

The Socio Demographic Correlates of Post-Traumatic Stress Disorder among Youth Undergoing Domestic Violence in Kenya

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Abstract—The current study was conducted during the coronavirus pandemic (COVID-19) period, soon after the lifting of the lockdown measures and schools had just re-opened. It investigated the sociodemographic correlates of Post-Traumatic Stress Disorder (PTSD) among adolescents (13-18 years) who had undergone domestic violence (DV) in Kajiado County, Kenya. The adolescents were administered a sociodemographic questionnaire to ascertain the forms of DV experienced, and those who met the criteria were assessed for the presence of PTSD using the Harvard Trauma Questionnaire (HTQ). Overall, 93 (90.3%) had experienced DV, and 57 (61.3%) had PTSD; where the severity and prevalence of PTSD increased with increased age, and it also increased significantly among those in higher academic levels, indicating that PTSD prevalence was chronic and additionally influenced by increased academic pressure. Social connections seemed to mitigate PTSD prevalence, whereas, regarding the family background, those living with guardians seemed to have more severe PTSD.

Keywords—Age, education level, gender, post-traumatic stress disorder.

I. INTRODUCTION

VIOLENCE within the home otherwise known as domestic violence is quite insidious, inflicting harm and it also contributes to poor life outcomes including mental health problems such as PTSD.

Domestic violence (DV) is any behavior within a household that inflicts physical, psychological, or sexual harm to those in the household [1]. Furthermore, children witnessing violence between their parents are adversely affected socially, mentally and psychologically. Spouses who have been abused by their intimate partners have a likelihood of retaliating on the children. Homes with various forms of DV thus become dangerous places for children and adolescents [2].

Exposure to DV is a precursor to PTSD [3]. PTSD mainly results from the presence of direct exposure or witnessing a traumatic event(s) resulting in thought intrusion symptoms, avoidance of traumatic incentives and negative transformations in thoughts and feelings [4]. Nevertheless, not all the people exposed to violence experience severe symptoms of PTSD. Research finds that only 20-30% of the general population develop PTSD, while as much as 90% of them experience traumatic stress [5]. Several studies have compared PTSD prevalence among domestic abuse victims/survivors where it is

found that regarding gender, females tend to have more severe symptoms and higher prevalence of PTSD compared to the males [6]-[8].

Studies also opine that the age of the victim at commencement of the violence can have an impact on PTSD symptoms. This is because exposure to DV may cause structural and physical adjustments in the child's brain construction which in turn, produces personal and social consequences [9]. Research indicates that the risk of developing PTSD for youths exposed to violence during childhood years is highest at adolescence going all the way to young adulthood [10], [11].

Adolescence is characterized by exponential cognitive, emotional and physical development [12] and therefore, adolescents can face confusion as they try to interpret the traumas they have experienced, adopt coping mechanisms and find their own identity while also coping with the numerous biological changes and social expectations. The structure of the family may as well predict a high probability of trauma, although direct connections for these associations are not clear cut. While children from single parenthood families are opined to have a higher probability of developing PTSD compared to those from both parent families, research finds that it is not the family type that imposes challenges but rather, it is the social economic disadvantages experienced in single parent families [13].

High levels of emotional and behavioral difficulties may be experienced as a result of economic disadvantages leading to high levels of psychological distress. Moreover, single parent families are insinuated to have less toughness in handling stress which may be exacerbated by the lack of a secure role model [14].

On the other hand, having both parents is itself not protective since in families where there are factors such as parental alcoholism and poverty, DV for offspring can be prevalent leading to PTSD development [15], [16]. This calls for further investigations that may pinpoint the predisposing and propagating factors within different family backgrounds. The role of social support from family, peers and family has also been found critical in mitigating against PTSD [17]-[19]. Nevertheless, more studies with a sample that has experienced the adverse impact of DV can help shed more light into this aspect. The impact of academic pressure on adolescent mental

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well-being is not well articulated across studies, mainly because education systems and cultures vary globally and hence, generalizations regarding what constitutes academic pressure or how it may influence adolescent mental wellness may vary. However, on the whole, research suggests that there are different aspects of academic pressure that may affect adolescents' mental health [20]. Thus, community-based evaluations become critical to highlighting the specific academic aspects that may influence PTSD severity.

A. Theoretical Importance

The research contributes to the understanding of PTSD prevalence and severity based upon the socio demographic factors among adolescents who have undergone DV, which is critical to informing intervention measures.

B. Research Aim

The purpose of this study was to examine the socio demographic correlates of PTSD among adolescents who had undergone various forms of DV in the informal settings of Kajiado County in Kenya.

II. METHODOLOGY

The study selected adolescents aged 13-18 years from two mixed-sex public secondary schools in Kajiado County. A total of 93 out of 103 students met the criteria for experiencing DV. A social demographic questionnaire was used to collect data on the various forms of DV. The HTQ was used to assess PTSD symptoms. Data analysis was conducted using the Statistical Package for Social Sciences (SPSS) version 29, utilizing descriptives and Analysis of Variance (ANOVA).

A. Data Collection and Analysis Procedures

Data were collected through a socio demographic questionnaire and the HTQ ($\alpha = .952$). The questionnaire assessed for experiences of DV, while the HTQ measured PTSD symptoms. The collected data were analyzed using SPSS, employing descriptive and correlation analyses.

B. Questions Addressed

The study aimed to answer the following questions:

1. What is the prevalence of PTSD among youth experiencing DV based on socio demographic characteristics?
2. Are there differences in PTSD severity based on socio demographic variables?

III. FINDINGS

The first assessment using the socio demographic questionnaire affirmed that the respondents had undergone various forms of DV as shown in Table I.

A total of $n = 93$ (90.3%) out of 103 students met the criteria for DV experiences (at least one form of DV). Almost half of the respondents ($n = 50$, 48.5%) indicated that their parents had separated. The most prevalent forms of abuse were verbal abuse ($n = 60$, 58.3%) which had been experienced by more than half of the respondents and physical abuse ($n = 46$, 44.7%). There were also youth who had witnessed parental conflicts such as

father beating mother ($n = 24$, 23.3%), a few had witnessed mother beating father ($n = 6$, 5.8%) and others, father shouting at mother ($n = 25$, 24.3%). Thus, even though both parents were reported as having perpetrated some violence, fathers were reported more as being the perpetrators of IPV against their wives. The respondents ($n = 93$) who had undergone DV were administered the HTQ to find out the prevalence of PTSD as shown in Table II.

TABLE I
 THE PREVALENCE OF PTSD BASED ON THE TYPE OF ABUSE EXPERIENCED

Type of Abuse	Frequency		Total respondents	
	N	%	N	Percent
Father beating mom	24	23.3%	103	100%
Mother beating father	6	5.8%	103	100%
Father shouting at mother	25	24.3%	103	100%
Parents separated	50	48.5%	103	100%
Been touched sex organs	14	13.6%	103	100%
Forced to touch others' sex organs	7	6.8%	103	100%
Forced to sexual intercourse	13	12.6%	103	100%
Had unwanted sex	8	7.8%	103	100%
Physical abuse	46	44.7%	103	100%
Verbal abuse	60	58.3%	103	100%
Other abuse	27	26.2%	103	100%
Overall abuse	93	90.3%	103	100%

TABLE II
 THE PREVALENCE OF PTSD BASED ON THE SOCIODEMOGRAPHIC CHARACTERISTICS

Socio demographic variables		PTSD Mean (Range: 0-160)	ANOVA	PTSD Prevalence ($M \geq 72$)	Total
Gender	Male	77.79	$F = 1.181$ $p = .280$	20 (60.6%)	33 (100%)
	Female	83.48		37 (61.7%)	60 (100%)
	Total	81.46		57 (61.3%)	93 (100%)
Age	13-14	73.22	$F = 2.611$ $p = .079$	5 (55.6%)	9 (100%)
	15-16	78.56		30 (54.5%)	55 (100%)
	17-18	89.51		22 (75.9%)	29 (100%)
	Total	81.46		57 (61.3%)	93 (100%)
Education level	Form1	71.15	$F = 4.357$ $p = .007$	10 (50.0%)	20 (100%)
	Form2	78.63		11 (57.9%)	19 (100%)
	Form3	80.46		19 (54.3%)	35 (100%)
	Form4	97.00		17 (89.5%)	19 (100%)
	Total	81.46		57 (61.3%)	93 (100%)
No. of Friends	None	87.38	$F = 2.183$ $p = .119$	9 (69.2%)	13 (100%)
	Few	87.25		20 (71.4%)	28 (100%)
	Many	76.87		28 (53.8%)	52 (100%)
Total	81.46	57 (61.3%)	93 (100%)		
Family type	Both	81.51	$F = .330$ $p = .804$	23 (62.2%)	37 (100%)
	Step-parent	79.43		4 (57.1%)	7 (100%)
	Single parent	79.89		22 (57.9%)	38 (100%)
	Guardian	88.00		8 (72.7%)	11 (100%)
Total	81.46	57 (61.3%)	93 (100%)		

Table II shows the prevalence of PTSD among the respondents based on the sociodemographic factors. Overall, there was high prevalence of PTSD for the sample ($n = 57$, 61.3%; $M = 81.46$, $SD = 24.20$). The comparisons of PTSD means (M) depicting severity within each sociodemographic category showed that highest PTSD means were among females ($M = 83.48$, 61.7%; $p = .280$), the older adolescents 17-18 years

($M = 89.52$; 75.9% ; $p = .079$), the form 4's ($M = 97.0$; 89.5% ; $p = .007$), those with no friends (87.38 ; 69.2% ; $p = .119$) and those from 'guardian' type families ($M = 88.00$; 72.7% ; $p = .809$). The statistically significant association between educational levels and PTSD severity ($p = .007$) implies that increase in academic pressure as respondents progressed academically intensified PTSD symptoms.

IV. DISCUSSION OF FINDINGS

This study found the prevalence of PTSD among the youth who had experienced DV to be quite high where more than half (61.3%) had PTSD symptoms. This high prevalence affirms a preponderance for PTSD among children and adolescents who have undergone various forms of domestic violence as noted in literature [5] and previous studies [3], [4]. The prevalence of PTSD was highest among those in higher classes (form 4) at 89.5%, the older adolescents (17-18 years) at 75.9%, then those from 'guardian' type families (72.7%) and those with few friends (71.4%). The severity of PTSD was highest among those in form 4 ($M = 97.00$), the 17-18-year-old ($M = 89.51$), those from 'guardian' type families ($M = 88.00$), those with no friends ($M = 87.38$) and the females ($M = 83.48$). The findings concur with previous studies suggesting that adolescence and young adulthood signify the age for PTSD development for youth who have undergone adversities such as DV during their childhood [10], [11]. The older adolescents could also have been the ones in the higher classes where the academic pressure was more as they were preparing for their national exams, amid the pandemic period which had been characterized by numerous lockdowns that had led to school closures. Hence, the higher prevalence and severity of PTSD among those in form 4 could signify development of PTSD symptoms with increased age or increased academic progression especially from form 3 to form 4. Research finds that academic pressure can have implications for mental wellbeing [20]. In contrast to previous studies [6]-[8], females had almost similar prevalence of PTSD at (61.7%), males (60.6%) which shows that in light of experiencing DV, victims/survivors are likely to develop PTSD symptoms regardless of gender. Nevertheless, the severity among females was more but the differences were insignificant. Probably what needs to be further investigated are the gender differences in the age of onset since the sample in this study were all within the 13-18 years age bracket. As found in other studies [17]-[19], peer connections were found to be important since the prevalence of PTSD was lowest (53.8%) among those with many friends as compared to those with few friends (71.4%) or no friends (69.2%), and severity was more for those with no friends. The respondents from the 'guardian type' families had the most severe PTSD ($M = 88.00$) amongst the family background categories which is an indicator of further underlying issues that probably led their being separated from their families of origin. Unlike what other studies find [14], respondents from families with both parents had more severe PTSD ($M = 81.51$) compared to those from single-parent families ($M = 79.89$) which could probably indicate ongoing abuse between their parents which made their symptoms worse.

A deeper focus on the predisposing factors in these family types nevertheless needs to be explored in future studies.

V. CONCLUSION

PTSD vulnerability was noted for adolescents who had undergone DV, especially the form 4's who were candidates and just about to sit for their national exams. PTSD means tended to increase with increased age suggesting chronicity and an increasing severity of symptoms with age progression for those exposed to DV. Contrary to the previous studies, the female preponderance was not significant since the DV experiences equalized vulnerability to PTSD for both genders. Those from guardian type families had the highest PTSD means suggesting further underlying causes requiring investigations. Social connections were deemed important as those without friends had the highest PTSD means. It is thus recommended that interventions be offered early for youth undergoing DV regardless of gender, with a focus on academic, family and peer connections susceptibility. Understanding the correlates of PTSD in this population is essential for informing effective intervention strategies.

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