.43	0.43[0.52,3.5]	0.34	0.3[0.03,3.1]
	One admission	8(14.3%)	13(7.2%)	0.166	0.43[0.2,1.9]	0.2	0.2[0.014,1. 9]
	Two or more	1(1.8%)	8(4.4%)	1	1	1	1

Those using only one substance were less likely to have experienced violence than those using two or more substances (95% CI 0.04, 0.6). Additionally, compared to those who have not perpetrated violence over the past year, those who have committed the violence were less likely to have been victims of violence themselves (95% CI 0.087,0.5). For prior admissions, when other factors were considered, there was no significant association with violent victimization.

Table 5: Disease factors associated with violent victimization (n=237)

Patient factors		Violence		P value	COR [95% CI]	P value	AOR[95% CI]
		Yes	No				
Substance use	No	37(66.1%)	133(73.5%)	0.651	0.82[0.351,1.9]	0.2	0.5[0.18,1.4]
	1	11(3.4)	13(5.5)	0.02	0.33[0.09, 0.8]	0.006	0.16[0.04,0.6]
	>/=2	8(14.3%)	35(19.3%)	1	1	1	1
Perpetrated violence (past year)	Yes	17(30.4)	15(8.3)	0.000	0.21[0.095, 0.45]	0.00	0.21[0.087,0.496]
	No	39(69.6%)	166(91.7%)	1	1	1	1

Discussion

Our study focused on the one-year prevalence of violent victimization among patients on follow-up at SPHMMC. The findings showed a 23.7% prevalence of violent victimization over the past year. Few studies have victimization prevalence of 20% which is similar to our findings (13,25). Results from international and western large-scale studies show that there is a high prevalence of violent victimization among PWMI. A Swedish study also found comparable victimization rates of 20%(18). In addition, two community-based case-control studies found a 16% and a 17% prevalence of violent victimization(24,27).

A community-based study in northern Ethiopia also found that 17.4% had a history of violent victimization over the past year (12). Another cross-sectional study in Addis Ababa among 610 patients on outpatient follow-up with a one-year prevalence of 27.4%(21). The findings from our study is slightly higher than the findings from the community based study this can be due to, the hospital based nature, our study including more participants with comorbidity and possibly more severe mental illnesses. This study has findings close to those found at AMSH, this can be due to the similarity in study population (hospital based).

In terms of specific types of violence, we have found that, of those with a history of violent victimization, most were psychological violence (83.9%), followed by physical violence (60.7%). In addition, studies from Egypt and Ethiopia found that all patients reporting victimization have a history of psychological/emotional violence, followed by physical violence (12,15).

For associated factors, we have found that substance use, living conditions, employment, and a previous history of perpetrating violence are associated with violent victimization. Similar findings have been reported in the U.S. (27). Substance use is a significant predictor of victimization in a cohort study, following participants for three years as well (28).

Our study found that a history of perpetrating violence in the past year is also associated with violence. A Paper from Egypt also found that those that had a history of perpetrating violence were more likely to be victims of violence themselves(15). Similar findings have been reported in studies from the U.S. and Europe and in studies from Ethiopia (12,24,27).

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Therefore, it can be understood that PWMI that have been violent in the past might be considered dangerous, which might predispose them to be victimized.

Another associated factor identified was employment status; we found that being a manual laborer had a higher likelihood of being a victim. However, most studies indicated that being unemployed rather than the type of employment was associated with victimization. Therefore, we can understand our findings as those doing manual labor having poor workplace safety and lack of accountability/structured workplace.

Even though statistically significant associations weren't found, a larger proportion of males were victims of physical violence. A meta-analysis in the U.K. has found that men are more likely to be victims of physical violence than women(30). Male preponderance to physical violence might be associated with men being viewed as more threatening.

In terms of who perpetrated the violence, although a small number responded in our study, only 55% reported that they knew the perpetrator, of which 33% said the perpetrator was a family member (parent or sibling). Similar findings were reported in a study in Egypt(15). A paper from India also showed that for the participants with a history of sexual violence, the most common perpetrator was the husband(20). One reason for this might be that most patients are living with and depending on their family for basic needs, increasing their contact. Furthermore, caregivers of PWMI often feel burdened, which might lead to increased expressed emotion and outbursts of aggression.

Strengths and Limitations of this study

Strengths: This study is one of the first studies exploring violent victimization in our setup.

Limitation: Single study site which involved participants from one institution might limit the diversity and representation of the larger community. Additionally, some participants could not read and had to have the questionnaire read to them, which might restrict their honesty. Since we used a questionnaire intended for violence against women, it might be difficult to generalize findings. Finally for violence perpetration only the word of the patients and any recent documentation of violent perpetration were taken into account, this might have underestimated the perpetration of violence

Conclusion and recommendations

Conclusions

This study showed a high rate of violent victimization among PWMI. Factors such as treatment duration, employment, substance use, living conditions, and violence perpetration have associations with victimization. Victimization can negatively affect treatment progress and worsen symptoms of PWMI, suggesting the importance of identifying and addressing the issue. These findings indicate the importance of identifying and addressing the issue.

Recommendations

In our clinics and practice, we usually assess for risk of violence perpetration, and we should make it routine to evaluate for victimization as it affects our patient's well-being and treatment outcomes.

Further studies with cohort and qualitative study designs should assess associated factors and determine the direction of the relationship. Large scale studies that formulate and validate questionnaires that assess violent victimization as well as perpetration of violence in our setup are needed.

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Annex

Annex I: Informed Consent Form and Questionnaire in English

Consent form

My name is Eden Workalemahu, a final-year Psychiatry resident at Saint Paul's Millennium Medical College. I brought this questionnaire to you to assess Violent Victimization and associated factors of patients with mental illness at SPHMMC, Addis Ababa, Ethiopia. The purpose of this study is to understand the magnitude of and identify the associated factors of violent victimization among patients with mental illness, to help find ways to improve the quality of life, and improve treatment outcomes of patients with mental illness at SPHMC, Addis Ababa. Therefore, your genuine participation by responding honestly to the questions is highly appreciated and helpful to attain the study objective. Your name will not be written on this form and no individual response will be reported to anybody. Therefore, your answers are completely confidential. You don't have to answer any question that you don't want to answer, and you may refuse to answer all of the questions at any point.

Sign _____ date _____

Address of P.I.

Tel: 0921785906, Edworkalemahu@gmail.com

	Variable	Response
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	Age	
	Sex	Male/Female
	Educational status	No formal education Primary education Secondary education Higher education
	Employment	Unemployed Manual labor/odd jobs Government work Private business/ merchant Other (specify_____)
	Residence	Urban /rural
	Living condition	With family (parents, spouse, with relatives) Home Homeless
	Psychiatric diagnosis	
	Duration of treatment	
	Disease severity	In remission In partial remission No improvement

	Have you ever been hospitalized?	
	If yes, how many times	
	Comorbid substance use	
	If yes to number 10, specify	

	Perpetration of Violence	
	Have you ever been violent towards someone?	Yes or No
	Have you ever used a weapon on someone?	Yes or No
	Have you ever severely beaten someone?	Yes or No
	Have you ever intentionally set a fire?	Yes or No
	Have you ever committed sexual assault or physical assault on someone?	Yes or No
	Have you ever gotten into a fight while under the influence of a substance (alcohol, khat..)?	Yes or No
	Have you ever intentionally caused physical injury to another person?	Yes or No

	Have you ever been pushed or shoved, shaken, or had something thrown at you?	Yes or No
	Have you ever been punched/hit with a fist/ arms twisted?	Yes or No
	Have you ever been slapped kicked dragged or beaten?	Yes or No
	Have you ever been attacked with a weapon knife gun or other?	Yes or No
	Have you ever been burnt or scalded?	Yes or No
	Have you ever been choked?	Yes or No
	Have you ever been physically forced to have sex?	Yes or No
	Have you ever been coerced to have sex or forced into sexual activity (you found it to be degrading or	Yes or No

	humiliating)	
	Psychological Violence	
	Have you been insulted or made to feel bad about yourself?	Yes or No
	Have you been belittled or humiliated in front of other people?	Yes or No
	Have people done things to scare or intimidate you on purpose?	Yes or No
	threatened to hurt you or someone you care about?	Yes or No
	Have you ever been deprived of privileges in the family by your husband? Have you ever been deprived of privileges in the family?	Yes or No
	Have you ever been denied your basic personal needs?	Yes or No

	Coping	
	Did you know the perpetrator?	Yes/No
	Who was the perpetrator?	Mother Father Spouse Sibling (brother /sister) Neighbor Friend Other (specify_____)
	How many times did the incident occur?	
	Has it affected your mental and/or physical health? If so how	Yes or No
	Have you ever been hospitalized for your injuries?	Yes or No
	What was your response to the attack?	Fight back Do nothing Report to law enforcement or tell others
	Whom have you told about this incident?	Mother Father Spouse

		Sibling (brother /sister) Neighbor Friend Other (specify_____)
	If you haven't told anyone, what was the reason?	

Annex 2: Consent form and Questionnaire in Amharic

የስምምነት ቅጽ

ኤደን ወርቃለማሁ እባላለሁ፣ በቅዱስ ፓውሎስ ሆስፒታል ሚሊኒየም ሜዲካል ኮሌጅ የመጨረሻ አመት ያዘመናል ህክምና ተማሪ ሱሆን ይህንን ጠያቂ ወደ እርስዎ ያመጣሁት የእምሮ ህመም ላለባቸው ታካሚዎች ላይ የሚደርስ ዓካለዊ፣ጾታዊ፣ እና ስነልቦናዊ ጥቃቶችን በቅዱስ ፓውሎስ ሆስፒታል ሚሊኒየም ሜዲካል ኮሌጅ አዲስ አበባ፣ ኢትዮጵያ ውስጥ ለማጥናት ነው። የዚህ ጥናት አላማ ባገኘነው ወጤት መሰረት የእምሮ ህመም ላለባቸው ታካሚዎች ላይ የሚደርስ ዓካለዊ፣ጾታዊ፣ እና ስነልቦናዊ ጥቃቶችን በመረዳት፣ እንዲሁም ተያያዥ ምክንያቶችን በመለየት የታካሚዎችን ያሉበትን ይጤና ሁኔታ ለማሻሻል የሚረዱ መንገዶችን ለማግኘት ይረዳል። ስለዚህም፣ ለጥያቄዎቹ ምላሽ በታማኝነት እና በእውነተኛ ተሳትፎ በመስጠት እዲተባበሩ በትህትና እንጠይቃለን። ትብብሮ ከላይ ላነሳነው ወጤት ለመድረስ የሚረዳ ነው። ስምዎ በዚህ ቅጽ ላይ አይጻፍም በተጨማሪም ምንም አይነት ምላሽ ለማንም አይነገርም። ስለዚህ፣ የእርስዎ መልሶች ሙሉ በሙሉ ሚስጥራዊ ናቸው። መልስ መስጠት የማይፈልጉትን ማንኛውንም ጥያቄ መመለስ የለብዎትም። ሁሉንም ጥያቄዎች ለመመለስ ፈቃደኛ አለመሆን ወደንም በመሃል ማቋረጥ (በማንኛውም ሰዓት) ይችላሉ።

ፊርማ _____

ቀን _____

የ PI አድራሻ

እሜል፣ Edworkalemahu@gmail.com

1.	ጾታ	ወንድ/ሴት
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2.	እድሜ	
3.	ትምህርት ደረጃ	መደበኛ ትምህርት የለም የመጀመሪያ ደረጃ ትምህርት ቤት ሁለተኛ ደረጃ ትምህርት ቤት ከሌጅ / ከፍተኛ ትምህርት
4.	የጋብቻ ሁኔታ	ያላገባ ተለያይተዋል ያገባ የተፋታ ባል/ሚስት የሞተባት/በት
5.	የስራ ሁኔታ	ስራ የለም የጉልበት ስራ/የእጅ ሥራ የመንግስት ተቀጣሪ/ሰራተኛ የግል ስራ/ንግድ ሌላ
6.	መኖሪያ	ከተማ ገጠር
7.	የመኖሪያ ስፍራ	ጎዳና ላይ ከቤተሰብ ጋር (ከወላጅ፣ ከትዳር አጋር፣ ከዘመድ)

		ለገቢ
8.	የህመም አይነት?	
9.	ህክምና ከጀመሩ ስንት ጊዜ ሆነ ?	
10.	ከዚህ በፊት ተኝተዋል ታክመዋል ያዉቃሉ ?	አው አይ
11.	ለ10ኛ ጥያቄ መልስ አዉ ከሆነ፤ ምን ያህል ጊዜ ተኝተዋል ታክመዋል?	
12.	ሱስ አምጪ ከሚባሉት ንጥረ ነገሮች (ለምሳሌ፡አልኮል፣ጫት፣ ሲጋራ፣ሃሺሽ....የመሳሰሉት) ይሚጠቀሙት አል?	አዎ አይ
13.	ካለ፣ምን አይነት?	

	(በላፈዉ አንድ አመት ውስጥ)	
14.	ከዚህ በፊት ስዉ ላይ ጥቃት አድረሰዉ ያዉቃሉ?	አዎ አይ
15.	መሳሪያ ተጠቅመዉስ	አዎ አይ
16.	አንድን ሰው አጥብቀው ይመተዉ ያዉቃሉ?	አዎ አይ
17.	ሆን ብለዉ እሳት አስነስተዋል	አዎ አይ
18.	ጾታዊ ጥቃት ፈጸመዉ ያዉካሉ?	አዎ አይ
19.	አልኮል ሲጠጡ/ ጫት እያኘኩ ተደባድበዉ ያዉቃሉ?	አዎ አይ
20.	አንድን ሰው ሆን ብለዉ አካላዉ ጉዳት አድርሰዉ ያቃሉ?	አዎ አይ

	(ባለፈው አንድ አመት ውስጥ)	
21.	ተገፍተዉ ወይም የሆነ ነገር ተወርውሮበት ያውቃል?	አዎ አይ
22.	በጥፊ ተመትተው፣ ተጎትተው ወይም ያውቃሉ?	አዎ አይ
23.	ተደብድበው፣ በእርግጫ ተመተዉ?	
24.	በመሳሪያ(ቢላዋ፣ ሽጉጥ ወይም ሌላ) ጥቃት ደርሶበታል?	አዎ አይ
25.	ተቃጥለው ወይም ተቃጥለው ያውቃሉ?	አዎ አይ
26.	ታንቀው ያዉቃሉ?	አዎ አይ
27.	በግብረ ሥጋ ግንኙነት እንድትፈጽም ተገድደህ ታውቃለህ?	አዎ አይ
28.	የግብረ ሥጋ ግንኙነት እንድትፈጽም ተገድደህ ታውቃለህ ወይም ተገድደህ ታውቃለህ (አዋራጅ ወይም አዋራጅ ሆኖ ተገኝቷል)	አዎ አይ
29.	በቡጢ ተመተዉ ያውቃሉ?	አዎ አይ
	(ባለፈው አንድ አመት ውስጥ)	
30.	በተደጋጋሚ ተሰድበዋል ወይም ስለራስዎ እንዲከፉ ተደረገዋል?	አዎ አይ
31.	ሰዎች ሆን ብለው እርስዎን ለማስፈራራት ወይም ለማሳቀቅ ነገሮችን አድርገዋል?	አዎ አይ
32.	እርስዎን ወይም የሚወዱትን ሰው ሊጎዳ ይሚዝት አለ?	አዎ አይ
33.	በሌሎች ሰዎች ፊት ተዋርደዋል ወይም አንዲሳቀቁ/አንዲሸማቀቁ ተደርገዋል?	አዎ አይ
34.	በቤተሰብ ውስጥ ካሉ ሙብቶች ተነፍገዉ ያውቃሉ?	አዎ አይ

35.	በመሰረታዊ የግል ፍላጎቶች ተከልክለው ያውቃሉ?	አዎ አይ
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	ጥቃት አጋጥሞት ከነበረ	
36.	ጥቃት የፈፀመውን ግለሰብ ያውቁ ኖሯል ?	አላውቀውም አውቀዋለሁ
37.	ማን ነበር ?	ወንድም እህት አባት እናት ዘመድ ጎሮቤት ጓደኛ ሌላ(ይጥቁሱ-----)
38.	ክስተቱ ስንት ጊዜ ተፈጠረ?	
39.	በጥቃቱ የአእምሮ እና የአካል ጤንነት ተጎድቶታል ብለው ያስባሉ?	አዎ አይ
40.	ለደረሰብዎ ጉዳት ወደ ህክምና ሄደዋል?	አዎ አይ
41.	ለጥቃቱ ምላሽዎ ምን ነበር?	ምንም አላደረኩም መልሶ ማጥቃት

		ለሌሎች መናገር/ ለህግ አካል ማሳወቅ/
42.	ስለ እነዚህ ክስተቶች ለማን ተናገሩ ?	ወንድም/እህት አባት/እናት ዘመድ ጎረቤት ጓደኛ ሌላ(ይጥቀሱ-----)
43.	ጥቃት መድረሱን ለማንም ካልነገሩ፣ ምክንያቱ ምን ነበር?	

Assurance if Principal Investigator

I the undersigned resident agree to accept all responsibilities for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as per terms and conditions of the Research and Publication Directorate and /or Department of Public Health of St. Paul's Hospital Millennium Medical College.

Name of the Resident: Dr. Eden Workalemahu

Signature: _____

Date: _____

Approval of Advisors

Name of Advisor: _____

Signature: _____

Date: _____

Name of Clinical Advisor: Dr. Girma Mamo

Signature: _____

Date: _____
