Psychosocial Consequence of Post- Traumatic Stress Disorder on Special police Forces that are Admitted at Police Hospital in Addis Ababa, Ethiopia .

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By

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Advisors approval sheet

I hear by certify that I have supervised, read and evaluated this thesis titled << Psychosocial Consequence of PTSD on Special Forces who are admitted at Police Hospital >> by Yemaryamwork Senay prepared under my guidance. I approve the thesis to be submitted for oral defense.

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Advisor Name	Signature	Date

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Acronyms and Abbreviations

AAU	Addis Ababa University
APA	American Psychological Association
DALYS	Disability Adjusted Life Years
DSM	Diagnostic Statistical Manual
GBET	Group Based Exposure Therapy
IPF	Inventory of Psycho -Social Functioning
LMICS	Lower and Middle Income Countries
NCS	National Co- Morbidity Survey
PTSD	Post- Traumatic Stress Disorder
PCL-M	Post- Traumatic Stress Disorder Check List - Military Version
SPSS	Statistical Software Package for Social sciences
TBI	Traumatic Brain Injury

Abstract

Many trauma related researches focus on the impact of the trauma on the individual's mental health disturbance. Less is known how the everyday Social Life as well as psychological wellbeing is disturbed and negatively impacted by PTSD on special police forces who are admitted at hospital settings.

This study aimed to identify the psychological and social impact resulting as a consequence of PTSD on special police forces who are admitted at Police Hospital found in AA, Ethiopia. Institute based cross sectional study is conducted by using purposive sampling.

The instrument used to collect data in order to measure PTSD Level and the impact of PTSD on Psychosocial Functioning of the Law Enforcement Forces was PCL-M with a cut point score of 32 & IPF with a cut point score of 11-30=mild impairment, 31-50= moderate impairment ,51-80= severe impairment, 81-100= extreme impairment respectively.

The results showed that among the police officers who were eligible for the study 36.9% of them are seen with PTSD Symptoms and their psychological and social functioning was impacted. According to the Inventory of Psychosocial Functioning (IPF), the patient's psychosocial status was assessed by the subscales romantic relationships, family, work, friendships and socializing, parenting, education and self-care. PTSD level of the participants has impacted their family life, self - care and friendship & socializing. The impairment is found to be mild with a mean score of 19.9, 24.16, 24.17 respectively. Their romantic relationship and parenting impairment is moderate with a mean score of 39.25, 35.44 respectively and the education and work life impairment is found to be severe with a mean score of (55.33, 72.59 respectively).

CHAPTER ONE

Introduction

1.1 Background

A person who has encountered or witnessed a traumatic event may develop post-traumatic stress disorder (PTSD), a mental health condition linked to trauma. After exposure, this illness begins to show symptoms within a month, however in rare circumstances, it may take up to a year.

The Diagnostic and Statistical Manual –fifth edition was released in 2013 by the American Psychological Association (APA). It has updated criteria for the diagnosis of post-traumatic stress disorder (PTSD) and places it under a new heading called Trauma and Stressors Related Disorders (dsm.psychiatryonline.org.).

The extent of being traumatized by a specific phenomenon may vary from person to person based on that person's life experience, the severity of the trauma, time, and other resilience influencing factors like age, sex, previous exposure, but in military the amount of pain they experience, exposure to death of a friend, the horrific memories they have witnessed will give them a common trauma with common manifestations and symptoms.

Veterans frequently experience psychological distress, night terrors, insomnia, reliving the traumatic event, loss of interest in activities, dysfunctional relationship management, loss of interest in the things they used to enjoy doing or the people they used to enjoy, flashbacks, and many other symptoms. These behaviors can result in low productivity and impairment in the normal mental and physical functioning of an individual.

In a sample of more than 36,000 US adults, the Wave Three National Epidemiological Survey on Alcohol and Related Conditions (NESARC-III) study indicated that the lifetime prevalence of PTSD, based on DSM5 criteria, was 6% overall.

Also, the Survey done by Sharon smith (2016), which included over 3,100 veterans among the total participants shows that the life time prevalence of PTSD among veterans was 7%.

This study wants to see if this mental disorder is recognized in hospital settings which are specific for police forces that have experienced different traumatic events and wants to study the extent of PTSD influencing their psychological and social wellbeing in order to understand its depth and level of existence. Also it wants to see the treatment options available at the hospital setting to be able to get an insight if the disorder is being treated adequately and using updated and well equipped techniques.

The researcher wants to dwell on this specific topic because veterans, police forces, medical helping professions or other front liners are vulnerable to traumatic events and are prone to develop PTSD after those events as many literatures and researches has proofed in different times and places. This evidences are not well found in this country and the researcher wants to fill that gap by providing this study on police forces and by recommending for more studies to come after this research related to the topic.

The specific hospital is chosen because the hospital is mainly specific for police forces and also has patients with PTSD and different work based trauma cases which will help in finding directly related data to the research objective.

1.2 Statement of the Problem

Post - Traumatic Stress Disorder has impacted the life of many veterans and police officers all over the world making them relive their traumatic experience and have impacted their psychological and social wellbeing in a way that is disturbing to them as well as to the people around. Unquestionably, one of the most challenging situations that people may face is war. Combat conditions inflict an unequaled physical, emotional, cognitive, and psychological strain on military soldiers and defense police forces. People who want to serve in the military must be carefully selected and prepared to handle stress and develop resilience in the face of probable trauma and obstacles.

Special Force members of the armed forces and law enforcement are subjected to a variety of stressful circumstances, including living in deployment locations, seeing fatalities and injuries, being very exhausted and malnourished, and being in hostile weather as the study conducted by koenen,(2017) stated. In addition, a significant workload, being apart from loved ones, being confined, and environmental limitations are all elements of military life that add to the overall stress that service members—men and women—experience. Because of this, compared to the general public, members of the armed forces and police Special Forces are more likely to experience psychological disorders like Post-Traumatic Stress Disorder (PTSD).

Chronic and serious, post-traumatic stress disorder (PTSD) is characterized by reliving terrifying memories and experiencing extreme anxiety as a result of long-term reactions to potentially fatal traumatic exposure based on Seo,(2021). Research by Koenen, (2017) indicates that PTSD impacts roughly 4% of the global population, thereby constituting a striking element

of the global illness burden. Relatively Nearly 8 million people worldwide go through PTSD each year, accounting for 227 million adult war survivors according to Heather Graham, (2015).

Kessler,(2009) also found that from the most common diseases, PTSD accounts for 54.8% and 41.2% of disabilities in 'industrialized and developing nations, respectively. Ayuso-Mateos,(2007) study also states that PTSD accounts for 0.4% of YLDs and is expected to rise to 0.6% worldwide.

A large-scale military personnel study by Milliken, (2007) revealed that more than two-thirds of deployed soldiers have experienced at least one conflict. One of the most obvious effects of US involvement in Iraq and Afghanistan is post-traumatic stress disorder (PTSD). National Academic Press, (2012) stated that PTSD affects 13–20% of the over 2.6 million soldiers serving in Afghanistan and Iraq.

A study done by Bolton & Sareen, (2021) shows PTSD is one of the top three most frequent mental diseases in Canada, with a lifetime prevalence of 21.0%. Among Canadian military personnel, the lifetime incidence of DSM-IV mental illnesses is found to be 54%.

There are important societal, physical, psychological, and interpersonal repercussions associated with PTSD based on the research done by Hruby, (2021). It shows that People with PTSD are more likely to be divorced, struggle to raise their kids, act aggressively toward their intimate partners, have depression and other psychological issues, have poorer quality of life, experience physical health issues, and also are prone to turn in to crime acts.

Ge Y and Xue C,(2015)indicated the risk factors for PTSD which included lower educational attainment, military rank, army in branch of duty, occupation, longer cumulative deployment duration, and more deployments. Due to PTSD, lower- and middle-income countries (LMICS)

are responsible for 3 million disability-adjusted life years (DALYS) globally according De Jong JT, (2001). As LMICS, the majority of countries with a recent or current history of conflict have little resources to address the widespread prevalence of mental illnesses, such as PTSD.

Three of ten (3/10) combat military personnel are at risk for post-traumatic stress disorder (PTSD), as the research findings from Nigeria by Abel J, (2018) indicates. Untreated mental health conditions thereby lower combat preparedness, raise the possibility of an early release from military or police service, and raise the danger of suicide according to Thyloth & Singh ,(2016). In four post-conflict contexts—including Ethiopia among refugees—16% of survivors of war or mass violence suffer from PTSD as De Jong, (2021) study finding implies.

1.3Objective

1.3.1General Objective

The general objective of this research is to understand the psychological and the social life impairments which are associated with Post - Traumatic stress disorder on police Special Forces who are admitted at Police Hospital in Addis Ababa Ethiopia in 2023.

1.3.2 Specific Objective

The specific objective of this research is

To understand the association between psychosocial impairments and PTSD among police Special Forces who are admitted at Police Hospital in 2023.

To look in to the treatment options of PTSD which are being provided at the Hospital in 2023.

1.4Research Questions

What psychosocial impairments are associated with PTSD on special police forces who are admitted at Police Hospital in 2023?

What treatment options are available for PTSD at the Police Hospital in 2023?

1.5 Operational Definition

PTSD- police officers with post-traumatic stress disorder with a PCL-M score of 32 and above. (Weathers, F.W, Litz, B.T, Herman,D.S, Huska, J.A., Keane,T.M.(1993).

Psychosocial functioning impairment – the disturbance of the collective wellbeing of an individual and have a mild to severe impairment scales based on the IPF scoring. Mark A.Feragne, Richard Longabaugh, and Jhon F.Stevenson. (1983).

1.6 Significance of the Study

PTSD causes a disruption in the normal mental functioning of a person day today activities, life experiences, social activities, the perception of the world around them, the insights they have and many more things are impacted in a way that changes their social and psychological aspect of their life.

The study will be an additional study as limited resources are available in our country and it will also help in understanding the psychological, social and over all mental functioning impairment of police special forces as a result of post-traumatic stress disorder and helps in giving much more emphasis on this mental illness in order to come up with pre exposure training's on the illness and find better and updated coping mechanisms , better treatment options including both

medication and psychotherapy as well as in making the people around them understand their illness so that they get support and care they desire. In order to help police forces with PTSD and their families to get a better understanding of the condition, its symptoms, potential co-occurring disorders, and the psycho-social repercussions that are frequently associated with PTSD, this paper aims to educate readers about it.

There are tools, educational guides and therapy techniques available for addressing PTSD for both the police men and the police's family. Additionally, it will help in increasing awareness and understanding of the psycho-social consequences of PTSD on their life. The police men's quality of life and the quality of life of their family can be both significantly impacted by the way these psychological disorders affect their day-to-day functioning.

In this research we looked in to the psychological and social consequences of PTSD among the special police forces at police hospital to understand the seriousness of this mental disorder, how far this mental disorder has affected the life's of the soldiers , their families, their work life, their relationship, their productivity as well as the way they see and perceive them - selves, how the disorder is taken seriously and it goes in to what treatment options are being provided in the hospital currently.

This study also gives an insight for the readers how the law enforcement forces can also be victims as they are front liner in every difficult situations happening in the country like war, any crime acts, natural disasters, Political havocs which make them part of the disturbing causes of death, blood shed or perturbing scenarios which caused the police forces to develop emotional, social, physical and mental disturbance or damage. These damages are not going to end as these personnel's are done with their shift. In fact, they take it home with them and live every moment till they start to manifest flashbacks, nightmares, sweating, and many more PTSD symptoms. So

the study tried to show the impact in order to bring improved understanding which will make their parents, spouses, higher officials, government officials and health care service providers to give a better treatment options as well as to be able to bring better mental health advocacy to the law enforcement forces beforehand.

CHAPTER TWO

Literature Review

This chapter tries to show the prevalence of PTSD around the globe based on evidences from the studies done related with the cases on military forces and police officers and tries to illustrate how the disorder is related with the work related experiences the soldiers encountered.

2.1 Prevalence

A study by Sundin & Fear, (2009) indicates Studies that used the PCL-M (Post-Traumatic Stress Disorder Checklist/Military Version) and were based on non-random anonymous surveys of line infantry units which showed the highest prevalence of PTSD. These studies indicate a reasonably consistent rate of PTSD among combat-deployed troops, ranging between 10% and 17%, although they may not be fully representative of all deployed military. However, the prevalence of PTSD tends to be lower, ranging from 2.1% to 11.6%, among the population and random samples that are more representative of all deployed soldiers.

According to an Australian study done by Rush, (2018) there was a significant correlation between the number of deployments and the occurrence of major depressive episodes, and veterans who had multiple deployments were more likely to meet the criteria for a major depressive episode. There was a significant correlation between the lifetime and deployment-related trauma exposures and all psychiatric disorders, and this also applied to the reported feelings of fear or horror experienced during the deployment trauma exposure.

Additionally, individuals who were older at the time of deployment—a mean age of 28 years—were more likely to have PTSD now than those who were younger at the time—a mean age of 26

years—indicating that the age at which PTSD was present was the only factor associated with PTSD .

A study done by Arment (2018), shows that Numerous characteristics, including having a history of deployment involving moderate to severe conflict, being married, serving in the Army, having an enlisted pay grade, and having lower educational levels, have been found to be strongly related with PTSD Moreover, compared to those who did not experience the listed cases, those who report higher baseline levels of PTSD severity, have co-occurring mental health conditions, use psychotropic medications, smoke currently, and have gone through stressful life events like physical or sexual assault, divorce, or a disabling illness are also more likely to experience PTSD. Moreover, it has been observed that the persistence of PTSD symptoms during follow-up evaluations is associated with a lack of social support.

Amare & Mohamed, (2019) has found the following factors to be strongly associated with post-traumatic stress disorder in a study of non-officer Ethiopian military personnel: serving for at least ten years; feeling that their lives were in danger; handling a fellow soldier's dead body; having a healthy but unsatisfactory relationship with teammates; and using drugs like nicotine, alcohol, or cannabis.

2.2 Psychological Consequence of PTSD

During the American Civil War (1861–1865), the signs and symptoms of post-traumatic stress disorder (PTSD) became more noticeable. The Civil War, which is frequently referred to as the bloodiest conflict in American history, saw the widespread adoption of telescopic sights, rapid-fire rifles, and other technological innovations that significantly increased combat destructiveness and left survivors with a variety of physical and psychological wounds as the

study done by Koenen(2017) shows .The frequency of PTSD among returning service soldiers is estimated to vary greatly between wars and historical periods. 13.5% of deployed and non-deployed veterans screened positive for PTSD in a large research involving 60,000 police officers and veterans of Iraq and Afghanistan; some studies report that the rate may be as high as 20% to 30%.Up to 500,000 American soldiers who fought in these conflicts throughout the previous 13 years have been identified as having PTSD as the study by Koenen (2017) indicates.

A study conducted in the United Kingdom by Victoria (2020), found that most people who had gone through a traumatic, non-morally harmful occurrence reported feeling threatened all the time and that they were disposable. Many talked of ongoing struggles stemming from deep-seated worries that other people would pose a threat. They also talked about having trouble building relationships or trusting others because they felt that the society they lived in was extremely unsafe. Fear-based cognition and concerns about oneself and surrounds were reported by veterans and police special forces that faced threats to their lives.

Nevertheless, in contrast to the trauma bare segment, soldiers who had gone through a "mixed" or morally damaging occurrence frequently had a universal belief that the world is a corrupt, terrible place. These veterans, especially after PMIEs involving the observation of human suffering, spoke of feelings of hopelessness and a diminished faith in others.

Another study done by Navid ;Ebrahimvandi, Alireza; Jalali , Ghaffarzadegan , Seyed Mohammad Javad (2016) on the dynamic model of post – traumatic stress disorder ,found that PTSD is highly co-morbid with other psychological side effects or mental illnesses that can arise after trauma, such as substance abuse, depression, anger and violence, guilt and shame, and suicidal thoughts. Long after being removed to a safe environment, people with PTSD continue to experience the psychological effects of trauma, such as reliving symptoms, avoiding similar

stimuli, negative cognition and mood, and increased physical arousal. A partner's psychological distress is linked to the presence of PTSD symptoms, and it can also significantly affect the mental health of the other partner. In order to create a caring and supportive atmosphere for healing, it is critical to attend the needs of both partners and look for the right interventions in how PTSD affects the level of relationships.

Brummett, (1999) discovered that a partner's military status can moderate both the relationship quality and psychological distress associations between PTSD and partners. According to the study, PTSD related to military service may have a greater effect on close relationships than PTSD related to civilians because it is more closely linked to hostility and anger. This will contribute to a larger association between PTSD and psychological distress among military samples.

According to the above study, psychological distress in the other spouse is linked to the anger and hostility of one spouse. Moreover, spouses of veterans might have had to handle deployments and other military-related stressors, which could be linked to a higher susceptibility to distress. The study also showed that the effect of PTSD on relationship quality may be influenced by gender variations in symptom expression. This suggests that the relationship between PTSD and partners' psychological distress, as well as the relationship between PTSD and relationship quality, may be influenced by factors such as gender and military status. Comprehending these elements can facilitate the development of suitable interventions and assistance for PTSD-affected couples as study done by Schwartz, Slater, Birchler, & Atkinson, (1991) indicates.

A study in US done by Laurence, Binder, Martin, Rohling, (2011) found that a high weekly hourly rate was predictive of suicidal thoughts among US Air Force personnel. This study shows

that adults with drinking disorders also typically have one or more of the following symptoms: panic attacks, intense fears or worries, compulsions, mood disorders like depression, sleep disturbance, attention problems, or acting in ways that harm others; addiction; abuse of street prescription drugs; alcohol use and abuse; long-term physical illnesses like diabetes, heart disease, liver disease, and persistent physical pain. It also suggests that PTSD typically co-occurs with other Axis I and Axis II disorders that are listed on the DSMIV.

Another study by Nadir & Jonathan, (2018) looked at the connection between pain and sleep disturbances in a sizable sample of veterans with PTSD, TBI, and co-morbid PTSD and TBI. Veterans with co-occurring traumatic brain injury and PTSD have reported the worst sleep disturbances. According to the data they used in their study, individuals with co-morbid TBI and PTSD do not exhibit a significant difference in sleep disturbances, and PTSD may be a greater contributor to the occurrence of sleep disturbances in comparison to TBI in their particular study population.

According to another US study by Elliott and Balba , (2018) officers who witness horrific deaths of others or who face a threat to their own safety are particularly vulnerable to developing severe traumatic stress disorder (PTSD). This research also examined the effects of PTSD on the mental and physical health of police officers. Among the symptoms that have been identified are depression, sleep loss, and a number of intrusion and avoidance symptoms, such as anxiety and flashbacks are found to be common symptoms.

The frequency of stressful events officers experience afterwards influences the severity and proximity of their symptoms according to a study conducted by Kopel & Friedman, (1999),Robinson, Sigman & Willson, (1997), Greene, (2001).

Numerous extensive studies of police officers in England, Australia, Canada, and the United States also concluded that dealing with homicide and serious accident victims, being attacked by aggressive criminals, handling rioters and protesters, and being involved in a war zone caused stress in officers. A study conducted by Coman & Evans , (1991) shows believe that if they seek assistance in the field, they are not dependable.

According to a study done in South Africa by Pearlman & McCann, (1990) police officers who frequently utilize dissociation as a coping mechanism after stressful events are more likely to develop chronic PTSD. Police officers are also very prone to experience delayed-onset dementia.

The likelihood of police officers developing delayed-onset PTSD which depression and anxiety problems are not brought on by the incidents listed is also very high. Instead, they are brought about (or made worse) by later-evolved events, circumstances, and situations. These conditions frequently represent a lack of meaning attached to the trauma and a perceived lack of social support. When the following components of South African policing are added, the mixture does indeed become volatile: a lack of security and stability (a continuous process of transformation); an external locus of control, intense anxiety, feelings of being undervalued and unappreciated, a lack of purpose in the work done, a lack of support or acknowledgment from the organization and a deterioration in group identity.

2.3 Social Consequence of PTSD

The above researches illustrate the social life impairments caused in association with PTSD on military personals as well as police forces around the world.

According to research by Samantha & Neil,(2017) the majority of veterans experience PTSD as a result of relationship with others, social support, role-related stressors, over commitment,

effort-reward imbalance, and job demand-family work imbalance .An all-too-common side effect of military deployments for military couples is relationship problems and imbalance, according to research on the detrimental effects of a history of trauma and PTSD symptoms on intimate partners.

A recent meta-analysis by Taft et al, (2011) examined the degree of relationships between PTSD severity and measures of partner conflict across 31 studies and found mean observed correlations ranging from.32 to.36. PTSD has been linked to increased relationship amity, poor relationship adjustment, and elevated psychological and physical aggression toward partners in this study.

When compared to females, these relationships were stronger in veteran populations and among males. When comparing the behavior of male veterans with that of their female spouses, the study found that the former exhibited greater distress and hostility during times of conflict than the latter. The spouses reveal little about them and don't make any remarks that would provide insight into their thoughts, desires, or beliefs. In comparison to veterans or men, spouses exhibited lower levels of happiness with their relationship quality and a desire to alter the situation.

The largest and most well-known study was likely the US National Co-morbidity Survey (NCS) conducted by Kessler (1995), which discovered a 7.8% lifetime prevalence of PTSD for the total population. One of the few studies using the more recent DSM-IV criteria found a current prevalence of 1.2% for men and 2.7% for women in a Canadian population sample.

In PTSD, co-morbidity is considered the rule rather than the exception according to a study done in US by Kulka and Schlenger, (1990) and in contrast to 41% of veterans without PTSD, 99% of Vietnam veterans with chronic PTSD were eligible for a second DSM-III-R diagnosis at some

point. According to this study, severe depression (20%), generalized anxiety disorder (44%), and substance addiction or dependence (75%), were the most common co-morbid conditions.

According to recent research conducted by Magruder, Fruch , (2004) PTSD is linked to greater rates of service use, as well as higher medical and societal costs, when compared to the majority of other psychiatric disorders .

A study conducted at the University of Denver in Colorado, USA by Benjamin, Sarah, (2011) looked at the relationship between soldiers' post-deployment low PTSD symptoms and how often they communicated with their spouses, particularly when there was high marital satisfaction. To conduct this study, deployed male soldiers who had recently tied the knot were discovered to be married, were in a relationship, and were in communication with their wives while deployed. Their degree of current post-deployment PTSD symptoms was attempted to be measured in connection to their degree of marital satisfaction. Low levels of PTSD symptoms are demonstrated by a high rate of marital satisfaction and regular communication with a spouse during deployment, supporting their prediction.

A Study by Lambert, Engh, Hasbun , Holzer , (2012) shows that Relationship problems are more common in those with PTSD because of their diminished capacity for humor, increased acrimony, and negative feelings. They frequently have issues with self-worth and find it difficult to come up with useful solutions to problems. These results offer a deeper understanding of the emotional and social difficulties that people with PTSD encounter, as well as how these difficulties affect relationships.

Another US study on police officers by Chae & Boyle, (2013) found that, of all professions police officers consistently have some of the highest rates of divorce, alcoholism, and suicide.

Psychosocial Consequence of PTSD

Research indicates that one of the main risk factors for suicidal thoughts is critical incident trauma.

According to Brian Anderson, (2004) (trauma response), an additional stressor is the unpredictable nature of the police profession, according to his study. As a result Selye,(1976) coined the term "General Adaptation" to describe the situation in which stress hormone levels must remain high condition. This researcher claims that one of the main differences in the stress levels of law enforcement officers and those in occupations like firefighting and Para- medicine is the public's perception of these groups. According to Anderson's research, people generally have a negative opinion of police officers. One of the primary goals of law enforcement According to Davidson and Hughes, (2004) organizations exist to serve the public good, which makes them socially thoughtful.

According to a study done by Ghaffarzadegan N ,Ebrahimvandi A & jalali MS (2016) on the dynamic model of PTSD for military personnel and veterans people who disclose their issues face a variety of negative outcomes, including a higher risk of losing their jobs or experiencing discrimination at work, social exclusion, a decrease in income, trouble renting an apartment, exclusion from social groups, and legal issues. In addition to the patients themselves, PTSD also has an indirect impact on the family members, friends, neighbors, coworkers, and employers of the patients.

Interpersonal relationships at work are crucial, and non-deployment stressors present a significant occupational mental health disturbance in routine military environments, according to the literature. A study conducted at King's College London, King's Centre for Military Health Research, Weston Education Centre, London, UK, by Samanth and Neil, (2017) suggested that social stressors like poor cohesion and social conflict with colleagues, harassment at work, and

job-related issues like role conflict and work overload present a significant occupational health hazard in the routine military work environment. Studies have demonstrated the serious and pervasive negative effects of PTSD on marital adjustment, overall family functioning, and the mental health of partners and kids. These unfavorable outcomes include problems like strained caregiver relationships, family violence, divorce, and compromised parenting as the finding of Beckaham Calho, (2002) indicates. The mentioned study claims that these detrimental effects lead to problems like bad parenting, domestic abuse, divorce, acrimony, and stress among caregivers. Further research in this area indicates that male veterans with PTSD are more likely than their non-PTSD counterparts to report marital or relational issues, greater levels of parenting difficulties, and a general worsening of family adjustment.

A related study by Solomon & Waysman, (1991) found that families of veterans with post-traumatic stress disorder were more likely to experience general relationship problems, physical and verbal aggression, and violence against a partner. It also indicates that compared to spouses of veterans without PTSD, female partners of veterans with PTSD self-reported higher rates of family violence. The mental well-being and quality of life of a veteran's partner may also be affected by PTSD.

Based on data from Nigeria by Abel & Anongo, (2018) also demonstrates the comparable effects of PTSD on veterans: 3/10 of combat veterans are at risk for developing PTSD.

Untreated mental health conditions raise the risk of suicide, premature military separation, and decreased combat readiness based on a research by Singh & Thaloth , (2016).

Comparably, a prior study carried out in Ethiopia by Amare & Mohamed, (2019) estimated that 16% of Ethiopian military personnel suffered from PTSD & Several factors were discovered to

be significantly associated in the majority of studies such as deployment duration, coping mechanisms, and length of deployment were overlooked.

Post-traumatic stress disorder (PTSD) was diagnosed in 21.9% (95% CI: 18.6, 25.2) of the 612 veterans in a recent study conducted at Bahirdar University by Assasahig , (2022). This is a higher percentage than in the previous study. Additionally, a bi-variate analysis of post-traumatic stress disorder and each explanatory variable found that the following factors were significant: female sex, number of deployments, nature of military duty, single status, history of mental illness, family history of mental illness, physical trauma and neglect experienced as a child, depression, combat exposures, brief resilience scale, handling dead bodies, aiding wounded; being attacked or ambushed and receiving artillery; being shot and receiving small fire; and seeing enemy forces wounded, killed, or dead).

2.4 Treatments of PTSD

Above are the treatment options being provided for treating PTSD world wide.
According to a research done by Schnurr & Monson, (2006) nationwide program to teach therapists Cognitive Processing Therapy (CPT) has been launched by the VA's Office of Mental Health Services. This treatment is a type of cognitive behavioral therapy (CBT), an empirically supported approach to PTSD recovery. CPT has been shown to be beneficial in treating PTSD in a number of populations, including veterans of combat. The goals of CPT are to lessen trauma memory avoidance and assist patients in comprehending and altering the meaning they attribute to their traumatic experiences. This makes it possible to assess and comprehend their experiences more fully. Through therapy, patients are able to understand the reasons behind the traumatic event and how it affected their views of the world, other people, and themselves. Finding

automatic thoughts and raising awareness of the relationship between thoughts and feelings are important components of the treatment.

Patients learning CPT are trained to recognize harmful beliefs that impede their ability to heal from trauma. After that, the patients write a thorough account of their most traumatic experience and share it with the therapist as part of a formal trauma processing process. This facilitates the processing of intense trauma-related emotions and breaks the avoidance pattern.

Patients continue to process emotions during CPT as they talk about their traumatic experiences in an effort to change unhelpful beliefs. Therapists assist patients in disproving their perceptions of the traumatic incident, lowering feelings of guilt and self-blame , and raising acceptance.

Teaching patients cognitive skills to recognize, assess, and change their beliefs about any traumatic experiences they may have had is the main goal of the treatment's last phase. Through CPT, patients can learn to recognize, comprehend, and question the assumptions they have made about their traumatic experiences that have become habitual and unrealistic. These abilities allow them to continue using what they have learned after therapy sessions end and to participate in adaptive coping outside of therapy. Twelve 50-minute sessions, held once or twice a week, are the standard format of CPT. Patients are required to complete practice assignments outside of sessions. The goal of the 15-session CBCT for PTSD treatment is to improve intimate relationship functioning while also reducing symptoms of the disorder. It works well for couples who are at different stages of their relationship—from unhappy to content.

Other study by Fredman & Vorstenbosch, (2014) recommended the Cognitive Behavioral Interpersonal Theory of PTSD, which contends that interactions between behavioral, emotional, and cognitive elements inside and between partners perpetuate the condition and its associated

relationship difficulties, forms the basis of the therapy. CBIT states that characteristics of the intimate connection can either sustain or intensify PTSD symptoms. PTSD symptoms can also lead to relationship challenges such as impaired intimacy, communication, and conflict management, as well as decreased relationship satisfaction and support. The accommodation of PTSD symptoms by a spouse is one relationship aspect that is considered to affect PTSD. In order to alleviate patient suffering or prevent relationship conflict associated to PTSD, partners may modify their actions in reaction to symptoms of PTSD For example, partners may participate in safety behaviors, shop for groceries for the patient, avoid crowded events, or avoid talking about relationship-related issues that could make the patient feel angry or distressed due to PTSD. These behaviors are all examples of PTSD-related avoidance of places, situations, or people that trigger patients' anxiety.

Renshaw & Allen , (2020) stated that Partner accommodation is linked to psychological distress in the relationship for both partners and can impede PTSD recovery, even though it is frequently driven by a desire to support trauma survivors or avoid relationship conflict . This is probably because the patient's avoidance tendencies are being reinforced. The goal of CBCT for PTSD is to address relational and individual variables, such as accommodation, which is thought to be a contributing role in the persistence of PTSD.

As a result, the results from the sample that was provided and the subsample of individuals who finished therapy showed that partner and veteran relationship satisfaction increased during the course of treatment, with the same rate of improvement for each group. From before to after therapy, veteran and partner relationship satisfaction rose significantly, and this gain persisted for both groups. Despite the fact that the group as a whole is not experiencing relationship distress, this finding is noteworthy since it indicates that the treatment improved relationship satisfaction

even if both veterans and partners were, on average, in the pleased range prior to treatment. The other data shows a substantial reduction in depression symptoms in veterans and their partners from the pre- to post-treatment period. Veterans experienced a higher change in depressed symptoms than couples, perhaps because they had more potential to improve. While couples had minor symptoms over the same duration of therapy, veterans often reported having moderate levels of depression symptoms prior to treatment.

Based on another research at the US Department of Veteran Affairs Medical Center in Atlanta, Georgia, done by Padin & Donovan, (2001) they treated soldiers with PTSD diagnoses using group-based exposure treatment (GBET). One of the most rigorous psychotherapies offered by the Atlanta VA Medical Center's specialist PTSD outpatient program is GBET. Since its implementation in 2003, GBET has been a complex, annualized cognitive-behavioral treatment. To treat persistent combat-related PTSD and depressive symptoms, GBET combines elements of psychological education, psychosocial skills training, and exposure to trauma memories.

Nine years of clinical expertise treating combat-related PTSD in a group setting and the adaption of strategies from other PTSD programs serving a comparable patient population came together to create GBET. It incorporates components of the Transcend program by Schnurr & Friedman, (2003).

Using the CAPS administered by the treating doctors, the first open trial of GBET with 102 war veterans demonstrated a significant benefit of therapy on PTSD symptoms at post treatment that were sustained at 6-month follow-up which was done by Ready & Thomas, (2008).A central aspect of GBET is that veterans' combat-related trauma narrative is presented within the psychotherapy group. Outside of therapy sessions, the veteran is required to regularly listen to audio recordings of his trauma narrative, much like in PE.

Psychosocial Consequence of PTSD

The majority of exposure therapies are intended for individual psychotherapy, even if group psychotherapy is the most often utilized treatment for PTSD among war veterans. The effectiveness of group-based exposure therapy for veterans of battle has not received much attention in the literature. Neither TFGT nor the control condition was shown to be better in this trial, and neither condition's majority of individuals had CAPS scores decline to a clinically meaningful degree.

Group exposure-based treatments are recommended for a number of reasons as Foa, Hembree & Rothbaum, (2007) indicates in their study. One of the main benefits they put was that patients may find that sharing their experiences with peers who have gone through comparable traumatic experiences helps normalize the negative reactions they had to deal with. Members of the group may also identify with and normalize problematic actions and symptoms following trauma, such as depressed thought patterns.

A research by Lie, Skogstad, Korin, Heir, & Weisaeth, (2013) found that some of the typical police pressures that lead to drinking or suicide are lessened by groups that provide counseling and coping methods .

According to a study by Chae & Boyle, (2013), it has been shown that PTSD symptoms that are not as severe can be mitigated by having a social network of support. People with PTSD always feel afraid and anxious. To get over their fear and accept help, the person needs to feel at ease and supported. In order for a patient to obtain good treatment, they must consistently attend and sustain their therapy sessions.

As a theoretical framework, we have seen in the research listed above that there is a cause-and-effect link between psychological wellness, law enforcement force functioning, and PTSD.

In conclusion The National Institute of Health defines social functioning as an individual's capacity to engage with their surroundings and carry out their responsibilities in settings including employment, social activities, and relationships with family and partners.

A person who is thriving is said to be in a positive frame of mind when they are in psychosocial health and well-being. It arises from the interaction of factors that affect an individual's mental health and well-being on the physical, psychological, cognitive, emotional, social, and spiritual levels. Our emotional, psychological, and social well-being is referred to as mental health. It influences our feelings, thoughts, and behaviors. It influences our ability to manage stress, interact with people, and make decisions. According to Yale School of Medicine (2020), psychosocial well-being is a superordinate construct that encompasses both social and communal well-being and emotional or psychological well-being.

Psychosocial impairment of a person as a result of PTSD are appropriately included in the inventory of psychosocial functioning by being classified as psychological functioning and falling under the categories of a person's interest in education, self-care, and romantic relationships with spouses or partners, family relationships, work-related habits, friendships, and socializing, as well as parenting as social functioning. Law enforcement personnel with PTSD diagnoses alter or negatively affect the aforementioned life experiences that they were accustomed to before to their trauma, depending on their psychological and social wellness. As a result, they develop an unhealthy and chaotic living pattern, which renders them dysfunctional and less effective.

2.5 Conceptual Framework

The conceptual framework of the study is taken from the literature's reviewed above.

It tries to illustrate how PTSD can be associated with the special police forces individual demographic factors like their age, sex, education, marital status, interpersonal relationship the person have with their spouse, their marriage partners, friends, co-workers and the people in their daily lives impact there level of PTSD, also to the organizational factors that influence the quality of the person's life like salary (economic background) , the work environment , the risks the person take at work places, the time period the person has spent in duty and it may also relate with the perception the community has about the work that person does, mental health, PTSD, and their support and understanding of the case, how the community support and accept the police community and how they understand the hardships they go through using the socio ecological model. The researcher found it to be suitable in describing and answering the research question on how PTSD relate with the listed factors and it touches the issues related to it which helps in guiding and understanding how individual, interpersonal ,organizational & community factors influence the psychosocial impairment of an individual related with PTSD as different literatures has clarified in the above studies.

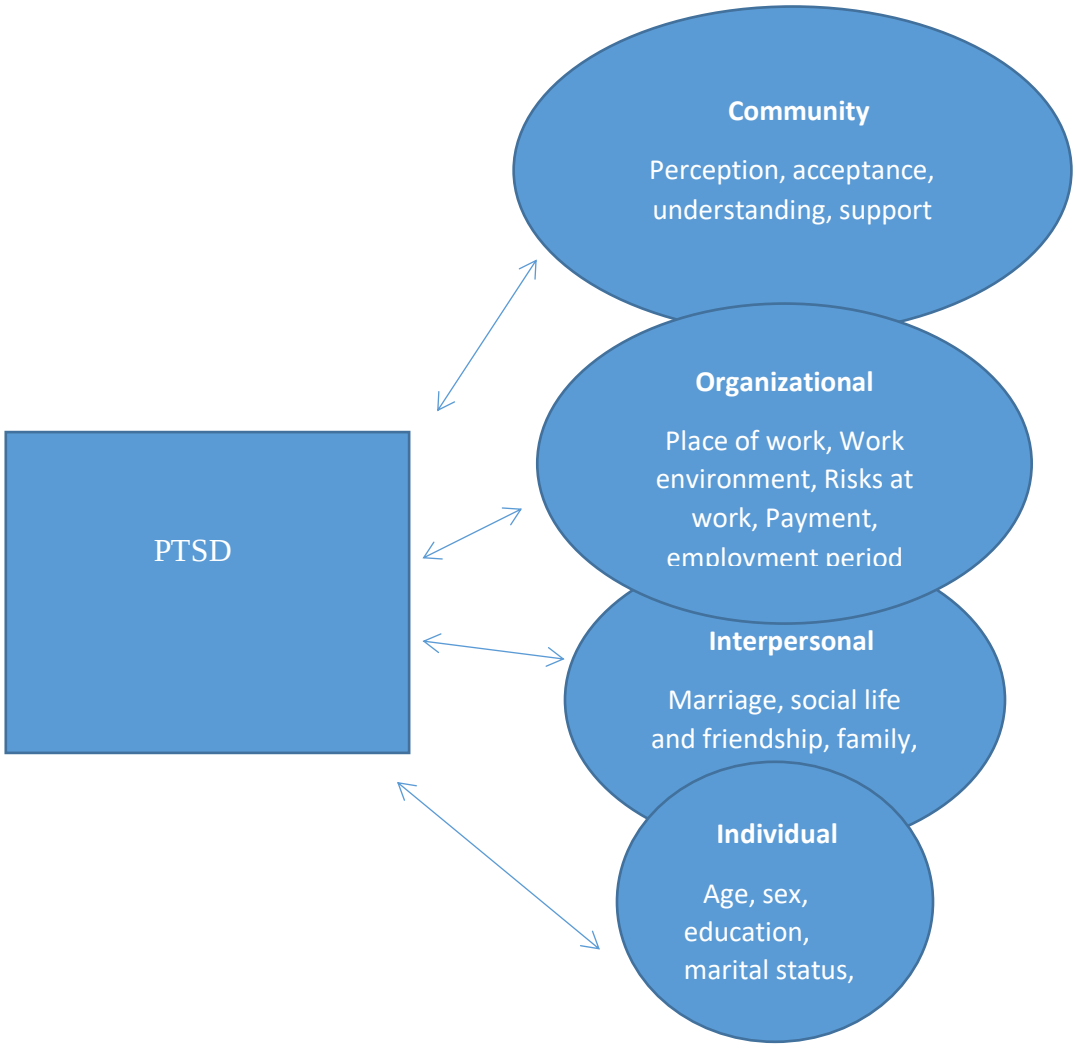

Figure 1- Socio ecological model (jill Fkilanowski,2017)

CHAPTER THREE

Research Methodology

3.1 Study Setting

The research setting is Police Hospital which is found in Addis Ababa, Ethiopia. This hospital has been treating Special Forces, Federal Polices and their family members in both inpatient and outpatient.

The special police forces came to the hospital from different parts of Ethiopia in different times with different medical, surgical and psychiatry cases.

This study area is chosen because it is a well -known hospital which is specific for police forces which is convenient for the researcher as the study is focused on the Special Forces who have had traumatic experiences in their work and who have been exposed to different outrageous activities which impacted their psychological and social life.

3.2 Study Period

The study is conducted from June - September 30, 2023.

3.3 Study Design

The study is conducted using cross sectional mixed method combining both qualitative and quantitative methods.

The quantitative data allow the researcher to identify the existence and level of PTSD on the police officers and also to identify the psychosocial functioning impairments which are related with PTSD. The researcher uses two checklists, one being the PCL-M which helped in looking in

to the PTSD levels of the police officers using 17 questions addressing trauma related experiences in their work space and the IPF which helped in understanding the psychosocial functioning impairment of the police officers related to their PTSD level using 80 questions with 7 subscales of family, friendship and socializing, romantic life, self-care, education, parenting and there work life balance.

The researcher also used qualitative data through interview guideline which helped in understanding the treatment options available at the hospital. The interview was with the doctors and nurses at the surgical and psychiatry wards of police hospital whom are responsible in treating patients with PTSD and related mental health disorders. The question and answer was first recorded and it is written word by word as a transcript. Then for convenience of the reader and for better understanding the researcher has thematized the all interview and tried to illustrate the all concept in an organized way.

3.4 Study Population and Sampling

Police Special Forces who were admitted to the surgical and psychiatric wards of the Police hospital comprise the study population. Study samples are selected using the ward and bed number they are admitted to, in accordance with the purposeful sampling approach which is non-probable sampling technique which help in choosing samples purposively based on the characteristics that are needed in the sample by the researcher.

The samples where purposefully selected from surgical ward because the ward consists of police officers who were in sever traumatic injuries with different physical disabilities and wounds which the researcher believe will lead to mental disturbance and instability as they have gone through a new experience and a change in their life style after the incident.

On the other hand, psychiatry ward is chosen as patients with PTSD and other mental health related cases are admitted at the ward and it is believed that those patients will provide the needed data related with PTSD developed at their work space.

The sample size was determined by applying a single population formula, assuming a 95% confidence interval and a 5% margin of error, and using the prevalence of PTSD as reported in a prior research conducted at Bahirdar University in by Assassaheg Tedla, (2022) which was 21.6%.

n=N/(1+N(e)2

$$n = \frac{(1.96)^2 \, o.216(1-o.216)}{(0.05)^2} = \underline{260}$$

From a total of 500 police officers who were admitted at surgical and psychiatry ward of the research site, the researcher used 215 of them using purposive sampling technique.

3.5 Variables of the Study

3.5.1 Dependent Variable

Post-traumatic stress disorder (Yes/No)

3.5.2 Independent Variables

Parenting - how individual interact with children and the quality of the relationship they have.
Friendship and socializing - the quality of the individuals social life.
Work life -how the individual act, behave and cooperate at work place.

Psychosocial Consequence of PTSD

Education- the level of education the individual has got.

Self -care - the practice of self - care activities.

Romantic relationship - how the individual interact and behave around their romantic partner.

Family - how the individual interact with family members.

3.5.3 Demographic Variables

Age

Gender

Educational Background

Marital Status

3.6 Data Collection Instruments

The study used post- traumatic stress disorder checklist military version PCL -M which is a standardized measurement to measure PTSD level of the military personnel. It is used to evaluate the existence and severity of PTSD symptoms in military personnel as specified by the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM–IV; American Psychiatric Association, 1994), the PTSD Checklist—Military Version (PCL–M; Weathers et al., 1993) was created. On a 5-point rating system, respondents indicate how bothersome each of the 17 PTSD symptoms was to them. Three subscale scores and the overall PTSD symptom severity score are produced by adding together the items.

Cut – point score =32

The PTSD level score Item reliability score is 0.997 indicating the reliability of the scale.

Reliability Statistics

Psychosocial Consequence of PTSD

Cronbach's Alpha	N of Items
.997	17

Table 1.1

The other instrument used was the IPF (inventory of psycho-social functional impairment) which was used to measure the psychological and social impact of PTSD on soldiers.

The IPF is an 80-item self-report tool that assesses functional impairment associated with PTSD .The following seven functional domains are assessed using sub-scales self-care, education, parenting, friendships and socializing, work, romantic relationships, and family connections. High content validity, the avoidance of confounding PTSD symptoms with associated impairment, and the lack of respondent attributions on the etiology of impairment are the main features of the IPF. By adding together all completed items (adjusting for reverse-coded items), dividing the total by the highest domain scale score that can be obtained for the items included, and multiplying the result by 100, each domain scale is given an independent score. Every domain scale produces a score between 0 and 100, where higher scores correspond to more disability.

Cut point score=

11-30=mild impairment

31-50= moderate impairment

51-80= severe impairment

81-100= extreme impairment

The IPF level items reliability score is 0.92 which indicate the reliability of the scale

Reliability Statistics

Psychosocial Consequence of PTSD

Cronbach's Alpha	N of Items
.915	80

Table 1.2

Both scales are translated from English to Amharic by language experts and rechecked by a mental health professional to make sure if any context of the question is changed and has taken all the proper procedures needed.

3.7 Data Collection Procedures

The police Special Forces fill out the questionnaires after obtaining each sample's informed consent. Three volunteer nurses has read the measurement tools to individuals who couldn't read, and the data collector noted the respondents' responses as they were provided.

3.8 Data Quality Control

An independent person translated the questionnaire from English to Amharic language spoken, and then back to English to ensure consistency and readability. A pilot study was done on 32 soldiers, or 5% of the total number staying at the Weyra Treatment and Rehabilitation Center, to assess the questionnaires' clarity and reliability and the tool was found to be clear and reliable. Prior to the start of the data collection period, two bachelor science psychiatric nurse supervisors and four bachelor science nurses who collected data were hired. The respondents received a detailed explanation of the research's goal. The investigator evaluated every completed questionnaire on a daily basis, continuous supervision, training provided by the data collectors one day before data collection, and other measures ensured the quality of the data.

3.9 Eligibility Criteria

Inclusion criteria-All police Special Forces who were admitted at surgical and psychiatry ward in 2023 and who were able to cooperate and give their consent for answering the questionnaire are included in the study.

Exclusion criteria – the study excluded patients who were unable to provide their consent, those who were not mentally stable are excluded from the study.

Police men who retired or admitted prior 2023.

Patients with PTSD who have been diagnosed with the disorder before they joined police force.

3.10 Data Analysis

Coding and editing are completed prior to data entry, and descriptive analysis is performed using the most recent version of SPSS.

The completeness of the data was verified before entering data and exporting it to the Statistical program for social science.

In the study, dependent and independent variables were described using proportions, frequency, and percentage. There were tables, graphs, and charts used to display the outcome.

To determine the association between PTSD and impairment in psychosocial functioning, correlation and regression is computed.

The treatment options available at the hospital is discussed using interview questions and interpreting and analyzing the answers was done by the researchers understanding and guiding of different literatures reviewed. The interview was with the doctors and nurses at the surgical and psychiatry wards of police hospital whom are responsible in treating patients with PTSD and

related mental health disorders. The question and answer was first recorded and it is written word by word as a transcript. Then for convenience of the reader and for better understanding the researcher has thematized the all interview and tried to illustrate the all concept in an organized way.

3.11 Ethical Consideration

After receiving letter of support from the School of Psychology , Addis Ababa University; Police Hospital is asked for consent for the study.

The researcher provided the letter of cooperation from the university and also gave the copy of the proposal for the medical director of the hospital to get the consent of the study.

Surgical ward and psychiatry ward are given a letter signed by the medical director of the hospital for cooperation of the study and to provide the researcher with information needed.

During the course of the study written informed consent was obtained from each participant.

Additionally confidentiality was guaranteed and the study populations specific identity and privacy was protected . The names of the respondents is not revealed .

The health care providers who were interviewed about the treatment being provided for PTSD are asked for consent by describing the purpose and the relevance of the research.

CHAPTER FOUR

Results

From the chosen 260 participants, a total of 215 patients were able to complete the questionnaire with a 95.3% response rate. The mean age of the respondents were 30.52 with a standard deviation of 5.8 , 65.6% (141) were male and 34.4%(74) were female . Similarly 65 % have attended primary education and 35% of them attended higher education.

From this population 20.9% (45) of them were single, 24.7%(53) of them were married and 54%(116) of them were separated or widowed whom 27%(58) of them have no children and 73 % of them have one or more children.

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age	215	18	41	30.52	5.804
Sex	215	1	2	1.34	.476
Educational status of the participant	215	1	2	1.34	.476
Marital Status of the participant	214	1	3	2.33	.803
Number of Children	215	0	8	1.96	1.649
Valid N (list wise)	214				

Table 1.3

According to the PCL-M , the result of the study indicates a mean total score of 36.69 with a standard deviation of total score ranging from 17 to 85. This indicate that from the total of 215 participants 36.69 % of them fulfill the criteria of PTSD diagnosis based on the cut point of the PCL-M scoring .

Psychosocial Consequence of PTSD

According to the Inventory of Psychosocial Functioning (IPF), the patient's psychosocial status was assessed by the subscales romantic relationships, family, work, friendships and socializing, parenting, education and self-care. PTSD level of the participants has impacted their family life, self - care and friendship & socializing. The impairment is found to be mild with a mean score of 19.9, 24.16, 24.17 respectively. Their romantic relationship and parenting impairment is moderate with a mean score of 39.25, 35.44 respectively and the education and work life impairment is found to be severe with a mean score of (55.33, 72.59 respectively).

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Romantic relationship new score	214	12	54	39.25	10.181
Family new score	215	10	35	19.91	2.887
Friendship and socializing new score	213	12	41	24.17	2.395
Parenting new score	157	16	54	35.44	8.247
Education new score	213	16	74	55.33	17.882
Self-care new score	214	8	40	24.16	2.733
Work total	215	30	100	72.59	19.607
Valid N	154				

Table 1.4

Correlation

A Pearson correlation coefficient was computed to assess the relationship between PTSD and psychosocial functioning. There was a negative correlation between the two variables with a coefficient of -0.877 for the romantic subscale, -0.822 for the parenting subscale, -0.850 for the education subscale and -0.901 for the work subscale with a corresponding p-value of 0.00. According to the study, the presence of PTSD is negatively proportional indicating psychosocial functioning decreases as PTSD level increase. As for the subscales of family, friendship and socializing, and self- care no significant correlation is found with PTSD.

Regression

This study has found that PTSD has a statistically significant association with romantic relationship and work life productivity of the police forces from the subscales of the inventory of psychosocial functioning based on the finding from the linear regression computed.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.919[a]	.844	.837	8.838

Table 1.5

a. Predictors: (Constant), Work total, self -care new score, family new score, parenting new score, friendship and socializing new score, romantic relationship new score, education new score.

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	61910.264	7	8844.323	113.224	.000[b]
	Residual	11404.574	146	78.114		
	Total	73314.838	153			

Table 1.6

a. Dependent Variable: PTSD level score new

b. Predictors: (Constant), Work total, self - care new score, family new score, parenting new score, friendship and socializing new score, romantic relationship new score, education new score

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	79.594	9.251		8.604	.000

	Romantic relationship new score	-1.134	.228	-.528	-4.982	.000
	Family new score	.398	.598	.047	.666	.507
	Friendship and socializing new score	-.107	.970	-.012	-.110	.912
	Parenting new score	-.136	.331	-.052	-.410	.682
	Education new score	.031	.189	.026	.164	.870
	Self-care new score	1.175	.698	.143	1.683	.095
	Work total	-.406	.180	-.365	-2.251	.026

Table 1.7

This outcome indicates PTSD has negatively impacted the life of police forces romantic relationship and work life productivity and the association exists.

As for the other subscales of psychosocial functioning the association is not found to be strong or doesn't have an association at all in some of them in this specific study population which might be related with different influencing factors the researcher didn't address in this study.

Treatment option

Results on the treatment options available at the hospital were measured qualitatively by interviewing the surgical ward facilitator doctor and the head nurse of the ward as well as the psychiatry ward facilitator doctor and head psychiatry nurse. They clearly illustrated that the treatment options vary with the cases as they treat from mild to severe PTSD.

Psychosocial Consequence of PTSD

The surgical ward head doctor illustrated that <<patients with mild to moderate PTSD symptoms are given a psychotherapy which is commonly based on trauma focused CBT>>. Trauma Focused CBT is a short term structured therapy technique which provide 8-25 sessions.

These therapy sessions are provided by the psychiatry nurses and psychologists who are responsible in the ward and get a consultation from a psychiatric doctor and a clinical psychologist when needed as the doctor tried to explain. The head nurse also added that<< the surgical ward patients often follow up their sessions in the outpatient after being discharged from the hospital. Most patients stay in the ward for 48-72 hours after surgical treatment is given because there is a shortage of beds at the hospital. For this reason they give the patients weekly appointments to follow up their progress and continue the therapy sessions but some patients might not come back for many reasons one being a physical disability and the other not understanding the need for taking the therapy sessions. This also makes the tracing back of patients difficult because the patients might change their phone number, they might be out of town, or doesn't have the potential to afford transportation to come back every week or two weeks for that matter >>. So this kind of reasons are mentioned as a contributing factor in resulting increase on the number of untreated PTSD cases and in resulting severe mental health disturbances to the patients. But in severe cases of PTSD the patients will be transferred to psychiatry ward and they follow up their CBT sessions and may also be put on other treatment options like medications as the researcher articulated from the answers given.

The head psychiatry doctor said << they commonly prescribe the SSRI drugs like Fluoxetine which is a drug used to treat the depressive symptoms which came along with PTSD and it is given with an initial dose of 10mg for a week then increased to 20mg per day orally after a week the maximum dosage being 80mg per day>>.

<<The other drug prescribed commonly at the hospital is sertraline which is also an antidepressant which works by increasing the level of mood enhancing chemicals (serotonin) in the brain. This drug is given 25mg per day then increased to 50mg per day as a therapeutic dose after a week.

Drug adverse reactions are assesses for 48 hours and any dose adjustment and change of medication is consulted to the senior doctors when needed.

This drugs are effective in stabilizing the patients and in adjusting their mood. After stabilizing the patients the doctors will link the patients with the psychiatry nurse, the clinical psychologist or the counseling psychologist to start on non-medication therapy techniques in addition to the treatment they started.>>

The psychiatry nurse said<< Trauma focused CBT (cognitive behavioral therapy) is commonly given therapy technique which they give for each individual patient and also is suitable to be given as a group therapy. >>

The nurse described that <<patients at the ward are given this therapy technique one or two time a week for an hour at private rooms which are assigned for this purpose and they include assignments like journaling, reading, experimenting and dream analysis to keep the patients interested with the therapy as the nurses explained. It is believed to give the patients a chance to explore their feelings and behaviors and make them realize the problems and dysfunctions they are facing.>>

They also said <<group therapy helps in making the patients understand their cases, make them feel like they are not alone in this, make them feel seen and heard, make them to be more open about their feelings and help them in socializing and building trust in the treatment process. >>

So the inpatient treatment is more suitable and effective to deliver and to follow up each patient

carefully for the health care providers as well as the patients compared to the outpatient treatments as the researcher understands from the above information gathered from the doctors and nurses.

All the health care providers mentioned that there is low awareness about PTSD and its consequences when it comes to the police forces because of the believe they develop in being resilient as their work behavior and ethics . So it makes it difficult for them to believe they even have this disorder and start on the treatment options available. The police forces are trained in numbing their feelings and to get back in the field as soon as possible after an injury or after an incident so they make it challenging for the psychologists in making them believe that they need the treatments. They recommended us in giving a training on the basics of PTSD for the managerial areas of the police hospital as well as the police forces in general so that they can understand the occurrence of PTSD and to make them aware of the symptoms and consequences so that they can seek help in time.

As a gap they also mentioned that training opportunities are not available at the hospital and since taking them as an individual is not cost effective for the healthcare providers updated treatment options and psychotherapy techniques are not being practiced and updated information’s are being missed at the hospital and that makes the effectiveness of the treatment more time consuming and outdated. But consultation of cases and case presentations which are prepared by the health care provider team gives them some informal updated information and sharing ideas and experiences help in tackling different difficulties in the work space.

CHAPTER FIVE

Discussion

The results of the PCL-M of this research shows that the police community in general could be vulnerable to many trauma and related experiences which may cause them to be prone for many psychological and social functioning impairments .

According to the DSM IV criteria, the study's findings indicate that from a total of 215 participants 36.69% of the participants or 78.8 of them tested positive for PTSD. This result can relate with a research conducted in the United States including 60,000 police officers and veterans of Iraq and Afghanistan. The study found that 13.5% of deployed and non-deployed veterans tested positive for PTSD. Up to 500,000 American soldiers who fought in these conflicts throughout the previous 13 years have been identified as having PTSD as research done by Koenen ,(2017) indicates.

The above study provides a comparable understanding to studies conducted in the United Kingdom, which found that most people who had gone through a traumatic, non-morally harmful occurrence reported feeling threatened or that they were disposable. Many talked about their ongoing struggles and their constant worries that the world is extremely hazardous. They also talked about how difficult it is for them to trust others or form connections because of their deep-seated worries other people may be a threat.

Based of victoria Williamsons ,(2020) study fear-based cognition and worries about oneself and surrounding were reported by veterans and police special forces who faced threats to their lives .It also demonstrates the same psychological effects as the study conducted in Canada by Ghaffarzadegan (2016),which found that even after being removed to a safe environment, people with PTSD continue to experience the psychological effects of trauma, such as reliving

symptoms, avoiding similar stimuli, having negative thoughts and moods, and having increased physical arousal.

The numerous epidemiological studies that have offered data on the prevalence of PTSD, the connection between specific traumatic experiences and the development of PTSD, demographic correlates, and PTSD and other disorder co-morbidity are the other finding that is found to be comparable with the current findings. Perhaps the biggest and most well-known of those studies was the US National Co-morbidity Survey (NCS), conducted by Kessler and colleagues, in (1995) which revealed a lifetime prevalence of 7.8% for PTSD in the whole .

Similar to this research, another study by Calhoun,(2002) demonstrates the societal impact of PTSD on law enforcement personnel. It also demonstrates the serious and pervasive negative effects of PTSD on marital adjustment, overall family functioning, and the mental health of partners and children. These unfavorable outcomes include problems including strained caregiver relationships, family violence, divorce, and degraded parenting which also connects to the other study done by Lambert,(2012) demonstrating the social and emotional difficulties PTSD sufferers have and how they affect relationships, which were previously exclusively investigated through self-report questionnaires.

Another noteworthy discovery was that three out of ten (3/10) war veterans were found to be susceptible to PTSD, according to studies conducted in Nigeria by Abel (2018). But over half (53%) of individuals who met the criteria for serious depression or PTSD at the time had visited a doctor or other mental health professional during the preceding year. In 2008, Tanielian came up with better results still demonstrating the same link between PTSD and law enforcement personnel as the above study does.

Psychosocial Consequence of PTSD

Similar effects of PTSD on police officers are also demonstrated by a South African researcher I.L. McCann,(1990), which found that police officers who often use dissociation as a coping strategy following stressful incidents had a higher risk of developing chronic PTSD. Police officers are also at a very high risk of acquiring delayed-onset PTSD, which is characterized by anxiety and despair without any connection to the instances on the list. Rather, they are caused (or rendered worse) by situations, events, and circumstances that have evolved later.

Comparably, a prior study carried out in Ethiopia by Amare (2019), found that 16% of Ethiopian military members suffered from PTSD. Another recent study done by Assasahig (2020), at Bahirdar University found that 21.9% (95% CI: 18.6, 25.2) of the 612 veterans in the study had post-traumatic stress disorder (PTSD). Even if the results varied in terms of percentile and quantity, they nonetheless relate to the idea that PTSD is prevalent in law enforcement community and that it needs a proper concern and emphasis.

CHAPTER SIX

Conclusion, Limitation and Recommendations

6. 1 Conclusion

According to the study PTSD is shown to be common for police officers and is shown to see that it affects the psychological and social life of the police officers as well as their family .The study illustrates that the impact of PTSD is clearly seen on the patients by manifesting as low self-care interest, lack of interest to their marriage, work life, parenting, educational participation as well as their overall psychological and social wellbeing and functioning. The findings also showed the relation between PTSD and psychosocial functioning to be directly related in impacting the life of the law enforcement forces as well as their families.

6.2 Limitations

The study doesn't include more factors associated with PTSD other than psychosocial functioning impairment which might have shown more comprehension about the relatable causes and contributing factors.

The researcher was not able to further investigate the treatment options effectiveness and outcomes other than gathering information from the healthcare providers.

6.3 Recommendation

Based on the study the researcher wants to recommend the following ;

Law enforcement force authorities to prepare veterans and police men for the traumatic incidents they are going to face at work and should make them be aware of PTSD and its symptoms so that they get clear understanding about their case.

Healthcare professionals should also prepare safe and helping environment for law enforcement forces and make them feel seen and heard and provide a better and well organized treatment options.

It is critical to give updated trainings for health care professional on the treatments of PTSD and new psychological approaches as other countries are providing a well- articulated and well organized treatment options and therapy techniques.

A research should be done ones in a while at a hospital settings to get precise data on the prevalence of PTSD especially related with Law Enforcement Forces since there are few studies on the topic in our country.

Researchers would get a better out come about PTSD if they can do a study on law enforcement forces in a well budgeted manner and using more man power. Also it would be better to do a study on other institutes which are specific for veterans and police men in different regional settings.

As for our countries hospital setting it is better if we can have full information about our patients as well as their contacts in a computerized and standardized manner including their place of birth, living address including house number and sub city, their contacts phone number and home address, and also try to link them with a nearby health center or hospital if they couldn't come back to medication refill or other therapeutic treatment options so that it would make it easy to follow up all patients and also to trace back lost patients .

Generally the impacts seen on romantic relationships, family, friendships, parenting of the law enforcement forces can be dealt with the partners and the family members better understanding of the causes and the impacts of PTSD to further help and be the part of the support system for the victim and also to be able to tackle the problem before it gets worse for both sides. The

impacts seen on the work life and low self -care interest of the law enforcement forces can also be minimized as the victims understand the problem beforehand, asking for help when they know they are experiencing this difficulties and also to engage in treatment plans properly ones they are diagnosed with PTSD.

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Annex I participants information sheet

My name is Yemaryamwork Senay . I am a Counseling Psychology Graduate student at Addis Ababa University college of educational and behavioral studies school of psychology . I am here to do my final research for my Master's Degree on the Psychosocial Consequence and Treatment of PTSD on Police Hospital.

The research wanted to understand how the experiences and traumas of the crime incidents has impacted the psychological and social life of the police officers admitted at the hospital and wants to know which treatment options are available and being provided by the hospital.

This will help the researcher as well as the hospital to get better awareness about the extent of the consequences and provide them with better and updated treatment options and strategies.

In order to meet that goal ,your genuine cooperation is going to be well appreciated and we want you to fill out the PTSD checklists and the psycho-social functional inventory to support the study.

Interview is going to be done for Doctors and Nurses as well as other Health Care Providers who provide treatment for the patients who are diagnosed with PTSD.

The research proposal is provided for the hospital medical director & the health care providers for them to better understand the purpose of the study and to get full cooperation from them.

All the information's we collect from you is going to be held private and anonymous .

Annex ll Consent form

I understand the participation is voluntary and that the outcome of the research is going to help me and my colleagues as well

as the facility am admitted to. For that reason am willing to give my honest and true answers for the questions asked.

Participants signature	Code number	Date
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Annex iii questionnaire

Interview questions asked for the treatment options available at Police Hospital

1. What treatment options are available to treat mild and moderate PTSD related with police work trauma ?

2. What are the common psychotherapy techniques used at the hospital ?

3. What medications are prescribed for sever form of PTSD?

4. How much time does the recovery take in both mild to moderate and severe cases ?

5. What are the challenges the hospital face related to treatment availability and effectiveness?

6. Are the health care providers near to trainings and updated treatment options?

7. How do you follow up patients and trace back lost to follow up patients after they are discharged from the Hospital?

PTSD CheckList – Military Version (PCL-M)

Patient's Name: _____ **Date:** _____

SSN:_____ **Service:**_____**Rank:**_____

Instruction to patient: **Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.**

		Frequency:				
No.	**Problem or Complaint:**	**Not at all (1)**	**A little bit (2)**	**Moderately (3)**	**Quite a bit (4)**	**Extremely (5)**
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful military experience?					
2.	Repeated, disturbing *dreams* of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful military experience?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking* about a stressful military experience or avoid *having feelings* related to it?					
7.	Avoid *activities* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest* in things that you used to enjoy?					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying* asleep?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty* concentrating?					
16.	Being "*super alert*" or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Inventory of psycho social functioning(IPF)

Scoring Instructions for the Inventory of Psychosocial Functioning (IPF)

- The IPF yields a mean score for the total scale and mean scores for each of the 7 subscales.
- Items are scored on a 0 (*never*) to 6 (*always*) scale, with higher scores indicating greater functional impairment.
- For each subscale in which 80% or more of the items are answered, we compute a score by summing all scored items (correcting for reverse coded items), dividing by the highest possible score for the items answered (i.e., # of items answered multiplied by 6), and multiplying by 100. Each subscale yields a score on a 0-100 range.
  - Subscales (underlined items are reversed in scoring)
    - Romantic relationships: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11.
    - Family: 12, 13, 14, 15, 16, 17, 18.
    - Work: 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39.
    - Friendships and socializing: 40, 41, 42, 43, 44, 45, 46, 47.
    - Parenting: 48, 49, 50, 51, 52, 53, 54, 55, 56, 57.
    - Education: 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72.
    - Self Care: 73, 74, 75, 76, 77, 78, 79, 80.
- Grand mean score: mean of all completed IPF scales. As participants may skip certain subscales that do not apply to them, the total sum of all completed IPF scale scores is divided by the actual number of subscales completed by the participant.

IPF

Instructions: Answer the questions at the beginning of each section to determine which sections apply to you. Then, within the sections that apply to you, read each statement and rate how often you have acted like that **over the past 30 days**. Circle only one number for each statement.

Romantic Relationship with Spouse or Partner

Have you been in a romantic relationship with a spouse or partner in the past 30 days?

☐ Yes ☐ No

If you have not been in a romantic relationship with a spouse or partner during the past 30 days skip this section and continue with the next section. Otherwise, please answer the following questions.

Over the past 30 days:	**Never**	**Sometimes**					**Always**
1. When necessary, I cooperated on tasks with my spouse or partner.	0	1	2	3	4	5	6
2. I shared household chores or duties with my spouse or partner.	0	1	2	3	4	5	6
3. I had trouble sharing thoughts or feelings with my spouse or partner.	0	1	2	3	4	5	6
4. I showed interest in my spouse or partner's activities.	0	1	2	3	4	5	6
5. I had trouble settling arguments or disagreements with my spouse or partner.	0	1	2	3	4	5	6
6. I was patient with my spouse or partner.	0	1	2	3	4	5	6
7. I had trouble giving emotional support to my spouse or partner.	0	1	2	3	4	5	6
8. I was affectionate with my spouse or partner.	0	1	2	3	4	5	6
9. My partner or spouse and I did activities that brought us closer together.	0	1	2	3	4	5	6
10. I was interested in sexual activity with my spouse or partner.	0	1	2	3	4	5	6
11. I had trouble becoming sexually aroused with my spouse or partner.	0	1	2	3	4	5	6

Family

In this section, family refers to all relatives other than your spouse/partner or children (for example, parents, brothers, sisters, grandparents, etc). Do not answer these questions in reference to your spouse/partner or children.

Have you been in contact with family members (parents, brothers, sisters, grandparents, etc.) in the past 30 days?

☐ Yes ☐ No

If you have not been in contact with family during the past 30 days skip this section and continue with the next section. Otherwise, please answer the following questions.

Over the past 30 days:	Never	Sometimes					Always
12. I stayed in touch with family members (e.g. phone calls, e-mails, texts).	0	1	2	3	4	5	6
13. My family and I did activities that brought us closer together.	0	1	2	3	4	5	6
14. I was affectionate with my family members.	0	1	2	3	4	5	6
15. I had trouble being patient with family members.	0	1	2	3	4	5	6
16. I had trouble communicating thoughts or feelings to family members.	0	1	2	3	4	5	6
17. I had trouble giving emotional support to family members.	0	1	2	3	4	5	6
18. I had trouble settling arguments or disagreements with family members.	0	1	2	3	4	5	6

Work (including home-based work)

Have you worked (either for pay or as a volunteer) in the past 30 days?

☐ Yes ☐ No

If you have not worked either for pay or as a volunteer during the past 30 days skip this section and continue with the next section. Otherwise, please answer the following questions.

Over the past 30 days:	Never	Sometimes					Always
19. I had trouble showing up on time for work.	0	1	2	3	4	5	6
20. I reported for work when I was supposed to.	0	1	2	3	4	5	6
21. I got along well with others at work.	0	1	2	3	4	5	6
22. I stayed interested in my work.	0	1	2	3	4	5	6
23. I had trouble being patient with others at work.	0	1	2	3	4	5	6
24. I performed my job to the best of my ability.	0	1	2	3	4	5	6
25. I completed my work on time.	0	1	2	3	4	5	6
26. I had trouble settling arguments or disagreements with others at work.	0	1	2	3	4	5	6
27. I solved problems or challenges at work without much difficu y.	0	1	2	3	4	5	6
28. I maintained a reasonable balance between work and home.	0	1	2	3	4	5	6
29. I was able to perform my work duties without needing any extra help.	0	1	2	3	4	5	6
30. When necessary, I cooperated on work-related tasks with others.	0	1	2	3	4	5	6
31. I showed my skills and knowledge of the job.	0	1	2	3	4	5	6
32. I showed others at work that they could depend on me.	0	1	2	3	4	5	6
33. I came up with ideas and put them into action at work.	0	1	2	3	4	5	6
34. I took responsibility for my work.	0	1	2	3	4	5	6
35. I prioritized work-related tasks appropriately.	0	1	2	3	4	5	6
36. I worked hard every day.	0	1	2	3	4	5	6
37. I made sure that the work environment was pleasant for others.	0	1	2	3	4	5	6
38. I had trouble expressing my ideas, thoughts or feelings to others at work.	0	1	2	3	4	5	6
39. I had trouble being supportive of others at work.	0	1	2	3	4	5	6

Friendships and Socializing

Have you been in contact with friends in the past 30 days?

☐ Yes ☐ No

If you have not been in contact with friends during the past 30 days skip this section and continue with the next section. Otherwise, please answer the following questions.

Over the past 30 days:	Never	Sometimes					Always
40. I was willing to meet new people.	0	1	2	3	4	5	6
41. I stayed in touch with friends (returning phone calls, emails, visiting).	0	1	2	3	4	5	6
42. My friends and I did activities that brought us closer together.	0	1	2	3	4	5	6
43. I had trouble being patient with my friends.	0	1	2	3	4	5	6
44. I had trouble settling arguments or disagreements with my friends.	0	1	2	3	4	5	6
45. I had trouble sharing my thoughts or feelings with my friends.	0	1	2	3	4	5	6
46. I had trouble giving emotional support to my friends.	0	1	2	3	4	5	6
47. I showed affection for my friends.	0	1	2	3	4	5	6

Parenting

In this section, children refers to anyone for whom you had parenting responsibilities.

Do you have children with whom you lived or had regular contact during the past 30 days?

☐ Yes ☐ No

If you do not have children with whom you lived or had regular contact during the past 30 days skip this section and continue with the next section. Otherwise, please answer the following questions.

Over the past 30 days:	Never	Sometimes					Always
48. My children were able to depend on me for whatever they needed.	0	1	2	3	4	5	6
49. I was interested in my children's activities	0	1	2	3	4	5	6
50. I had trouble communicating with my children.	0	1	2	3	4	5	6
51. I was affectionate with my children.	0	1	2	3	4	5	6
52. I appropriately shared thoughts or feelings with my children.	0	1	2	3	4	5	6
53. My children and I did activities that brought us closer together.	0	1	2	3	4	5	6
54. I talked with, or taught, my children about important life issues.	0	1	2	3	4	5	6
55. I was a good role model for my children.	0	1	2	3	4	5	6
56. I had trouble giving emotional support to my children.	0	1	2	3	4	5	6
57. I had trouble settling confli ts or disagreements with my children.	0	1	2	3	4	5	6

Education (including distance learning)

Have you been involved in a formal educational experience, either in or outside of the school setting, during the past 30 days?

☐ Yes ☐ No

If you have not been involved in an educational experience during the past 30 days skip this section and continue with the next section. Otherwise, please answer the following questions.

Over the past 30 days:	Never	Sometimes					Always
58. I attended classes regularly.	0	1	2	3	4	5	6
59. I stayed interested in my classes and schoolwork.	0	1	2	3	4	5	6
60. I arrived on time for my classes.	0	1	2	3	4	5	6
61. I had trouble being supportive of my classmates' achievements.	0	1	2	3	4	5	6
62. I turned in assignments late.	0	1	2	3	4	5	6
63. I solved problems and challenges in class without much difficu y.	0	1	2	3	4	5	6
64. I took responsibility for my schoolwork.	0	1	2	3	4	5	6
65. I was patient with my classmates and/or instructors.	0	1	2	3	4	5	6
66. I had trouble settling disagreements or arguments with instructors and/or classmates.	0	1	2	3	4	5	6
67. I had trouble remembering what the instructor said.	0	1	2	3	4	5	6
68. I could easily remember what I read.	0	1	2	3	4	5	6
69. I understood course material.	0	1	2	3	4	5	6
70. When necessary, I cooperated with classmates.	0	1	2	3	4	5	6
71. I got along with classmates and/or instructors.	0	1	2	3	4	5	6
72. I completed my schoolwork to the best of my ability.	0	1	2	3	4	5	6

Self Care

Over the past 30 days:	Never	Sometimes					Always
73. I had trouble keeping up with household chores (for example, cleaning, cooking, yard work, etc).	0	1	2	3	4	5	6
74. I maintained good personal hygiene and grooming (for example, showering, brushing teeth, etc).	0	1	2	3	4	5	6
75. I had trouble managing my medical care (for example, medications, doctors' appointments, physical therapy, etc).	0	1	2	3	4	5	6
76. I ate healthy and nutritious meals.	0	1	2	3	4	5	6
77. I had trouble keeping up with chores outside the house (shopping, appointments, other errands).	0	1	2	3	4	5	6
78. I had trouble managing my finan es.	0	1	2	3	4	5	6
79. I was physically active (for example, walking, exercising, playing sports, gardening, etc).	0	1	2	3	4	5	6
80. I spent time doing activities or hobbies that were fun or relaxing.	0	1	2	3	4	5	6

የድህረ ሰቀቀን የአዕምሮ እክል ማመሳከሪያ - ለመከላከያ ሀይል የተዘጋጀ መጠይቅ

ስም፡_____**ቀን**_____**ገልግሎት**

ዘመን፡_____**ደረጃ፡**_____

መመሪያ፡ ከታች የተዘረዘሩት የመከላከያ ወታደሮች በተጨናነቀ ወታደራዊ ግዳጅ ምክንያት የሚመጡባቸው ችግሮች/ሁኔታዎች ናቸው እያንዳንዱን ጥያቄ በጥንቃቄ ካነበቡ በኃላ በዚህ አንድ ወር ውስጥ ያለዎትን ስሜት የሚገልፀው ሳጥን ላይ የ'x' ምልክቱን ያስቀምጡ

የስነልቦና እና ማህበራዊ መስተጋብር መለኪያ መጠይቅ

መመሪያ፡ በመጀመሪያ እናንተን ሊገልፅ የሚችለውን ክፍል ይምረጡ። በመቀጠል በእያንዳንዱ ክፍል ላይ ያሉትን ጥያቄዎች በጥንቃቄ ካነበቡ በኃላ ባለፉት 30 ቀናት ውስጥ በምን ያህል መጠን ተግባራዊ እንዳደረጉ መለኪያ ያስቀምጡ።

የፍቅር ግንኙነት ጋር የተያያዘ

ባለፉት 30 ቀናት ውስጥ የፍቅር ግንኙነት ውስጥ ነዎት?

☐**ነዎ** ☐**ላይ**

ካለዎት እባክዎ የሚከተሉትን ጥያቄዎች ይመልሱ፤ ከሌለዎት ወደሚቀጥለው መጠይቅ ይለፉ

ባለፉት 30 ቀናት ውስጥ		**በፍፁም**	**አንዳንድ ጊዜ**					**ሁልጊዜ**
ተ ቁ		0	1	2	3	4	5	6
1	እንደአስፈላጊነቱ ከፍቅር አጋሬ ጋር በተለያዩ ስራዎች ላይ አብሬ							

	እሳተፋለሁ							
2	የቤት ውስጥ ስራን እና የተለያዩ ግዴታዎችን ከፍቅር አጋሬ ጋር እጋራለሁ							
3	ስሜቶቼን እና ሀሳቦቼን ከፍቅር አጋሬ ጋር ለመጋራት ያዳግተኛል							
4	የፍቅር አጋሬ በሚያከናውነው/በምታከናውነው ስራዎች ላይ ፍላጎት አሳያለሁ							
5	ከፍቅር አጋሬ ጋር የሚኖሩ አለመግባባቶችን ለመፍታት/ለማብረድ እቸገራለሁ							
6	ከፍቅር አጋሬ ጋር ትዕግስተኛ ነኝ							
7	ለፍቅር አጋሬ የስሜት ድጋፍ ለማድረግ እቸገራለሁ							
8	ለፍቅር አጋሬ ፍቅሬን እገልፃለሁ/አሳያለሁ							
9	ከፍቅር አጋሬ ጋር ሊያቀራርቡን የሚችሉ ነገሮችን በጋራ							

	እናደርጋለን							
10	ከፍቅር አጋሬ ጋር የግንኙነት ፍላጎት አለኝ							
11	ከፍቅር አጋሬ ጋር ግንኙነት ለማድረግ ያለኝን ፍላጎት ለማምጣት እቸገራለሁ							
ቤተሰብ								
ባለፉት 30 ቀናት ውስጥ ከቤተሰብዎ ጋር ግንኙነት ነበሮት? ☐ **አዎ** ☐ **አይ** **ከሌለዎት ወደሚቀጥለው ክፍል ይለፉ**								
12	ከቤተሰቦቼ ጋር ያለኝን ግንኙነት አላቋረጥኩም (በድምፅ በስልክ፤ በመልዕክት							
13	ከቤተስቦቼ ጋር ይበልጥ ሊያቀራርቡ የሚችሉ ነገሮችን በጋራ እናደርጋለን							
14	ከቤተሰቦቼ ጋር ፍቅር እንገላለፃለን/እናሳያለን							
15	ከቤተሰቦቼ ጋር ትዕግስተኛ							

	መሆን ይከብደኛል							
16	ለቤተሰቦቼ ስሜቴን እና ሀሳቤን ለማጋራት እቸገራለሁ							
17	ለቤተሰቡ አባል የስሜት ድጋፍ ለመስጠት እቸገራለሁ							
18	ከቤተሰብ ጋር የሚፈጠሩ አለመግባባቶችን ለመፍታት እቸገራለሁ							
ከስራ ጋር የተያያዘ **ባለፉት 30 ቀናት ውስጥ የሰሩት ስራ አለ (በክፍያ/ያለክፍያ)?** **አዎ አይ** **ከሌለ ወደሚቀጥለው ክፍል ይለፉ**								
19	ስራ በሰዓት መገኘት እቸገራለሁ							
20	ለስራ በተጠራሁበት ጊዜ ምላሽ ሰጥቻለሁ							
21	ከስራ ባልደረቦቼ ጋር እግባባለሁ							
22	ለስራዬ ያለኝ ፍላጎት አልቀነሰም							
23	ስራ ቦታ ካሉት ጋር ትዕግስተኛ መሆን እቸገራለሁ							

24	ስራዬን በሙሉ ብቃት አከናውናለሁ							
25	ስራዬን በተገቢው ሰዓት አጠናቅቃለሁ							
26	ከስራ ባልደረቦቼ ጋር የሚፈጠሩ አለመግባባቶችን ለመፍታት እቸገራለሁ							
27	ስራ ላይ የሚፈጠሩ ችግሮችን እና ፈተናዎችን ብዙ ሳልቸገር መፍታት እችላለሁ							
28	ስራ እና የቤት ህይወቴን በተመጣጠኝ መልኩ አስኬዳለሁ							
29	የስራ ግዴታዎቼን ያለምንም ተጨማሪ እርዳታ ለማከናወን እችላለሁ							
30	እንደአስፈላጊነቱ ከስራ ጋር በተያያዙ ጉዳዮች ከሌሎች ጋር እተባበራለሁ							
31	በስራው ላይ ያለኝን ችሎታ እና							

	ዕውቀት በተገቢው አሳይቻለሁ							
32	በስራዬ ላይ ሌሎች እንዲደገፉብኝ/እንዲተማመኑብኝ አድርጌያለሁ							
33	ከስራ ጋር የተያያዙ ጉዳዮችን ቅድሚያ እሰጣለሁ							
34	ለስራዬ ሃላፊነትን እወስዳለሁ							
35	የስራ ሃሳቦችን አመጣለሁ፤ስራ ላይ አውላቸዋለሁ							
36	በየዕለቱ በጥንካሬ እሰራለሁ							
37	የስራ ቦታው ለሁሉም ምቹ እንዲሆን አደርጋለሁ							
38	ስራ ላይ የራሴን ሃሳብ፤ስሜት ለመግለፅ እቸገራለሁ							
39	ስራ ላይ ሌሎችን ለመደገፍ እቸገራለሁ							
ጓደኝነት እና ማህበራዊ ኑሮ **ባለፉት 30 ቀናት ከጓደኛዎት ጋር ተገናኝተው ነበር?** ☐ **አዎ** ☐ **አይ** **ካልተገናኙ ወደሚቀጥለው ክፍል ይለፉ**								

40	አዳዲስ ሰዎችን ለመተዋወቅ ፈቃደኛ ነኝ							
41	ከጓደኞቼ ጋር የነበረኝን ግንኙነት አላቋረጥኩም (ስልክ ጥሪ እመልስ ነበር፤ በአካል አገኛቸው ነበር)							
42	ከጓደኞቼ ጋር ይበልጥ ሊያቀራርቡን የሚችሉ ነገሮችን አብረን እናከናውናለን							
43	ከጓደኞቼ ጋር ትዕግስተኛ መሆን እቸገራለሁ							
44	ከጓደኞቼ ጋር የሚፈጠሩ አለመግባባቶችን ለመፍታት እቸገራለሁ							
45	ለጓደኞቼ ስሜቴን እና ሃሳቤን ለማጋራት እቸገራለሁ							
46	ለጓደኞቼ የስሜት ድጋፍ ለማድረግ እቸገራለሁ							
47	ለጓደኞቼ ፍቅርን አሳያለሁ							
ወላጅነት/አሳዳጊነት								

ባለፉት 30 ቀናት ውስጥ አብረውት የኖሩት/በተደጋጋሚ ያገኙት ልጅ አለዎት? **አዎ አይ** **ከሌለዎት ወደሚቀጥለው ክፍል ይለፉ**								
48	ልጆቼ የሚፈልጓቸው ነገሮች ሁሉ በእኔ ይተማመኑ ነበር							
49	ልጆቼ በሚያደርጓቸው ድርጊቶች እና እንቅስቃሴዎች ላይ ፍላጎት አሳያለሁ							
50	ከልጆቼ ጋር ለመነጋገር እቸገራለሁ							
51	ለልጆቼ ፍቅር አሳያለሁ							
52	ከልጆቼ ጋር ስሜቴን እና ሀሳቤን በአግባቡ እጋራለሁ							
53	ከልጆቼ ጋር ሊያቀራርቡን የሚችሉ ነገሮችን በጋራ እናደርጋለን							
54	ከልጆቼ ጋር ስለ ህይወት እና አንዳንድ ጠቃሚ ጉዳዮች ላይ እናወራለን/እንማማራለን							
55	ለልጆቼ ጥሩ አርዓያ ነኝ							

56	ለልጆቼ የስሜት ድጋፍ ለማድረግ እቸገራለሁ							
57	ከልጆቼ ጋር የሚፈጠሩ አለመግባባቶችን ለመፍታት እቸገራለሁ							
የትምህርት ህይወት **ባለፉት 30 ቀናት ውስጥ በመደኛ ወይም በርቀት ትምህርት ወስደዋል ወይ?** ☐ **አዎ** **አይ** **ካልወሰዱ ወደሚቀጥለው ክፍል ይለፉ**								
58	ትምህርቴን ተከታትያለሁ							
59	በትምህርቴ እና ከትምህርት ጋር የተያያዙ ስራዎች ላይ ፍላጎት አሳያለሁ							
60	ትምህርቴ ላይ በሰዓቴ እገኛለሁ							
61	የክፍል ጓደኞቼ በሚያገኟቸው ጥሩ ውጤቶች ላይ ድጋፌን/ደስታዬን አሳያለሁ							
62	የትምህርት ቤት _____ በጊዜው አስረክባለሁ							

63	ክፍል ውስጥ የሚያጋጥሙኝን ችግሮች እና ፈተናዎች ያለብዙ ችግር እፈታለሁ							
64	ለትምህርት ቤት ስራዬ ሃላፊነት እወስዳለሁ							
65	ለክፍል አጋሮቼ እና አስተማሪዎቼ ትዕግስትን አሳያለሁ							
66	ከክፍል ጓደኞቼ እና አስተማሪዎቼ ጋር የሚፈጠሩ አለመግባባቶችን ለመፍታት እቸገራለሁ							
67	አስተማሪ ያስተማረኝን ለማስታወስ እቸገራለሁ							
68	ያነበብኩትን በቀላሉ ለማስታወስ እችላለሁ							
69	የምማርባቸውን መፃህፍት እረዳቸዋለሁ							
70	እንደአስፈላጊነቱ ከክፍል ጓደኞቼ ጋር በመተባበር እሰራለሁ							
71	ከክፍል ጓደኞቼ እና							

	ከአስተማሪዎቼ ጋር እግባባለሁ							
72	የትምህርት ቤት ስራዎቼን በሙሉ አቅሜ አጠናቅቃለሁ							
ለራስ የሚሰጥ እንክብካቤ **ባለፉት 30 ቀናት ውስጥ ለራስዎ የሰጡት እንክብካቤ አለ?** **አዎ አይ**								
73	ቤት ውስጥ የሚሰሩ ነገሮችን ለማከናወን እቸገራለሁ። ለምሳሌ ቤት ማፅዳት፤ ማብሰል፤የግቢ ውስጥ ስራዎችን መስራት							
74	ራሴን እና የአካሌን ንፅህና በሚገባ እጠብቃለሁ (ገላ መታጠብ፤ ጥርስ መቦረሽ.)							
75	ጤናዬን ለመከታተል እቸገራለሁ (የሆስፒታል ቀጠሮ ላይ መገኘት፤ መድሃኒት በአግባቡ መውሰድ፤ የሰውነት እንቅስቃሴ ማድረግ)							
76	ጤናማ እና በንጥረነገር የበለፀጉ ምግቦችን እመገባለሁ							

77	ከቤት ውጪ የሚደረጉ ነገሮችን ለማከናወን እቸገራለሁ (ዕቃ መግዛት፤ ቀጠሮ)							
78	ገቢዎች በአግባቡ ለመጠቀም እቸገራለሁ							
79	የአካል እንቅስቃሴ ላይ ጎበዝ ነኝ (የእግር ጉዞ፤ስፖርት፤አትክልት መኮትኮት)							
80	እኔን ሊያዝናኑ እና ሊያስደስቱ የሚችሉ ነገሮችን በማድረግ ጊዜዬን አሳልፋለሁ							