A STUDY ON THE PREVALENCE AND ASSOCIATED RISK FACTORS FOR PTSD (POST TRAUMATIC STRESS DISORDER) AMONG THE YOUNG FEMALES IN BANGLADESH

By

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A thesis submitted to the School of Pharmacy in partial fulfillment of the requirements for the degree of Bachelor of Pharmacy

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Declaration

It is hereby declared that

1. The thesis submitted is my/our own original work while completing degree at Brac University.
2. The thesis does not contain material previously published or written by a third party, except where this is appropriately cited through full and accurate referencing.
3. The thesis does not contain material which has been accepted, or submitted, for any other degree or diploma at a university or other institution.
4. I/We have acknowledged all main sources of help.

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Approval

The thesis titled "[A STUDY ON THE PREVALENCE AND ASSOCIATED RISK FACTORS FOR PTSD (POST TRAUMATIC STRESS DISORDER) AMONG THE YOUNG FEMALES IN BANGLADESH]" submitted by [Shahrin Jabin Rahman (20346018)], of [Spring], [2024] has been accepted as satisfactory in partial fulfillment of the requirement for the degree of Bachelor of Pharmacy.

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Ethics Statement

If review or non-human or animal studies: This project does not involve any kind of animal and human trial.

OR

For lab-based work, you will need to provide the Ethical Permissions as given by the IRB.

Abstract

Background: PTSD is one of the most common mental disabilities in humans including three symptoms, reexperiencing, numbing and hyperarousal. The prevalence of PTSD and the risk factors of PTSD is increasing alarmingly all over the world including Bangladesh and mostly young females are victims of it.

Objective: The aim of the study is to detect the prevalence rate and associated risk factors of PTSD among Bangladeshi young females.

Method: In this study, we did offline cross-sectional study among 868 young female participants using forms. To collect socio demographic information, we used structured questionnaires. We used PCL 5 scale to detect PTSD level. Finally, by using statistical tools we interpret the result and evaluate the prevalence and associated risk factors among young females in Bangladesh.

Result: Prevalence of PTSD among young females in our country was found 47%. Among them, 34% have mild PTSD,10% have moderate PTSD and 3% have severe PTSD. After data analysis, we have found out that BMI and residence area play a vital role in our study as associated risk factors for PTSD.

Conclusion: According to present study results, a high proportion of young women are suffering from PTSD in Bangladesh. Although only BMI and residence area were found to be associated risk factors for PTSD. Therefore, to reduce the prevalence rate and risk factors of PTSD we recommend counseling, arranging medical camps, proper treatment guidelines and public awareness to create better mental and physical health**.**

Keywords: mental disability; young women; high prevalence rate; BMI; residence area; cross sectional study

Dedication

The project was dedicated to my parents and teachers.

Acknowledgement

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List of Acronyms

PTSD	Post traumatic stress disorder
CED	Chronic energy deficiency

Chapter 1: Background

1.1 Importance of this topic

Mental health problems nowadays are a most alarming issue all over the world likewise in Bangladesh. According to WHO 2008,13% of the mental health disorders are considered as global burden of disease (WHO,2008). Among most of the mental health problems we have conducted our research to detect the PTSD level among young females because the rate of PTSD among women is increasing rapidly day by day**.**

Nowadays young women go through a lot of mental health problems. Among a lot of problems PTSD (post-traumatic stress disorder) is one of them. PTSD (post-traumatic stress disorder) is a mental disability in humans. It can be detected by three symptoms: reexperiencing, numbing, hyperarousal (Sekoni et al., 2021). When a person goes through a negative situation in his/her lifespan and that situation bothers that person throughout that situation is known as post-traumatic stress disorder. For example, in April 2013 during the 'Rana Plaza' incident it got a lot of media attention as it was one of the most traumatic events in Bangladesh. As a consequence, it created PTSD symptoms among many people hence they were experiencing flashbacks of tragedy, nightmares and severe emotional distress (Yehuda, 2002). PTSD is mostly seen in women than men. In an article it is described that mostly women experience avoidance which is a symptom of PTSD and they suffer from depression anxiety. According to a report of WHO 260 million people have anxiety also according to report of 2016, depressive disorders found 7% among the disability-adjusted life years (DALYs) lost among women of reproductive age(15–49 years) (Kuringe et al., 2019).Similarly for PTSD, according to a report of USA it is showed that 1 in 10 women will have PTSD compared to 1 in 25 men (*What Does PTSD Look like in Women?*, 2021).As it is seen that there is a high possibility of women who are young can be affected by anxiety and PTSD easily than men so it is very important to assess the level of anxiety and PTSD in young women so that

the mental health condition will remain stable among them. Also, if a woman is suffering from PTSD, it can hamper other sectors such as workplace, education, relationships etc. Recent research in Vietnam was performed in 2005 which indicates that the condition of PTSD is related to the economic outcomes. So, from these it is clearly seen that assessing anxiety and PTSD among young women is very important. Also, if it can be detected in an early stage it can be improved by treatment easily

1.2 Prevalences & consequences

The prevalence of PTSD has been described in many journals and articles. In Bangladesh, 59.0%, respectively, was found as prevalence of stress (Mamun & Griffiths, 2019). In Bangladesh, in 2013 when the 'Rana Plaza' strategy occurred 1134 deaths, 200 unidentified bodies and 2500 injuries were found. It was also addressed in the same article that 20.5% had gone through physical health problems,51% had gone through unemployment problems and 10.5% had gone through psychological trauma from that Rana Plaza strategy that occurred six years ago. A 27 year old man who tried to help the survivors during the tragedy, also committed suicide. Evidence had proved that the reason behind his death was post traumatic disorder or PTSD (Mamun & Griffiths, 2019). Cross sectional study was performed on 148 Rohingya people living in Bangladesh to detect the trauma history, daily environmental stressor and mental health outcomes. Study results showed a high percentage of PTSD and other mental health problems among them (Riley et al., 2017). One study revealed during the SARS outbreak in China, 10% had high levels of PTSD symptoms (Wu et al., 2005). Likewise, another study (Wu et al., 2005). Recent studies have described that nowadays stress related problems like PTSD are increasing more and more and mainly girls are getting affected by them (Bremberg et al.,2006). Recent research conducted in Pakistan by Mirza and Jenkins addressed that the prevalence of depressive disorder is 29-66% in women whereas it

is 10-33% in men. The women who participated were 15-49 years old, which means basically young women (Mirza & Jenkins, 2004). In Malawi a

research conducted and it showed that adolescent girls and young women who are out of school are at higher risk of getting mental health disorders than school going girls (Rock et al., 2016). The prevalence of PTSD is also high in women. According to studies PTSD is more usually seen among women. Those who are in their Middle Ages are at greater risk. (Olutoyin Sekoni, 2021). In the United States a research report published that 8% of the total population have PTSD and among them women are greater in number than men (What Does PTSD Look Like in Women, 2021).

The consequences of PTSD are many. Though there were no previous evidence of suicide due to PTSD, but other countries had recorded of suicide due to PTSD (Gradus, 2018). PTSD can create a feeling of anger, mood swings among women. Moreover, PTSD might create a negative impact on physical, mental and socioeconomic life. Recent research examined that unemployment rate increases for those who are experiencing trauma (Olutoyin Sekoni, 2021). A recent analysis has found that a patient with PTSD has a high chance of getting cardiovascular, metabolic and musculoskeletal diseases (Ryder et al., 2018). A study conducted in California states that 19% women who are suffering from PTSD have gone through unemployment problems (Kimerling et al., 2008). In Bangladesh after 'Rana Plaza' strategy it was seen that many workers protested as they did not financially compensate for the loss of their working ability. The workers get unemployed due to that incident (Mamun & Griffiths, 2019). So, the consequences of anxiety and PTSD on women should be considered so that they can live with better mental and physical health.

1.3 Why women are more vulnerable

There is much research ongoing to find out the consequences behind women having more mental disorders PTSD. Many cross-sectional population-based studies have shown that women who

belong from low middle income countries are at greater risk of having mental health related problems. As previously it was described that women are at higher risk of having PTSD. A population based longitudinal study in India described that hormonal and biological mechanisms are responsible for the higher rate of getting mental health problems among women. In addition, gender disadvantage which initiates toward partner violence become risk factors for women. Also, in high income countries the use of tobacco and alcohol can be a reason for women having mental health problems (Patel et al., 2006). A report by Gove and Tudor 1972 described a survey which was performed on men and women who were mentally ill indicating that women are more prone to mental illness than men. The reason behind this situation is could be marital status of women (Gove, 1972).A survey was conducted in Canada described that women are found at significantly increased risk of PTSD because of going through exposure of serious trauma and sexual trauma (Stein et al., 2000).A study also described that high rate of sexual traumatization is an important factor for causing PTSD more on women rather than men (Stein et al., 2000).Mainly psychological, biological and social factors are responsible for young females to become prone to mental health problems. In case of biological hormonal differences can accelerate stress, anxiety and trauma among women more than men. In the case of psychological factors, women are more emotionally vulnerable than men so they can easily get affected by mental health issues. Also, women sometimes face sexual violence and domestic abuse but men do not have to go through these problems. As a consequence, these situations create anxiety and trauma which in future turn into post traumatic disorder. After going through a lot of articles it can be said that the consequences of women getting more prone to mental illness are physical health, psychological and biological problems as well as marital status, having trauma for lifetime and also

unemployment among women. So, for these specific reasons women are more prone to getting mental health problems than men.

1.4 Why the study was done in Bangladesh

The study is conducted on the Bangladeshi population to detect the prevalence and risk factors for mental health problems. It is already found from an article that, lower-middle income country women are more prone to getting mental health disorders. Bangladesh is known as a lower-middle economic country. As a consequence, there must be a high chance that the population will face mental health problems at a higher rate than other countries. Mental illness creates a bad impact on a particular population as it can cause a lot of chronic disease and eventually reduced the life expectancy by 20%.A literature suggest that mental health disorders which is more vulnerable on woman ranges from 6.5 to 31%(Hossain et al., 2014b).A study on Bangladesh conducted on mental health has discovered that there is not enough opportunities for the mental disorder affected persons and also there is no specialization course on psychiatric training. This initiates mental health problems among Bangladeshi population (Hossain et al., 2014). According to research, as most of the people in Bangladesh are basically women who are underdiagnosed and untreated from mental health problems, it creates a high prevalence among them to get affected by mental illness which will later lead to serious conditions. Also, social stigma in Bangladesh is creating a big impact on mental health problems. As most of the people are not well aware about mental health problems and their consequences, they think that taking help of counseling or psychiatric nursing will promote unacceptance from the society. Moreover, mental health illness hampers the productivity of life. As the rural women of Bangladesh have less knowledge about mental health and in rural-area they have some specific beliefs and values which will create trauma among the rural women and accelerate towards mental health distress. Also, Bangladesh faces natural calamities as well as socio-political challenges frequently. For, this reason the people of

Bangladesh suffer from mental health disorders. The study that we have conducted will be able to find out the prevalence and risk factors of mental health problems among Bangladesh's young female population so that they will become more cautious about mental health problems and will try to find out the solution by getting diagnosed properly. By this study we can interpret the PTSD level among Bangladeshi young females and make them aware about mental health problems. By knowing about the mental health problems Bangladeshi women can easily integrate mental health care which will improve overall health outcomes. To ensure a better quality of life, to increase productivity and also to create mental well-being among Bangladeshi female population it is necessary to conduct study on the prevalence and risk factors among Bangladeshi female population.

1.5 Knowledge gap

The knowledge gap in the field of mental health is many. According to a research article on mental disorder in Bangladesh by Mohammad Didar Hossain and others in 2014 described that the people of Bangladesh do not consider mental health disorder as a health problem and do not give priority to mental illness. The number of epidemiological and health related data are very less in Bangladesh. There are very less estimates about mental health related problems like PTSD and only a few articles published it (Hossain et al., 2014b). There are less studies performed on young people in Bangladesh which will lead to hinder initiation of public health making policy (Mamun & Griffiths, 2019). In Bangladesh, there are lack of primary and secondary facilities as well as primary health care practitioners are less likely to treat and detect mental health problems(Nuri et al., 2018b). Women play a vital role in the RMG sector of Bangladesh. They are responsible for the increasing rate of Bangladesh economy yet there is a little knowledge about how they lived, their roles and their responsibilities and also mental health of them(Akhter et al., 2017).Lastly ,the knowledge gap of our study is less research on women mental health, insufficient amount of data

related to mental health research, social stigma of not considering mental health disorder as a problem, less amount of longitudinal study and less availability of treatment of women who are suffering from mental health disorders. Also, less knowledge about the risk factors of having mental health problems can also be a knowledge gap for the study that we have conducted. Young women are less aware about PTSD and the risk factors of having trauma in future. So, these are the knowledge gap that we have found during this study.

Rationality and Objective: There are very few studies in Bangladesh which express the mental health of Bangladeshi women. Though there is little research, they are unclear and have some knowledge gaps. In our study we aimed to evaluate the mental health among young women in Bangladesh. As the rate of mental health problems among women is more than men so we have decided to conduct the study on young women. We tried to assess the PTSD level among young women as PTSD is getting common among young females. Also, our study aimed to find out prevalence and associated risk factors for the poor mentality among young women. These are the rationality and objectives of our study. We believe that this study will create awareness among people of Bangladesh and the study findings will help to improve the mental health of Bangladeshi young females. We also believe that our research on young females will be able to reduce the knowledge gaps and the findings will be helpful for detecting PTSD level and detecting the risk factors of PTSD so that women will get aware and try to resolve this mental health problem

Chapter 2: Method

2.1 Study design and study population

I have accomplished this cross-sectional offline survey using forms from April 24,2024 to September 18,2021. I have collected a total 868 responses among them more than 60% data are collected from rural and 40% are collected from urban. Initially I have required 337 data from urban and 372 data from rural total. 709 data were collected between the age group 18-45 young women. After that to gather more data from rural areas I have collected 159 data again from the village of Comilla. The objective of these studies, eligibility and procedure were well known by all the participants. At first, I took consent from the participants. All the participants were women and belong from Bangladesh. Most of the participants are from rural areas and some are from urban areas of Bangladesh. I have taken the responses from young women who are between 18-45 years old and excluded the participants over 45 years and under 18 years.

2.2 Detailed questionnaire

I have gathered information to find a correlation between the prevalence and risk factors with mental health problems among young women. Later with the help of mental health tools PTSD level among young women has been assessed. At first a pre structured questionnaire is used. Questionnaires were first made in English then converted into Bangla. After that English and Bangla versions are combined together to ensure clear understanding for the participants. After that, I have started preliminary testing among the randomly selected participants from urban areas to confirm the clarity of the questionnaire. After getting some responses from urban people I have started to collect data from rural women. I collected the responses by giving the forms in person to the participants and sometimes by taking interviews from them about the questionnaire. The questionnaires included age, weight, height, residence area, smoking habit, marital status, living

status and 20 mental health related questions which are detecting PTSD level among young women.

2.3 Scale

The scale that has been used to detect PTSD is **PCL 5.PCL 5 is** another scale used to detect PTSD level among young women. It contains twenty questions to detect the symptoms of PTSD for at least one month. Each questionnaire contains 5 scores. From 0-4,0 indicates not all,1 indicates a little bit,2 indicates moderately,3 indicates quite a bit and 4 indicates extreme. After that the scores summed together and higher scores indicate higher degree of PTSD.

PCL 5: The post-traumatic stress disorder checklist has been the instrument to PTSD symptoms. Because the population of Diagnostic and mental health disorder of DSM-5 and PCL has been updated and confront four factors of PTSD conceptualization of DSM. Its associated symptoms are re-experiencing, avoidance, hyperarousal and reactivity (Md. Saiful Islam1, 2022). The PCL 5 contains 20 items corresponding to the criteria of PTSD. In a report, it is addressed that the 31-33 which has 80% sensitivity and 60% specificity (Bovin MJ, 2016). From 30-39 it was considered as mild PTSD and from 40-59 it was moderate and above 60 it was considered as severe level of PTSD.

2.4 How did I reach the respondents

Firstly, I have started collecting data from urban areas from my known ones such as relatives, friends who are within the age group of 18-45. I have given the forms containing mental health related questionnaires and they filled up the forms and returned them back to me. Then, I visited a village in Comilla named ‘Chandina’ to collect data from rural women. From that village I have found many women were interested to participate but most of them are not able to read. For this reason, I have taken interviews and collected data from them. So, that is how I have reached the respondents.

2.5 Statistical analysis

The data analysis was performed with the help of Microsoft Excel 2019 and SPSS. Microsoft Excel was used for data sorting, data processing, table, and graph. SPSS was used for data analysis. To analyze the different categorical groups, we used the chi square test. We also did a t test to identify group differences. We have found p value from the chart and if it is <0.05 then we consider it significant.

2.6 Ethical approval

The research received ethical approval from University of Asia Pacific, Dhaka, reviewed and approved by an Institutional Review Board (UAP/REC/2023/201-S). The objective and purpose of this study is already discussed at the beginning of the questionnaire and consent has also been taken from the participants.

Chapter 3: Result

3.1 Description of study population

It is seen in the table that the data are collected between 18-25 years age,26-35 years age and 36-45 years age.18-25 were found 36%,26-35 were found 34% and 36-45 years were found as 30%.For BMI, almost 397 persons that means 46% are in normal range,48% are obese and 6% are CED.25% respondents low income,23% respondents have high income and 53% respondents have medium income.69% women were married and 31% women were unmarried.57% women were rural and 43% women are from urban area. The respondents were 26% graduate or above,22% primary,12% illiterate and 40% were secondary level educated.

3.2 Prevalence rate of PTSD

The prevalence of PTSD found among young women is 47%.and 53% women have no PTSD. In the graph it is shown that there are women who have mild PTSD in Bangladesh around 34%,10% women have moderate PTSD and only 3% women have severe PTSD which is shown in the graph. There is a 47% age group of people between 18-45 who have PTSD and the p value for age was found 0.55, which is >0.5, so it is not statistically significant. BMI “p” value was 0.03 which was <0.05, so it is statistically significant. The “p” value of family income was found 0.58>0.05, it is not statistically significant. (Table 1)

In table 1, we estimated married women have 31% PTSD whereas unmarried women have 14% PTSD and the p value was 0.78>0.05 not statistically significant. No associations between PTSD and marital status.

In table 1, we can see graduate people have 12% PTSD, secondary educated people have 18% PTSD, primary educated people have 10% PTSD and illiterate people have 5% PTSD. The “p” value was found 0.78>0.05, not statistically significant. No association between PTSD and education.

In table 1, we can see those who live with family they have 43% PTSD. Those who live without family have 3% PTSD. The “p” value was found p=0.06>0.05, so there is no association between PTSD and living status.

In table 1, we found out 44% have PTSD and smoker 2% have PTSD. The “p” value was 0.14>0.05, so there is no association between PTSD and smoking habit.

In table 1, 25% of rural people have PTSD and 21% of urban people detected PTSD. The “p” value was found 0.04<0.05, so we can say that there is an association found between PTSD and residence area.

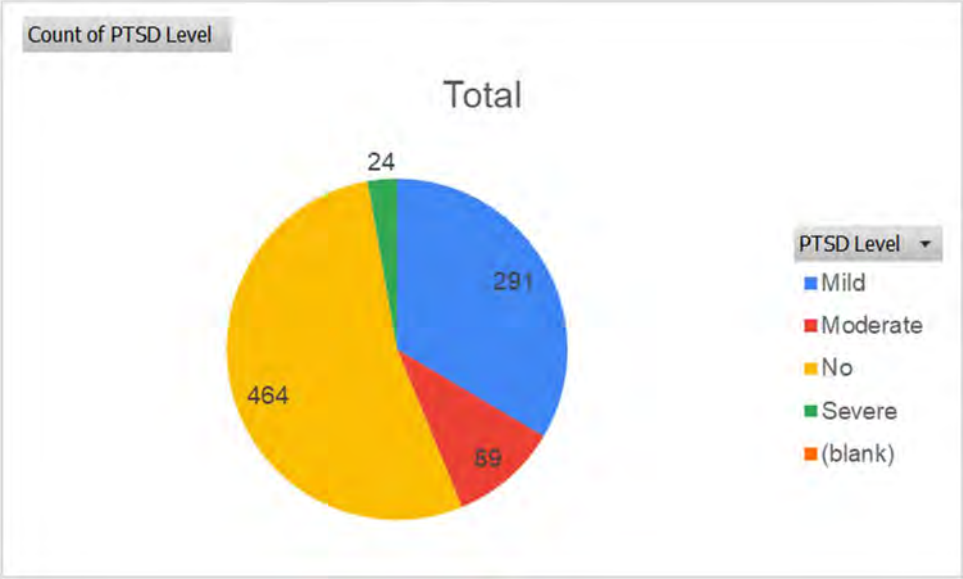

***Figure 1**: Prevalence of PTSD among young women*

Table 1: *Socio demographic variables and their prevalence and association with PTSD*

	n	%	P value
Age	404	47	0.55
BMI	404	47	0.03
Family income:	404	47	0.58
Marital status: Married	276	31	0.78
Unmarried	128	14	
Living status: With family	378	43	0.06
Without family	26	3	
Residence Area: Urban	188	21	0.04
Rural	216	25	
Education: Graduate	108	12	0.78
Secondary	157	18	
Primary	91	10	
Illiterate	48	5	
Smoking Habit: Non smoker	383	44	0.14
Smoker	21	2	

3.3 Correlation among parameters

From the 2nd table we can see that there is no correlation between PTSD and age, PTSD and family income. However, there is a significant relation between BMI and PTSD. The "r" value is 0.1 and p value<0.05. So, we can say that there is a very weak correlation between PTSD and BMI. In the 2nd table, we see the r value is 0.69 and p value is <0.05. This r value indicates moderate positive(negative) relationship between PTSD and residence area. The risk estimates among rural and urban populations are 1 which indicates equal risk estimates for rural and urban.

Table 2: *Correlation between demographic factors*

Demographic factors	**r value**
Age	0.09
BMI	.107
Family income	0.09
Marital status	0.09
Living status	0.06
Smoking habit	0.04
Education	0.03
Residence area	0.69

Chapter 4: Discussion

The key findings of our study are that almost close to half of young women participating in our study had detected PTSD. The risk factors that could be responsible for having PTSD is BMI. In our study we have found a slight relationship between BMI and PTSD. The second risk factor that had been detected in our study is residence area. In the study I have found out that those who live in rural areas suffer from PTSD at a higher rate than urban people. There is a moderate correlation found between PTSD and residence area.

The major risk factor of PTSD is sexually assaulted by more than one person, having acute stress disorder, having depression and having history of earlier drama (Möller et al., 2014).One study has found that preexisting affective disorder can predict PTSD in women(Bromet et al., 1998).A study reported persistent dissociation can be considered as a risk factor of PTSD(Ehring et al., 2006).It is also found in a report that negative attention from the society considered as another risk factor among women(Andrews et al., 2003).According to a report 2008,it was addressed that the prevalence of PTSD do not depend on age. On the other hand, previous trauma among women has importance in the regression analysis until depression and anxiety are introduced. Also, social support plays a significant role, if someone receives negligence in society then there is a high chance of getting PTSD. Anxiety was not found as an indicator of creating anxiety among women. Depression was found as the cause of PTSD among women. Negative affectivity and dissociation are significantly predicted for PTSD in women (Christiansen & Elklit, 2008). The risk factors that are detected in that study are stabbing incidents and social support but age and previous trauma do not predict PTSD (Christiansen & Elklit, 2008). According to a report no relationship between PTSD and age and marriage was not found but socioeconomic status has a relationship with PTSD (Coronas et al., 2007). It is seen in a study that those who have higher PTSD sleep less, smoke

more, have less physical activity. Sociodemographic factors and BMI are non- significant in case of PTSD (Gavrieli et al., 2016)

If the comparison occurs between available knowledge and the key findings there will be many factors that arise. In our analysis, we have found out BMI and residence area as the risk factors. We did not find any relation among age, education level, family income, smoking habit with PTSD. According to Coronas (2008) it was found out that age and marriage were not responsible for PTSD which has similarity with our study. On the other hand, in the study they found socioeconomic status as a risk factor whereas in our study we didn't find any relation between PTSD and economic impression. On the other hand, a report by Gavrieli (2016) stated that socio demographic factors and BMI were not responsible for PTSD but in our reserch we found BMI as the risk factor for PTSD. Also, in a study smoking was considered as a risk factor. In our analysis we did not find any relationship between smoking habits and PTSD because in our country the rate of smoking among women is very low. The prevalence we found in our study was 46% rate of PTSD among the women in our country. On the contrary, according to a report almost 70% of respondents detected PTSD through WHO survey. That is how we can compare the key findings and available knowledge in the same field.

The uniqueness of our study is it is the first approach in Bangladesh which will assess the level of PTSD among urban and rural women. We have done the study on young women between 18-45 years of age. Our study has found two risk factors BMI and residence area which is quite significant for the women of our country. Most of the studies have not clearly addressed the risk factors responsible for PTSD. Our study has detected a large number of PTSD among Bangladeshi women. By this study we can create awareness among them as well as can create better mental health for them. These are the uniqueness of our study that will help future studies in this field.

The strength of that study is the study is as the survey has done offline, so, it has higher response rates. It has been conducted on a large population.868 data are collected so the sample size is quite big. Secondly, we have collected the data offline so there were no issues with the internet. Due to offline surveys, there is less chance in our study of data manipulation, accessibility to the people is more than online surveys. It created a more in-depth engagement with the participants as well. The questionnaires were typed in Bangla and English both, so it was easy for the people to understand.

The limitation of the study could be as the survey had been done offline, so it took more time than online survey. The parameters that we have found previously responsible for PTSD did not completely match with our study. We assessed PTSD on young females only which could be a limitation as men or other age groups might have PTSD too. At last, the information might not be accurate sometimes as the understanding of a few respondents might be poor than others. So, this could be the limitations and strengths of our study.

The findings of our study have a large opportunity in clinical implication. The prevalences rate of PTSD among Bangladeshi women and the risk factors associated with PTSD are proven among Bangladeshi women. One can easily understand from the study which socio demographic factor is responsible for PTSD in Bangladesh and which factors are not related to PTSD. Our study has assessed that BMI and residence area are two key factors for PTSD. The health care authority should focus on this matter as the rate of PTSD among women in our country is prevalent. Most of the women do not know they are suffering from PTSD. So, the authorities should arrange medical camps or seminars based on PTSD to create awareness. The authority can impose a strict guideline so that better treatment for the patient ensures. The authority can arrange counseling

programs more often. The study will also initiate thinking of PTSD levels among young women all over the world.

The future suggestions to study in this field could be using google forms to collect data early. Data can be collected from different parts of the country to get better results. Long term effects of PTSD level can be detected in these fields. These are all the future suggestions that will be needed in this field.

Chapter 5: Conclusion

The present study result suggests a higher prevalence rate of PTSD among Bangladeshi women. The associated risk factors for causing PTSD are BMI and residence area. Based on this present study, medical camp, counseling, psychologist and patient awareness need to be increased. By decreasing the prevalence rate of PTSD, the suicidal rate will also be increasing. BMI was found as a risk factor so maintaining good physical health is also important to get a happy and healthy life. However, future studies that will conduct to detect PTSD among women should find out the actual cause behind PTSD.

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