

Depression, Anxiety, and Stress among Internally Displaced People (IDPs) from
Somali and Oromia Regions Border in Genda Koticha, Dukem

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COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES
SCHOOL OF PSYCHOLOGY

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Declaration

Depression, Anxiety, and Stress among Internally Displaced People (IDPs) from Somali and Oromia Regions Border in Genda Koticha, Dukem.

I, the undersigned declared that this is my original work and has not been presented for a degree in any other University and that all sources of materials used for the thesis have been duly acknowledged. Brief quotation from this thesis is allowable without special permission provided that accurate acknowledgement of source is made.

Dabale Eliyas

Signature: _____

Date: _____

This thesis has been submitted for examination with my approval as a supervisor

Seleshi Zeleke (PhD)

Signature: _____

Date: _____

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Abstract

The main purpose of this study was to assess the incidence of depression, anxiety and stress among internally displaced people from Somali and Oromia regions border. To achieve this purpose the cross-sectional survey designs were used. Sample of 228 (114 males and 114 females) youths were selected through purposive sampling technique as research participant. The measures used for data collection were Harvard Trauma Questionnaire-Cambodian Version (14 items) and DASS 42 items. Descriptive Statistics (mean, frequency and percentages) and inferential statistics (T-Test, One Way ANOVA, and Pearson Correlation) were used to analyze the data. Tables, frequencies, and percentages were used to analyze trauma events and incidence of depression, anxiety and stress. Independent Samples T-test and One Way ANOVA were used to examine sex and marital statuses difference in depression, anxiety and stress scores of internally displaced people. In addition, Pearson Correlation was used to examine relationship between depression, anxiety and stress scores of internally displaced people. Thus, the findings of the present study revealed that the incidence of depression(89.9%) and anxiety(93.4%) were high among internally displaced youths. The T- Test and One Way ANOVA results showed that there were no statistically significant differences in depression, anxiety, and stress scores neither between males and females, nor between those who have married, unmarried and widowed. Moreover, the Pearson Correlation result showed positive correlation between the depression, anxiety and stress scores of respondents. It was concluded that there were high incidence of anxiety and depression among internally displaced youths who were exposed to different trauma events at the time of displacement.

Keywords: (Trauma Events, Depression, Anxiety, Stress)

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ABBREVIATIONS AND ACRONYMS

APA	American Psychological Association
CPA	Canadian Psychiatric Association
DASS	Depression, Anxiety, Stress Scale
DSM	Diagnosis and Statistical Manual of Mental Disorder
GRID	Global Report on Internal Displacement
HTQ-R-CV	Harvard Trauma Questionnaire Revised Cambodian Version
IDMC	Internal Displacement Monitoring Center
IDP	Internally Displaced People
IDY	Internally Displaced Youths
NICE	National Institute for Health and Care Excellence
NIMH	National Institute of Mental Health
OCHA	Office for Coordination of Humanitarian Affairs
PTSD	Post Traumatic Stress Disorder
UNHCR	United Nations High Commissioner for Refugees
WFMH	World's Federation for Mental Health
WHO	World Health Organization
VCY	Virginia Commission on Youth

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Mental health problems are the most important contributor to the burden of disease and disability worldwide. It is the most leading problems can affect the way people think, feel and behave. WHO (2003) defined mental health as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their.

Worldwide studies have shown the prevalence of mental health problems and their disabling effect at individual and national levels to be quite significant. Common mental health problems such as depression, anxiety disorders, and posttraumatic stress disorder (PTSD) have a definitive impact on any population, may also develop into long-term disorders with accompanying forms of disability, and should be addressed within the context (NICE, 2011).

Depression is a disorder that presented with depressed mood, decreased interest or pleasure in activities, significant change in appetite, weight loss, or weight gain, insomnia or hypersomnia, feelings of restlessness or lethargy, fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think, make decisions or concentrate, and recurrent thoughts of death or attempted suicide (DSM 5, 2013).

Anxiety is a state of uneasiness and apprehension of fear caused by the anticipation of something threatening (Raja, 2017). Stress is a condition or feeling experienced when a person

perceives that demands exceed the personal and social resources the individual is able to mobilize (Bhargava & Trivedi, 2018).

Violent conflicts throughout the world have left millions of people displaced, some within their own country (the internally displaced) and some across international borders (refugees) (Knezevic & Olson, 2014). Forced displacement of civilians within the borders of their country is an all too common result of armed conflict (Richards et al., 2011). The outcomes of different types of violence including domestic violence, war, and community violence were PTSD, depression, general anxiety, aggression symptoms, and internalizing and externalizing symptoms (Buchmüller et al., 2018).

Several reviews have found that people who affected by violence and conflict have higher rates of mental disorders such as depression, post-traumatic stress disorder (PTSD), anxiety disorders. The study conducted by Elbedour et al. (2007) cited in Mohammed et al., 2014 on Palestinian adolescents living in the Gaza Strip, to evaluate and describe the psychological effects of exposure to war-like circumstances. In this study, 68.9% were found as having developed PTSD, 40.0% reported moderate and severe levels of depression, 94.9% were demonstrated severe anxiety levels, and 69.9% demonstrated undesirable coping responses.

On the other hand, despite experiencing different kinds of trauma and stressful life events, most of IDPs function normally. The presence of multiple resilience factors (individual qualities and environmental factors) facilitates their acculturation process, despite their traumatic exposure (Sossou, 2008). The study conducted by Ergun (2008) showed that the overall prevalence of

depression among displaced people were 9.4%. Study conducted by Siriwardhana et al. (2013) showed the prevalence of mental health problems among internally displaced people; depressive disorders (12.4%) anxiety disorders (1.3%), PTSD (2.8%). Other study conducted by Freitag et al. (2012) shown that the prevalence of depressive and anxiety disorders were (9.3%) and (9.2%) among people who affected by conflicts.

Despite, many studies conducted in different areas of the world to reveal the prevalence of mental health problems among displaced population, there is no agreement among the investigators and the results about the magnitude and incidence. Therefore, the area needed a further investigation about the incidence of these disorders and trauma events.

1.2 Statement of the problem

Mental health issue has been an important part of life in various aspects. Depression, anxiety, and stress levels are considered important indicators for mental disorders, and the inability to detect and address these psychological disorders negatively affects individuals (Tehck, et al., 2015). Due to experiencing different kinds of stressful life events, internally displaced people have significant potential to experience psychological problems which can influence their mental health. Such traumatic events include lack of food, water, shelter and medical care, imprisonment, combat and injury, abuse and isolation, torture, murder, death of family member as well as lack of food, water, shelter and medical care (Ajibade et al., 2017).

According to Laksh (2008) and Goldberg (1998) (cited in Al-Shawi (2018)) displacement due to wars and disasters is public health problems as the people with displacement exposed to different kinds of trauma, violence, injuries, making them more vulnerable for large scale of psychological

disorders such as PTSD, depression, anxiety, suicidal ideation. A prevalence of symptoms of all PTSD, depression, anxiety was highest among currently displaced persons (Husain et al., 2011).

The intensity of depression, anxiety and stress varies through areas, population and situations. Housen et al. (2017) on their study of the “Prevalence of anxiety, depression and post-traumatic stress disorder in the Kashmir Valley” reported that high prevalence of depression (90%) and anxiety (71%) among internally displaced people. In addition, Ayazi et al (2014) indicated that the prevalence of anxiety disorders in a post-conflict setting were high (74.8%). Other study conducted by Crepulja et al. (2011) indicated that the prevalence of depression in war survivors displaced people were 24.3%.

One study conducted in Ethiopia also revealed that the prevalence of depression among the population who affected by conflict were 44% (Kinfu, et al., 2014). Likewise, in Feyera et al. (2015) in the study on prevalence of depression among Somali refugees in Melkadida camp, identified 38.3% of depression.

Mental disorders can affect internally displaced peoples in various ways. Exposure to violence or disaster, loss or separation from family members and friends, deterioration in living conditions, the inability to provide for one’s self and family and lack of access to service, can all have immediate and long term consequence on individuals, families and communities, including posttraumatic stress disorders, psychosomatic illness, depression, anxiety and even violence (Haruna et al., 2017).

The present study differs from all aforementioned in filling the gap that has not been filled yet. For example, the local study by Asnakew et al (2019) differs in which its aim was identifying prevalence of post-traumatic stress disorder and associated factors among landslide survivors.

There is also another study by Getnet, Medhin, and Alem (2019) that was aimed to examine relationship between exposure to trauma and psychological symptoms in Eritrean refugees who live in Ethiopia. These all studies conducted in Ethiopia differ from a current study on their aim of the study, area of the study and the population and samples participated on the study, and trauma measures included under this study.

1.3. Research Questions

Based on the statement of the problem, this study aims to answer the following major research questions.

- What are the major trauma events experienced by IDPs?
- What is the incidence of depression, anxiety, and stress among IDPs?
- Are there sex difference in depression, anxiety and stress among IDPs?
- Are there marital status difference in depression, anxiety, and stress among IDPs?
- Is there relationship between depression, anxiety, and stress scores of the IDPs?

1.4 Objectives of the study

The general objective of the study was examining the incidence of depression, anxiety, and stress among internally displaced people in Genda Koticha, Dukem

Under the general objectives, this study specifically aimed to:

- Assess trauma events which are experienced by IDPs at that area.

- Examine sex difference, in depression, anxiety, stress among the IDPs at the study area.
- Examine marital status difference, in depression, anxiety, stress among the IDPs at the study area.
- Determine whether there is relationship between depression, anxiety, and stress scores of the IDPs at that area.

1.5 Significance of the study

Mental disorders should be critical because of its impact on internally displaced people's daily activities. Therefore, examining and presenting the severity of these disorders is very important in order to create healthy, normal, and visionary citizens. The result of this study indicates the incidence of depression anxiety and stress among internally displaced people that would help to provide the advice/suggestion about. Thus, the results of the study will be important for those involved in counseling psychology, social psychology, social work, guidance and counseling service, and education to identify the intensity of depression, anxiety and stress. It gives scientific information and appropriate recommendation for government, NGOs and other concerned bodies to be aware of the severity of psychological problems among internally displaced people, and help to formulate strategies to solve the problem, serve as aspiring board for taking their own action accordingly. Displaced peoples at the study area can get support based on the findings. In general, it can serve as a source of data for mental health professionals, media organizations, and institutions and for future researchers who are interested to study further.

1.6 Delimitation of the study

So far as this investigation was concerned its scope is bound to assess the incidence of depression, anxiety and stress among internally displaced peoples. The researcher selected displaced youth from Somali and Oromia regions border, who were settled before April 30, 2011 (E.C) and living in Dukem, Genda Koticha area. The researcher did this because most of displaced peoples from Somali & Oromia regions borders are living at this area, so the researcher believed that they are easily available to get data wanted to be collected. The study was more delimited to internally displaced youths.

1.7 Limitation of the study

The data were collected based on self-reporting questionnaire. As data were collected by questionnaire in IDP site, the researcher could not apply a detailed interview which helps to gain deeper understanding about traumatic events they experienced. In addition, it lacks on literatures regarding to IDP's most literatures focuses on refugees. Another limitation of this study were; the analysis limits inference about directionality of association between exposure to traumatic and stressful events and incidence of depression, anxiety and stress.

1.8 Operational Definition

Trauma events- threaten injury, death, or the physical integrity of self or others (experienced/witnessed/heard about) as measured by Harvard Trauma Questionnaire- Revised Cambodian Version developed by Harvard Medical School (1998).

Depression-a mood disorder that presents with dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia as measured by DASS scales developed by Lovibond and Lovibond (1995).

Anxiety –a mood disorder which is presented by autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious effect as measured by DASS scales developed by Lovibond and Lovibond (1995).

Stress- difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient as measured by DASS scales developed by Lovibond and Lovibond (1995).

Youths - a person's between ages of 16-33

CHAPTER TWO

Review of Related Literature

Under this chapter different literature are organized. Among these, the following sub-topics like: concepts of Depression, Anxiety, and Stress (with types, risk factors, theories) trauma events experienced by displaced people, displacement and mental health problems, sex and marital status difference in depression, anxiety and stress; the relationship between depression, anxiety and stress were discussed.

2.1 Overview of Depression

The word depression derives from Latin word “depressus” means pressing down, suffering, exhausted, woeful, sorrowful, discouraged, and deaden (Basha & Kaya, 2016). Symptoms of depression include fatigue, irritability, inability to make decisions, somatic problems, lack of interest in day-to-day activities, and suicidal thoughts (Galambos et al., 2004). The common characteristic of the depressive conditions is the presence of sad, empty, or irritable mood, which together with specific cognitive and somatic symptoms, leads to significant distress or impairment in functioning (Maina et al., 2016).

There are some somatic, behavioral and emotional changes related to depression (Stoyanova, 2014). Depending on the number and severity of symptoms, a depressive episode can be classified as mild, moderate, or severe. An individual with a mild depressive episode will have some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely. During a severe depressive episode, on the other hand, it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent (WFMH, 2012).

Depression is a significant contributor to the global burden of disease and affects people in all communities across the world (WFMH, 2012). It has become a major public health problem, demonstrating a constant increase in prevalence (Milanovic et al., 2015). According to WHO (2017), the total number of people living with depression in the world is 322 million. It is more common among females (5.1%) than males (3.6%). Prevalence varies by WHO region, from a low of 2.6% among males in the Western Pacific region to 5.9% among females in the African region.

2.1.1 Types of depression

Depressive disorders are mood disorders that come in different forms. Three of the most common types of depressive disorders from DSM 5 are discussed below. The common feature of all of these disorders is the presence of sad, empty, or irritable mood, poor appetite or alternatively over eating , sleeping disturbances (insomnia or hypersomnia), loss of energy, poor concentration, difficulty in decision making, hopelessness accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differ among them are issues of duration, timing, or presumed etiology.

(I)Major depressive disorder

Major depression is characterized by a combination of symptoms that last for at least two weeks in a row, including sad and/or irritable mood, that interfere with the ability to work, sleep, eat, and enjoy once pleasurable activities, difficulties in sleeping or eating can take the form of excessive or insufficient of either behavior (Bhowmik, 2012).

It is characterized by discrete episodes of at least 2 weeks' duration (although most episodes last considerably longer) involving clear-cut changes in affect, cognition, and neuro-vegetative functions and inter-episode remissions (DSM 5, 2013 pg 155).

Individual with this type of depressive disorder typically show dysphoric mood and anhedonia accompanied by physical changes such as weight loss or gain, increased or decreased appetite, alteration in sleep pattern and sustained fatigue. Disturbances in cognitive and executive functions are also manifested by lack of concentration and coherent thinking as well as morbid preoccupation by thoughts of death and suicide (Fekadu, 2017).

(II) Persistent depressive disorder/Dysthymia

Dysthymia is defined as a chronic mood disorder which persists for at least two years in adults, and one year in children (Moch, 2011). It is diagnosed in adults when individuals have not been free of their depressive symptoms for longer than 2 months over a 2-year period. In children and adolescents, the criteria span a 1-year period (Melrose, 2017).

A person diagnosed with this form of depression may have episodes of major depression along with periods of less severe symptoms (NIH, 2016).

(III) Disruptive mood dysregulation disorder (DMDD)

DMDD is defined as severe recurrent temper outbursts in response to common stressors which manifest verbally or behaviorally, are grossly out of proportion in intensity or duration to the situation or provocation and inconsistent with the child's developmental level (Agarwal & Tiwari, 2013). It is characterized by severe and recurrent temper outburst that are grossly out of

proportion in intensity or duration which occur, on average three or more time each week for one year or more (Zaky, 2015). DMDD should not be used before age 6 or after age 18 (Tapia & Joh, 2018).

The core feature of DMDD is “chronic, severe persistent irritability” accompanied by severe temper outbursts, at least three times per week, that are out of proportion to provocation and inconsistent with developmental level. Symptoms are pervasive in the sense that they characterize the child’s comportment across multiple settings. The minimum duration of symptoms is 1 year (without interruption exceeding 3 months), with onset by age 10 (Roy et al., 2014).

2.1.2 Risk factors of Depression

There is no single known cause of depression, rather, resulting from a combination of genetic, biochemical, environmental, and psychological factors. The parts of the brain responsible for regulating mood, thinking, sleep, appetite and behavior appear to function abnormally. In addition, trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger a depressive episode NIFMH (2011).

An external event often seems to initiate an episode of depression. Thus, a serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can trigger a depressive episode. Very often, a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder. Stressors that contribute to the development of depression sometimes affect some groups more than others (Bhowmik et

al., 2012). Stressful life events and chronically stressful circumstances are typically the triggers of depression (Hammen, 2009).

2.1.3 Theories of Depression

(I) Beck's Cognitive Theory

Cognitive theories of depression have been hypothesized as way one way to understand the developmental etiology and maintenance of depression. These theories share the general hypothesis that the ways in which individuals attend to, interpret, and remember negative life events contribute to the likelihood that they will experience depression (Lakdawalla et al., 2007). They emphasize the role of negative cognitions or maladaptive belief systems as diatheses in the initiation and continuation of depressive symptomatology.

Beck cognitive theory proposes that negative, depressogenic schema, with contains dysfunctional attitudes (i.e rigid and extreme beliefs about the self and the world that are drawn from certain early experiences in life) influences how individuals interpret, encodes and retrieves information. (Hanklin et al., 2008). The model proposes that negative views of the self, the world, and the future, the negative cognitive triad serve as a proximal cause for depression in the face of negative life events (Carolyn et al., 2007).

The theory is based on the assumption that the way people think about situations in their lives influences how they feel and what they do. When people are depressed, they exhibit problematic ways of thinking that increase their depression (Martell et al., 2010).

Typically a stressor or life event, early maladaptive schemas and dysfunctional assumptions are activated, which results in negative automatic thoughts and the behavioral, motivational, affective, cognitive and somatic symptoms of depression. Maladaptive schemas such as; abandonment/instability, mistrust/abuse, defectiveness/shame, social isolation/alienation, dependence/incompetence, vulnerability to harm or illness, failure, insufficient self-control/self-discipline, subjugation, and emotional inhibition act as mediators between stressors and depressive symptoms:, (Brenning et al., 2012; Shah & Waller, 2000).cited in Poote, 2013).

According to Beck, depression is due to the attitude and mindset of private individuals and the symptoms showing signs of depression are a result of non peaceful thoughts. Those who are depressed are more likely to perceive their future experience as an understanding of the personal and impersonal factors. Cognitive structure between the input stimulus and response personality of the beliefs and assumptions relate to an object, event or environment. They also consider the future of their experience as negative and unrealistic (Johari & Marzuki, 2013).

(II)Fester’s Reinforcement Theory

From a behavioral perspective, all learned behavior, both functional dysfunctional, is acquired through the same two processes of classical and operant conditioning. A person’s ‘dysfunctional’ behavior is viewed from the behavioral perspective not as pathology but as “problems in living.” These problems arise from the failure to learn needed behaviors or from having learned behaviors that, in one’s current environment, result in a lack of reinforcement or in punishment (Kevin, 2004;pg 251). These theories explain the development and persistence of depressive symptoms as a result of decreased environmental rewards, associated reductions in positively reinforced healthy behavior, reinforcement of depressive or passive behaviors and punishment of healthy behavior (Fester 1973: Lewinsohn,1974) cited in Carvalho & Hopko 2011).

One of the first to apply a behavioral analysis to the problem of depression was Charles Ferster (1973), who viewed depression as a generalized reduction of rates of response to external stimuli. His pioneering theoretical work highlighted avoidant behavior as a determinant of depressive behaviors and symptoms, stressing the need to analyze relationships between environmental contexts and behavior to understand and treat depression (Rehm, 2015).

According to Fester, certain characteristics of the depressed person such as excessive crying, irritability and self-criticism is associated with the loss of other types of activities. The variables that are influencing this type of repertory are lowered frequency of positive reinforcement and the increase of negative reinforcement (Abreo & Santos, 2008)

2.2 Anxiety

Anxiety is a word used to describe feelings of unease, worry and fear, which incorporates both the emotions and the physical sensations we might experience when we are worried or nervous about something (Marsh, 2015). It is a group of mental disorders characterized by various combinations of key features; excessive anxiety, fear, worry, avoidance, and compulsive rituals that are associated with impaired functioning or significant distress (CPA, 2006). As such, it is distinguished from fear, which is an emotional response to a perceived threat (Parashar et al., 2012).

Anxiety symptoms can be broadly classified in four groups. Cognitive symptoms: indecisiveness, worry, impaired attention and concentration, memory impairment; affective/emotional symptoms: nervousness, anger, sadness; physical symptoms: muscle

tightness, disturbed sleep, body-aches, high blood pressure, dry mouth, etc; behavioral symptoms; irritability, impulsivity etc. (Chouhan & Sharma, 2017).

Feelings of anxiety affect almost everybody from time to time and may be regarded as a normal part of human life. To consider anxiety as an illness, distress and impaired function should also be present (Obi-Nwosu, 2016).

Different surveys suggest that anxiety affects one-eighth of the total population of the world (Soodan & Arya, 2015). A series of primary studies has established that anxiety disorders are widespread in the general population. Lifetime prevalence rates range from 13.6% to 28.8% (Michael et al., 2007).

2.2.1 Types of Anxiety

(I)Panic Attack

Panic disorder is a type of anxiety disorder which is characterized by recurrent unexpected panic attacks involving a sudden onset of intense fear or discomfort that is accompanied by physical symptoms (e.g., palpitations, sweating, and shaking), cognitive symptoms (i.e., fear of dying, losing control), or both (Antony & McCabe, 2006).

It is characterized by sudden attacks of terror, usually accompanied by a pounding heart, weakness, faintness, or dizziness. During these attacks, people with panic disorder may flush or feel chilled; their hands may tingle or feel numb; and they may experience nausea, chest pain, or smothering sensations (NIMH, 2009). In panic disorder, the fundamental emotional constructs of

anxiety, panic, and consequent phobic avoidance come together in an intricate relationship that can devastate the lives of those who develop it in severe form (Bouton, 2001).

Symptoms can be somatic or cognitive in nature and include palpitations, sweating, trembling or shaking, sensations of shortness of breath or smothering, feeling of choking, abdominal distress, derealization or depersonalization, fear of losing control or "going crazy," fear of dying, paresthesias. The attack has a sudden onset and builds to a peak rapidly (usually in 10 minutes or less) and is often accompanied by a sense of imminent danger or impending doom and an urge to escape followed by at least 1 month of persistent concern about having another panic attack, worry about the possible implications or consequences of the Panic attacks, or a significant behavioral change related to the attacks (DSM-IV-TR, 2000).

(II) Generalized Anxiety Disorder

When anxiety (worry, fear, apprehension, or unease) happens over otherwise common things or events, is difficult for the individual to control, is excessive, and lasts at least 6 months, it is called generalized anxiety disorder (Torpy et al., 2019).

To meet criteria, individuals must experience worry more days than not for at least 6 months about a number of events or activities. Additionally, their worry and anxiety is generally associated with at least three of the following six physical symptoms: (a) restlessness or feeling keyed up or on edge, (b) being easily fatigued, (c) difficulty concentrating or mind going blank, (d) irritability, (e) muscle tension, and (f) sleep disturbance characterized by difficulty falling or staying asleep, or restless, unsatisfying sleep. To meet criteria, individuals must experience

worry more days than not for at least 6 months about a number of events or activities (Szkodny & Newman, 2014).

(III) Agoraphobia

Agoraphobia is a fear and avoidance of being in places or situations from which escape might be difficult in the event of sudden incapacitation (Letchie et al., 2013). It is an anxiety symptom involving the fear of being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of an unexpected or situationally predisposed panic attack or panic-like symptoms (Hara et al., 2012) .

Agoraphobia is characterized as a marked fear and avoidance of being alone, or in public places from which escape might be difficult, or help not available in case of sudden incapacitation (DSM-III, 1980 (p. 227), cited in Telch et al., 2014).

(IV) Social Phobia

Social phobia is defined as an anxiety disorder characterized by a strong and persistent fear of social or performance situations in which the person might be embarrassment or humiliation (Chhabra, 2009). Individual's level of fear or anxiety associated with either real or anticipated communication with another person or persons (White et al., 2015, cited in Rasmussen & Rasmussen, 2017).

Social anxiety disorder is characterized by excessive anxiety on exposure to potential scrutiny or evaluation by others (Albuquerque, 2002). In this type of phobia, there is a feeling of shyness in an individual person which builds into a high or heavy fear. People suffering from it can feel

self-consciousness and uncomfortable in participating everyday social situations (Naveed et al., 2013).

Individual's level of fear or anxiety associated with either real or anticipated communication with another person or persons (White et al., 2015, p. 24, cited in Rasmussen & Rasmussen, 2017).

Social phobia is a disorder is a persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The somatic symptoms of social phobia including excessive sweating, slurred speech, palpitations, blushing, tremor and nausea (Alkhalifa, 2017).

2.2.2 Risk Factors of Anxiety

Anxiety is deriving from complex origins and among the most important influences is actually genetic disposition; environmental impact upon one individual, especially early adverse event; and acute stressors that result in adaptational changes (Wiedemann, 2015). It involves the experience of dread and apprehensiveness, and the physiological reactions of anxiety usually include trembling, sweating, elevated heart rate and blood pressure, and increases in muscle tone.

They are commonly experienced in the general population and may significantly impair psychosocial function. In their extreme form these negative affective states develop into clinical depression and anxiety, the most commonly experienced psychiatric disorders today (Kemp & Felmingham, 2008).

2.2.3 Theories of Anxiety

(I) Freud's Psychoanalytic theory

Psychodynamic models are derived from early psychoanalytic conceptualizations, including ego psychology, object-relations theory, self-psychology, and attachment theory (Ribeiro, et al., 2018). In psychodynamic terms the use of worry as a way to avoid thinking about other trouble issues would be labeled a defense mechanism (Christoph, 2002).

According to Freud, at a most basic level, anxiety is a signal to the ego (the aspect of personality that deals with reality) that something overwhelmingly awful is about to happen and that it needs to employ a defense mechanism in response (MHF, 2014). He conceptualized the person as being comprised of three mental structures: the id, the ego, and the superego. The id operated according to the pleasure principle, which was to seek pleasure and avoid pain, and was fueled by sexual and aggressive drives. The ego operated on the reality principle and sought appropriate means for satisfaction. The superego was one's conscious and represented internalized parental or societal values. For a healthy person, the ego maintained a balance between the id and superego, limiting both by employing defenses in a flexible manner. Psychopathology and anxiety arrived when there was not a healthy balance or when there was a rigid use of defenses (Patric, 2010).

Freud mentions three different kinds of anxieties: *Realistic anxiety*; which everyone would call fear (for example, if you throwed into a pit of poisonous snakes, you might experience realistic anxiety), *Moral anxiety*; a feeling when the threat comes not from the outer, physical world, but

from the internalized social world of the superego (feelings like shame and guilt and the fear of punishment), *Neurotic anxiety*; the fear of being overwhelmed by impulses from the id. If you have ever felt like you were about to "lose it," lose control, your temper, your rationality, or even your mind, you have felt neurotic anxiety. (Boeree, 2006).

Freud initially developed the topographic model in part as an attempt to explain the subjective experience of anxiety. Anxiety is the symptomatic consequence of the latent, or unconscious, buildup of energy that emerged from excessive internal (instinctual) or external stimulation related to trauma (Wong, 2016). The unconscious is the existence of thoughts and feelings of which we are not aware that motivate our strivings and behavior (Kenny, 2016).

(II) Emotional Processing Theory

Emotional processing theory developed by Foa and Kozak (1986) has informed the conceptualization of anxiety disorders as a pathological fear structures that “involve excessive response elements and resistance to modification” and the associations among the different elements that do not accurately represent reality (Rauch & Foa, 2006).

According to this theory the persistence of a pathological fear structure is due to behavioral and cognitive avoidance, as well as to cognitive biases in processing information at various stages (encoding, interpretation, and retrieval). The avoidance and cognitive biases interfere with the acquisition of relevant information that is inconsistent with the existing elements of the pathological fear structure (Rothbaum, 2006).

When a normal fear structure is activated by a dangerous situation (e.g., a car veering toward the person), it generates fear and leads to adaptive maneuvering by the individual (e.g., moving to safety) to avoid danger. A pathological fear structure contains associations among the stimulus, response, and meaning representations that distort reality and includes excessive response elements (e.g., avoidance of safe situations).

2.3 Stress

Researchers usually define stress as the undesirable response people have to extreme strain or other sort of burden placed on them (Khan et al., 2013). Historically, the Latin word ‘stress’ has been in common language since the seventeenth century and was used to address hardship, adversity, or affliction (Samira et al., 2015). ‘Stress’ can be defined as the condition that results when person-environment transactions lead the individual to perceive a discrepancy (whether real or not) between the *demands* of a situation and the biological, psychological or social *resources* of the individual (Evans, 1987; cited in Berto (2014)).

At the most basic level, stress is our body’s response to pressures from a situation or life event called a ‘stressor’ (MHF, 2018). This response has two divisions that are specific response and non-specific response. Specific response is the one which is actual response to the particular stimulus that involves only a particular body system. However, non-specific response is the one which is common to any type of stress and involves different body systems and leads to fight or flight response.

2.3.1 Types of stress

There are many types of stress from minor incidents to chronic stress. However these reviews were focused on two of the most common types of trauma and stressors related disorders from DSM 5.

(I) Adjustment disorders

Adjustment disorder (AD) is defined as a maladaptive reaction to an identifiable psychosocial stressor or multiple stressors that usually emerges within a month after the onset of the stressor (Maercker & Lorenz, 2018). From a global mental health perspective, typical precipitating stressors are losses of resources due to economic hardships, forced migration, or acculturation to a new culture. The symptoms of AD are characterized by stress responses that are out of step with socially or culturally expected reactions to the stressor and/or which cause marked distress and impairment in daily functioning (O'Donnell et al., 2019).

By definition, the disturbance in adjustment disorders begins within 3 months of onset of a stressor and lasts no longer than 6 months after the stressor or its consequences have ceased. If the stressor is an acute event the onset of the disturbance is usually immediate and the duration is relatively brief). If the stressor or its consequences persist, the adjustment disorder may also continue to be present and become the persistent form.

In order to be diagnosed as an adjustment disorder, the child's reaction must occur within three months of the identified event. Typically, the symptoms do not last more than six months, and the majority of children quickly return to normal functioning (Medical Center of Central Georgia, 2002; cited in VCY (2017)).

(II) Posttraumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is the psychiatric disorder that can result from the experience or witnessing of traumatic or life threatening events such as terrorist attack, violent crime and abuse, military combat, natural disasters, serious accidents or violent, personal assaults (Alshawi, 2018). It is a disorder in which a person who has directly experienced a traumatic event develops a characteristic set of symptoms. PTSD symptoms can occur at any age, and present within 3 months of the trauma, but may occur years later (Kirkpatrick & Heller, 2014).

According to DSM-5, 2013 symptoms of PTSD were categorized into four clusters (1) *intrusion/re-experiencing* symptoms (recurrent and intrusive memories, images, thoughts, distressing dreams, dissociative reactions such as flashbacks, strong emotional and physical reactions to cues that resemble or symbolize an aspect of the trauma); (2) *avoidance symptoms* (efforts to avoid thoughts, feelings, conversation or activities, places or people connected to trauma); (3) *negative cognitions and mood* (amnesia for important aspects of the trauma, a persistent and distorted sense of blame of self or others, persistent negative emotional state (e.g., fear, horror, guilt, shame), inability to experience positive emotions, feelings of detachment or estrangement from others, markedly diminished interest in activities) and (4) symptoms of *hyper-arousal* (increased anxiety, sleep difficulties, poor concentration; increased irritability, outbursts of anger, reckless or self-destructive behavior. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before criteria for the diagnosis are met

2.3.2 Risk factors of Stress

Stress manifests as a subjective feeling and a physiological response that occur when a person feels that he or she does not have the capacity to respond and adapt to a given situation (Clayton et al., 2017). We all experience stress when we are anxious, worried, shamed, or angry, whether the source of our feeling is ourselves, some other person, or something that happens to us (Saleh, 2015).

Operationally, studies of psychological stress focus either on the occurrence of environmental events that are consensually judged as taxing one's ability to cope or on individual responses to events that are indicative of this overload, such as perceived stress and event-elicited negative affect (Cohen et al., 2007).

The circumstances that cause stress are referred to as stressors; they vary in duration of occurrence and severity. Stressors are conditions that may potentially precipitate stress or demand of life which eventually leads to stressful situations (Joseph, 2013). So, stress arises when there are burden on the person which exceed his available assets (Khan et al., 2013). Moreover, environmental and demographic factors of work can also have an important effect on stress such as justice, social capital, work-life balance, traumatic events, age, experience, and race (Husain, Sajjad, & Rehman, 2014).

2.3.3 Theories of stress

(I)General Adaptation Syndrome (GAS) theory

The definition of stress as a response was developed and described by Selye, who defined stress as a nonspecific response of the body to any kind demands applied on it (Fink, 2009). According to H. Selye (1936) stress is an acute threat to the homeostasis of an organism. It may be real (physical) or perceived (psychological) and posed by events in the outside world or from within. Importantly, stress evokes adaptive responses that serve to defend the stability of the internal environment and to ensure the survival of the organism (Konturek et al., 2011)

Term of general adaptation syndrome was coined by Hans Selye (1907-1982)(Baffy, 2017). Selye in order to differentiate the cause of stress from the response to this introduced the term ‘stressor’ naming so any factor can cause stress and affect the balance of the individual. He mentions, due the fact that stress is a state of the body, it can only observed within the changes occurring in it. This full body response general adaptation syndrome, (GAS) is manifested by releasing certain hormones, which resulted is changes in the structure and chemical composition of the body (Papathanasiou et al., 2015).

Selye introduced the General Adaptation Syndrome (GAS) to describe the short-term and long-term nonspecific physiological responses to stressors. The GAS has three stages of coping with a stressor: first, an initial “alarm reaction,” which is basically Cannon’s fight-or-flight response; second, “stage of resistance,” during which the body adapts to the stressor by activating the neuro-endocrine system; and third, a “stage of exhaustion,” which is the gradual decline of stress

resistance, eventually resulting in physiological damage and organismic death (diseases) if continued (Goldstein & Kopin, 2006; Huether, 1996). (Kim, 2017).

(II) Appraisal Theory

Appraisal theory was developed by Lazarus and Folkman (1984) who state that a specific event or stressor influences individual cognitions of an event, termed appraisal. The theory examines the process by which emotions are elicited as a result of an individual's subjective interpretation or evaluation of important events or situations; hence, it is the evaluation of events to determine one's safety in relation to his or her place in the environment (Lazarus, 1999 cited in Matheu & Ivanoff (2006). According to this theory, there are two types of appraisal, primary appraisal and secondary appraisal. Primary appraisal is the individual's evaluation of an event or situation as a potential hazard to his or her well-being. Secondary appraisal is the individual's evaluation of his or her ability to handle the event or situation.

Primary Appraisal is a process when person faced with a stressful situation evaluate potential, personal relevance and significance in terms of its impact on valued personal goals. When a stressor is perceived as relevant and significant, an individual will evaluate the controllability of the stressor and his/her resources and options. Primary appraisals alone, however, are not sufficient to determine affective responses (Lazarus, 1991) cited in Jamieson et al., 2018).

Primary appraisals assess (consciously and/or unconsciously) whether situations are emotionally relevant (benign or stressful) or irrelevant. Irrelevant situations are those that do not require instrumental responding or impact health/well-being. Emotionally relevant situations that are

appraised as benign-positive only signal positive outcomes. Stressful primary appraisals, however, are further subdivided into “threat” and “challenge.” Threatening situations involve potential for harm or loss, whereas challenging situations refer to opportunities for growth, mastery, or gain (Lazarus, 1991) cited in Jamieson et al., 2018).

Therefore, Lazarus and Folkman (1984) viewed stress as not as a stimulus or a response, but as a person- environment relationship that is perceived as taxing or exceeding a person’s resources. When faced with a stressful situation, a person will evaluate its potential personal relevance and significance in terms of its impact on valued personal goals (Ntoumanis et al., 2009).

2.4 The Concept of Internal Displacement

In recent years displacement of peoples due to man-made impact gets attention of the public and has caused national and international concern. Violent conflicts throughout the world have left millions of people displaced, some within their own country (the internally displaced) and some across international borders (refugees) (Knezevic & Olson, 2014). The term ‘internal displacement’ has been defined as the obligation by force the persons and people to flee involuntarily their living places, residential, homes, and cities but staying inside their countries’ borders (Al-Khafaf, 2017).

The intensity of internal displacement arising from different factors, which include violent conflicts and natural disasters, has become a global problem (Durosaro & Ajiboye, 2011). Civilian populations have been increasingly targeted in recent wars, with ‘ethnic cleansing’ campaigns and deliberate massacres becoming a common reality (Ehnholt & Yule, 2006).

Armed conflicts also result in displacement of persons seeking refuge in neighboring countries or secure areas of their own country (Husain et al., 2011).

Ethiopia had the highest number of new internal displacements associated with conflict worldwide in 2018 (IDMC, 2019). According to OCHA (2018) the humanitarian situation in Ethiopia has been further exacerbated by an upsurge in conflict around the border areas of Oromia and Somali regions, since early September 2017. Over the course of the following months, the conflict has left hundreds of thousands displaced, often in areas already experiencing ongoing drought-related humanitarian need. The conflict IDPs are settled in close to 400 locations, either in IDP sites, with host communities or in “collective centers” along the border areas and in major towns or villages across Oromia, Somali, Harar regions, and Dire Dawa and Addis Ababa cities.

2.5 Internal Displacement and Trauma Events

History bears witness of conflicts and clashes between states, cultures, religions, kingdoms and so on. As a result, people worldwide are exposed to a diversity of trauma events because of mass violence and instability specific to every conflict (Bhat et al., 2017). Trauma event is one that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs (APA, 2008).

One of the most trauma events that may face individuals in their life is the war and conflict (Mohammed et al., 2014). War can lead to a range of severely traumatic experiences among civilian populations. Such trauma events include lack of food, water, shelter and medical care, imprisonment, combat and injury, abuse and isolation, torture, murder, death of family member

as well as lack of food, water, shelter and medical care (Ajibade et al., 2017). Armed conflict can result in profound health consequences including death, injury, infectious disease, and malnutrition. It can result in destruction of social networks, family separation, human rights abuses, and sociopolitical marginalization, which can contribute to long-term physical and psychological sequelae (Husain et al., 2011).

Many IDP have undergone psychological and physical trauma before and/or during their displacement ordeal (Siriwardhana & Stewart, 2012). Being displaced can have several adverse effects on the physical, social, emotional and spiritual wellbeing of a person. Relocation following war, political conflict or natural disaster intensifies the individual's loss of control and sense of threat that are caused by the losses that accompany the move (Shwartz et al., 2011).

Several studies showed high prevalence of trauma events among population affected by conflict (Kartal & Kiropoulos; 2016, Stavropoulou & Samuels; 2015). Study conducted by Marshall et al. (2005) showed, among people who were affected by war and conflict, 96% forced to labor (like animal or slave), 90% had a family member or friends who were murdered, and 54% were tortured. Other study conducted by Tagurum et al., 2015 found different trauma events among victims of violence and conflicts; witnessing some form of ethno-religious violence(67.2%) , witnessing someone get stabbed and shot (36.8%), (16.7%), loss of property (31.4%), and relocation from residence (26%).

Study conducted in Ethiopia by Zewdu & Suleyiman (2018) shows high prevalence of trauma events such as; imprisonment (80.8%), facing ill health condition without access to medical care

and 241 (64%), exposing for serious physical injury from combat situation. 211 (56.1%), witness of beatings to head or body 174 (46.2%), exposed for any witness of torture; 171 (45.4%), forced to separate from family members; 168 (44.6%) among population affected by violence.

2.6 Displacement and Mental Health Problems

The world's population of people forced to abandon their homes and communities because of war, political violence, or related threats include not only those displaced outside their country of residence but also internally displaced persons, asylum seekers, stateless persons, and recently returned refugees (Porter & Haslam, 2005).

Exposure to violence or disaster, loss or separation from family members and friends, deterioration in living conditions, the inability to provide for one's self and family and lack of access to service, can all have immediate and long term consequence on individuals, families and communities, including posttraumatic stress disorders, psychosomatic illness, depression, anxiety and even violence (Ronald et al., 2017).

It is well documented that conflicts, wars, violence, and being displaced negatively affect the victims' well-being and result in complex humanitarian crises (Hamid et al., 2010). Internal displacement and particularly the internal displacement which takes place due to an armed conflict cause various psychological difficulties including posttraumatic stress disorder, depression, anxiety, somatization, and change in one's beliefs (Mujeeb, 2015). The strongest predictor of PTSD and depression in internally displaced persons and refugees was the level of perceived distress during exposure to war-related stressors (Crepulja et al., 2011).

Armed conflict and violence disrupt social support structures and expose civilian populations to high levels of stress (Patricio & Marquez, 2017). Moreover, internally displaced persons belong to areas where they have strong social values which are different from the values of the areas in which they are settling down. So their different values, language, and climate conditions are cause of stress, anxiety and depression in them. Lack of resources makes it is quite difficult to manage camps, food and other facilities. There prevails a consistent stress and anxiety about the damages to their houses, lands, and crops. They are also under stress because there is dearth of particular rehabilitation facilities offered by the government (Mujeeb & Zubair, 2012).

Study conducted by Morina et al., (2018) indicates depression and anxiety disorders are the second and third most commonly reported mental disorders among IDPs and refugees. Over two thirds of internally displaced peoples met symptom criteria for depression (Roberts et al., 2008). In addition, Thapa & Hauff (2005) found (80.3%) depression symptoms, & (80.7%) anxiety symptoms among displaced people. Housen et al., 2017 found high prevalence of depression (90%) and anxiety (71%); among internally displaced people.

According to Wiseman (2015) among people who experienced trauma events; 58.7% had symptoms of anxiety above the normal range. Lumley et al., (2018) found 71% & 79% depression and anxiety symptoms which is higher than normal levels (with 60% and 68% in the elevated ranges i.e moderate, severe, and extremely severe) among survival of violence and war. Of those, 42% (depression) and 57% (anxiety) were in the extremely severe range.

However, Study conducted by Kartal, Alkemade & Kiropoulos (2019) indicated normal levels of PTSD (66%), depression (70%) and anxiety (58%) symptoms among refugee population. Other study (Salah et al., 2012) the most common disorders among internally displaced people were major depressive disorder (24.3%), generalized anxiety disorder (23.6%), social phobia (14.2%) and PTSD (12.3%). Siriwardhana et al (2013) found depressive disorders (12.4%), and anxiety disorder (1.3%), PTSD (2.8%) among internally displaced people.

The presence of mental health problems among the internally displaced persons contribute to difficulties in coping and resettlement in normal life (Ajibade et al., 2017). Increased exposure to war experiences led to higher levels of: traumatic reactions, depression and grief symptoms. Being raped, seeing others raped, the death of a parent/s, being forced to fight, and having to hide to protect oneself were the strongest predictors of depressive symptoms (Morgos et al., 2007).

Common mental disorders among conflict-affected populations such as PTSD, depression and anxiety can cause substantial suffering and may reduce a person's ability to function fully, which affects not only themselves but also their families and communities (Roberts et al., 2017).It is imperative to understand the nature of the psychological distress of internally displaced people to develop appropriate evidence-based interventions (Richards et al., 2011).

2.7 Sex difference in Depression, Anxiety and Stress

There are many sex differences relating to mental health issues and they concern all aspects: diagnosis, treatment and incidence (Lenzo et al., 2016). Many theories are proposed to clarify the variations in stress effects between men and women; some of which include: gender socialization

and gender roles, tokenism, family status and children, workloads, social support, or self-reported variations. Moreover, environmental and demographic factors of work can also have an important effect on stress such as justice, social capital, work-life balance, traumatic events, age, experience, and race (Husain et al., 2014). Besides, various factors including genetic, neurodevelopment, environmental, and neurobiological, are hypothesized to be responsible for the sex differences reported in anxiety disorders (Jalnapurkar et al., 2015).

The multiple traumas of conflict, displacement, poverty, unemployment, compounded by the loss of property, family members, uncertainty about the future and so much, when added all together resulted in widespread psychological and psychiatric issues amongst IDPs of all ages of both gender (Aleemi et al., 2015).

The study conducted by (Sheikh et al., 2015) shows that one in two and one in six IDPs developed post-conflict probable depression and definite depression respectively. The female gender, been beaten and having a co-morbid diagnosis of PTSD were independent predictors of probable depression among the IDPs. Internally displaced females were experiencing more stress, anxiety and depression as compared to internally displaced men (Mujeeb & zubair).

Other study conducted by Mujeeb (2015), Farooqi & Habib (2010) showed significant gender differences in depression, anxiety, and stress among internally displaced people and between survivors of violence. Study conducted by Qeshta et al., 2019; Ayazie et al., (2014) showed absence of sex differences in depression and anxiety and stress scores among displaced people.

2.8 Marital statuses and Depression, Anxiety, Stress

An individual naturally adapts as occasion changes, but most psychologists would maintain that there is a core of consistency which defines the nature of the individual which can be discussed as the personality, which is simply described as actions, attitudes and behavior one possesses (Olatunji & Mokuolu, 2014). It is not only individual characteristics that may account for marital status differences in depression. Being married and living with a spouse is a powerful resource that can produce all instrumental goals, which in turn are necessary in order to produce psychological well-being. (Schaan, 2015).

Marital status is well recognized as a key demographic variable associated with both mental and physical health (Willitts, 2004). Death of the spouse, or separation (legal or otherwise), appears to affect both the sexes in different ways and the psychological effect of these events is immense (Trivedi et al., 2009). Anxiety and stress scores of widowed people anxiety and stress were high compared with people who are married, single (Willitts et al., 2004).

Notably, never married exhibit fewer depressive and anxiety symptoms than divorced and widowed counterparts, although their levels of depression are somewhat higher than married (Brown et al., 2005). According to Palner & Mittelmark (2002) married individuals were at higher levels of perceived mental health than unmarried. Unmarried individuals had significantly lower score on the perceived mental health variable, compared to the married (Palner & Mittelmark, 2002).

The study conducted by Salihu and Udofia (2016) showed significant association between depression and marital status (there were more married among the depressed than non-married). Another study conducted by Fan et al., 2011 showed the absence of statistically significant difference in DASS scores between married, unmarried, and widowed/separated among people affected by violence.

2.9 The relationship between Depression, Anxiety and Stress

Depression, anxiety, and stress levels are considered important indicators for mental health, and the inability to detect and address these psychological disorders negatively affects individuals (Bahhawi et al., 2018).

Rates of mental health disorders, such as anxiety disorders, post-traumatic stress disorder (PTSD) and depression were higher among refugees and internally displaced populations in comparison to the general population. This increased vulnerability has been linked to experiences prior to migration, such as war exposure and trauma. Additionally, anxiety and other mental health disorders can manifest due to stressors post-migration, such as separation anxiety and the added load of resettlement in a new country. This process can create a considerable amount of stress for new refugees trying to restart lives in new countries and places, often resulting in anxiety and depression, as well as the exacerbation of post-traumatic stress (Hameed et al., .

Depression and anxiety are psychological symptoms of stress (Babazadeh, et al., 2016).

The study conducted by Jahanara (2015) indicated that depression, anxiety, and stress scores of people who affected by conflict were positively correlated to each other. Tinghog et al. 2011

found the strongest correlations and co morbidities between depression and anxiety; between stress and depression among the population who affected by disaster. Other study conducted by Qeshta (2019) shows significant positive correlation between anxiety and depression among internally displaced people.

CHAPTER THREE

Methodology

3.1 Research design

The researcher used cross-sectional survey research design. The cross-sectional design is one of the most commonly used survey- research designs. In a cross-sectional design, one or more samples are drawn from the population at one time. The focus in a cross-sectional design is describing the characteristics of a population or the differences among two or more populations at a particular time (Shaughnessy et al., 2012).The researcher chooses survey because the approach helps to examine the variables with a view to describe the situation of internally displaced youths.

3.2 The Study Area

The study was conducted at Dukem, located in Oromia special zone surrounding Addis Ababa, 37 km far from Addis. The selected study site was chosen purposively based on high prevalence of resettled IDPs from the borders compared to other areas. The study was conducted at Genda Koticha IDP site, where internally displaced people were settled. This site was selected purposefully due to the proximity or ease of its access. Therefore, the site was suitable to collect data in depth.

3.3 Population of the study

The population of the study was internally displaced youths from Somali and Oromia borders, who are settled before April 30, 2011 (E.C), currently living in Dukem site one. The reason for selecting internally displaced youth from these borders were because the displaced people from Somali and Oromia regions border are the populations who are subject to psychological

problems since they experience different traumatic life events through different displacement phases.

3.4 Sample and Sampling Procedure

In this study, a purposive sampling technique was used. Purposive sampling is deliberate choice of participant due to the qualities the participant possesses (Etican et al., 2016). The reason for using purposive sampling technique is to get equal number of both sexes as research participants. The total IDYs population was 427(203 males and 224 females). The researcher took 228 approximate representative samples from youths by using Krejcie & Morgan (1970) sample size determination table, which takes 201 samples for 420 populations. This is because the Krejcie and Morgan table is easily applicable to any defined population than other sample size determination technique. Therefore, by using purposive sampling technique, 114 males and 114 females were purposively selected as research participants. Table 1 indicates the population and sample according to this table.

Table 1: Krecje and Morgan Table for Determining Sample Size from a Given Population

N	S	N	S	N	S
10	10	90	73	240	148
15	14	95	76	250	152
20	19	100	80	260	155
25	24	110	86	270	159
30	28	120	92	280	162
35	32	130	96	290	165
40	36	140	103	300	169
45	40	150	108	320	175
50	44	160	113	340	181
55	48	170	118	360	186
60	52	180	123	380	191
65	56	190	127	400	196
70	59	200	132	420	201
75	63	210	136		
80	66	220	140		
85	70	230	144		

Where: N is Population

S is Sample

3.5 Data Collection Measures

I. Demographic data

The demographic data was collected based on demographic questions, which focuses on background information such as age, sex, and marital status.

II. HTQ-R-CV

Trauma events were measured by HTQ-Revised Cambodian version (1998) developed by Harvard Program in Refugee Trauma, Harvard Medical School. HTQ is a cross-cultural instrument designed for the assessment of trauma and torture related to mass violence and their sequelae. The Original and Revised Cambodian HTQs, DSM-IV PTSD symptoms are followed by a number of items describing other reactions to violence and displacement (Mollica et al., 1998; 2004) cited in Shoeb, 2007.

Originally, HTQ-R-CV consist of 4 subparts; trauma events (experienced/witnessed/heard about), Personal description (most hurtful or terrifying, and worst event), Head Injury (indicate if there was a loss of consciousness and for how long), Trauma Symptoms (symptoms after experiencing hurtful or terrifying events). Trauma events part contains 41 item, that checked by "yes" or "no" and which measures the types of traumatic events. Accordingly, the researcher purposefully selected fourteen items from trauma events part by considering the context in which IDP was living and traumatic events they may experienced.

III. DASS-42

In order to collect data from respondents about the incidence of their depression, anxiety and stress, DASS (42-items) were used. The Depression Anxiety Stress Scale (DASS) is a 42-item

self-report measure of anxiety, depression and stress developed by Lovibond and Lovibond (1995) which is increasingly used in diverse settings (Crawford & Henry, 2003). The instrument comprises three sub-scales: (1) the Depression sub-scale which measures hopelessness, low self-esteem, and low positive affect; (2) the Anxiety scale which assesses autonomic arousal, musculo-skeletal symptoms, situational anxiety and subjective experience of anxious arousal; and (3) the Stress scale which assesses tension, agitation, and negative affect (Tran, 2013).

Items are measured on a 4-point Likert scale Did not apply to me at all (0), Applied to me to some degree, or some of the time(1), Applied to me a considerable degree, or a good part of the time (2), Applied to me very much, or most of the time (3). Alpha values for original DASS 42 item scales were: Depression 0.91; Anxiety 0.84; Stress 0.90 (Lovibond & Lovibond, 1995).

Severity ratings of DASS were interpreted as follows.

Table 2: DASS severity ratings

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-12	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

Source: Lovibond and Lovibond (1995).

Study conducted by Ramli et al, (2007), shows Cronbach alpha values for DASS 42 items; 0.75, 0.74 and 0.79. The tool was also widely used scale in Ethiopia, for instance, Bekele & Damota (2018) on their study of the Depression, Anxiety and Stress among First Year Addis Ababa University Students and found Cronbach alpha of .75, .72, and .86 for depression, anxiety and stress.

3.6 Pilot Report

A Pilot study helps to check the feasibility of the study and adequacy of the tool for the aim of revising the relevance and clarity of the instruments. A pilot study is the first step of the entire research protocol and is often a smaller-sized study assisting in planning and modification of the main study (In, 2017). It is also helps to know consistency of instrument to measure the variables (reliability of the instrument).

To reduce the language effects the original versions of HTQR-CV (14) and DASS 42 were translated into Afan Oromo by language experts (with the help of two English teachers and one Afan Oromo teacher). The Afan Oromo version of the instrument was pilot tested on a randomly selected sample of 60 participants (37 males and 23 females) who were who were settled after April 30, (E.C). Hence, the responses of the respondents had scored and the reliability of the three scales was computed using the SPSS software package, version 20.

Each of DAS scale consisting of all 14 items (Cronbach alpha 0. 89 for depression; 0. 90 for anxiety; 0.88 for stress), and all three scales has good reliability according to the rule of thumb of George and Mallery (2003).

Table 3: Reliability of DASS

Scale	Number of Items	Original Measure(α)	Pilot(α)	Main Study(α)
Depression	14	0.91	0.89	0.93
Anxiety	14	0.84	0.90	0.89
Stress	14	0.90	0.88	0.89

3.7 Data Collection Procedure

The original versions of HTQR-CV (14 items) and DASS 42 were translated into Afan Oromo by language experts. All the three parts of the questionnaire were translated into English again, and the consistency between the English and Afan Oromo form have examined. Again, the Afan Oromo form was revised by examining in terms of meaning and grammar. A formal letter that shows the legality of the study was received from the School of Psychology and send to Dukem administration to get permission. The data were collected by the researcher and other three individuals (the researcher's friends) in three days. The questionnaires were translated orally for 17 individuals who can't read and write by the researcher and her friends (3 individuals) during data collection.

3.7 Method of data analysis

In this study, both descriptive and inferential statistics were used to indicate the mean, standard deviation of the result and to check the statistical significance of the results. The methods of analysis were used based on the type of research question to be answered. Accordingly, the following descriptive and inferential statistics were used.

- ✓ Descriptive statistics (frequency, tables and percentage) has been used to analyze the information generates from the DASS 42 and the rest two parts (HTQ-CV 14 items and demographic information).
- ✓ Independent Sample T-test was used to analyze whether there is sex difference in depression, anxiety and stress or not.
- ✓ One Way ANOVA was employed to check whether significant mean difference in DASS scores among married unmarried and widowed participants.
- ✓ Pearson Correlation was used to examine the relationship between depression, anxiety and stress scores of the respondents.

Statistical significance was set at $p=.01$, (2 tailed) for Pearson r , $p=.05$, (2-tailed) for Independent Samples T- Test and One way ANOVA. The data were analyzed by using Statistical Package for Social Science SPSS (IBM version 20).

3.8 Ethical Consideration

After getting official approval from Dukem administration, the researcher clearly explained the purpose of the study and obtained informed consent from the participants of the study. Moreover, the researcher assured the respondents that the information to be gathered will never be used for other purpose rather than the consumption for only the study. Before distributing the

questionnaire, adequate orientation on how to respond to the questionnaire was given to participants. To keep confidentiality of the information and security of the respondents, the data were collected without the names of the respondents.

CHAPTER FOUR

Results

This chapter focused on the results of the quantitative data. The study emphasized to assess incidence of depression, anxiety, and stress among internally displaced youth. During the data collection, questionnaires were distributed to internally displaced youth. After gathering the necessary data from the representative sample, the analysis involved the following procedures.

4.1 Background Information of the respondents

Table 4: Background information of the respondents

Characteristics	Level	Frequency	Percentage
Sex	Male	114	50
	Female	114	50
	Total	228	100
Age	16-24	147	64.5
	25-33	81	35.5
	Total	100	100
Marital Status	Unmarried	121	53.1
	Married	80	35.1
	Widowed	27	11.8
	Total	228	100

As shown in table three, in this study 114 (50%) of respondents were males and 114 (50%) respondents were females ($M=1.5$, $SD=.501$). The highest percentages among displaced people

were represented by age group of 16-24 years; 147 (64.5%) ($M=1.36$, $SD=.480$). Regarding to their marital status; most, 121(53.1%) of them were unmarried, and 80(35.1%) of them were married, and 27(11.8%) of them were widowed ($M=1.89$, $SD=.903$).

4.2 Trauma events experienced by respondents

Trauma events were events which IDY's experienced when they displaced from their home. As a result, respondents' responses were analyzed in the following table.

Table 5: Trauma Events Experienced by the Respondents

Items	Responses	Frequency	Percentage
Forced to hide	Yes	170	74.6
	No	58	25.4
Witness combat situation	Yes	155	68.0
	No	73	32.0
Lack of food or water	Yes	137	60.1
	No	91	39.9
Disappearance or kidnapping other family member or friend	Yes	137	60.1
	No	91	39.9
Murder or death due to violence of family member or friend	Yes	130	57.0
	No	98	43.0
Forced separation from family members	Yes	129	56.6
	No	99	43.4
Forced evacuation under dangerous conditions	Yes	119	52.2
	No	109	47.8
Witness torture	Yes	97	42.5
	No	131	57.5
Witness killing/murder	Yes	95	41.7
	No	133	58.3
Forced to betray family member, or friend placing them at risk of death or injury	Yes	93	40.8
	No	135	59.2
Kidnapped	Yes	83	36.4
	No	145	63.6
Ill without access to medical care	Yes	74	32.5
	No	154	67.5
Witness rape or other sexual abuse	Yes	56	24.6
	No	172	75.4
Rape	Yes	11	4.8
	No	217	95.2

Table 4 illustrated different responses on traumatic events that the respondents experienced when they were displaced from their home. From the total participants, 170 (74.6%) were forced to hide; 155 (68.0%) of them witnessed combat situation; 137(60.1%) of them responded that their family member or friend were kidnapped and disappeared. 130 (57.0%) of participants responded that their family or friend were murdered or died due to violence. Besides 11(4.8%) were raped, 56 (24.6%) were witnessed rape and other sexual abuse; 74 (32.5%) of responded that they were ill without access to medical care; 83 (36.4%) were kidnapped.

4.3 Depression, Anxiety, and Stress Score of the Respondents

DASS 42 was used to assess the incidence of depression, anxiety and stress among IDY. The findings were presented in Table 5, 6, and7.

4.3.1 Depression scale results of the respondents.

Depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, and lack of interest/involvement, anhedonia and inertia symptoms of the respondents. The results were analyzed as follows.

Table 6: Depression scores of the Respondents

Scores	Magnitude	Frequency	Percentage
0-9	Normal	23	10.1
10-13	Mild	13	5.7
14-20	Moderate	43	18.9
21-27	Severe	77	33.8
28 and above	Extremely severe	72	31.6
Total		228	100

As Table 4 shown 72 (31.6 %) of respondents were at extremely severe level of depression and most, 77 (33.8%) of respondents' score indicated that they were at severe depression level. 43 (18.9%) of respondents were at moderate level of depression, 13(5.7%) of respondents score indicates that they were at mild depression level, while the remaining 23(10.1%) of them were at normal depression level, that means most of them were at a severe level of depression.

4.3.2 Anxiety Scale results of the respondents

The Anxiety Scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious effect. The results were analyzed as follows.

Table 7: Anxiety score of the respondents

Scores	Magnitude	Frequency	Percentage
0-7	Normal	15	6.6
8-9	Mild	13	5.7
10-14	Moderate	55	24.1
15-19	Severe	54	23.7
20 and above	Extremely severe	91	39.9
Total		228	100

In this study, 213 (94.3%) of respondents had anxiety symptom. Most 91 (39.9 %) of respondents were at extremely severe level of anxiety, 54 (23.7 %) of respondents score indicates that they were at severe anxiety level, 55 (24.1%) of respondents at moderate level of anxiety, 15 (6.6%) of respondents score indicated that they were at mild anxiety level, while the rest 13 (5.7%) of them were at a normal anxiety level.

4.3.3 Stress Scale results of the respondents

The Stress scale assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. The results were analyzed as follows.

Table 8: Stress Scores of the respondents

Scores	Magnitude	Frequency	Percentage
0-14	Normal	50	21.9
15-18	Mild	36	15.8
19-25	Moderate	78	34.2
26-33	Severe	58	25.4
34 and above	Extremely severe	6	2.6

As the above table showed, the prevalence of stress among internally displaced youth was 78.1%. Of these, 15.8% (36) of them were at mild level of stress, but, 34.2 % (78) of respondents score indicated that they were at moderate level of stress. 25.4 % (58) of them were at severe level of stress, and the remaining 2.6% (6) of them were at extremely severe level of stress.

4.4 Sex difference in depression, anxiety, and stress among internally displaced youth

To examine sex difference in depression, anxiety and stress scores of IDY, the Independent Samples T-test was used. The results were presented in below table.

Table 9: Independent Samples T-test result of the respondents comparing depression, anxiety and stress scores based on sex

	Sex	N	M	SD	df	t	p
Depression	Female	114	23.1579	9.76591	226	0.49	.961 (ns)
	Male	114	23.0974	8.91441			
Anxiety	Female	114	18.2105	8.58943	226	-0.179	.858 (ns)
	Male	114	18.4035	7.68370			
Stress	Female	114	20.5526	7.85160	226	0.86	.932 (ns)
	Male	114	20.6404	7.59498			

Note: ns=not significant

As shown in Table 7, the Independent Samples T-test was computed to see whether there was sex difference in males' and females' in DASS scores. The result revealed that there was no statistically significant mean difference between internally displaced male youth (M=23.0974; SD=8.91441) and female youth (M=23.1579; SD=9.76591) on their depression score with ($t(226) = .049; p=.961$). Besides, Independent Sample T- test result for anxiety ($t(226) = .142; p=.858$) indicated that the difference between males (M=18.4035; SD=7.68370) and females (M=18.2105; SD=8.58943) anxiety score is not a statistically significant. In addition, the Independent T-test result for stress scores revealed that there were no statistically significant mean difference between males (M=20.6404; SD=7.59498) and females (M=20.5526; SD=7.85160) internally displaced youth on their stress score with ($t(226) = .086; p=.932$).

4.5 Marital status difference in depression, anxiety and stress

In order to analyze difference marital statuses difference in depression, anxiety, and stress; One Way ANOVA were used. The results were presented as follows.

Table 10: One Way ANOVA results for comparing depression, anxiety and stress scores of internally displaced youth based on marital status.

	Marital Status	N	M	SD		Sum of the squares	Df	F	Sig
Depression	Married	80	21.7263	9.78504	Between Groups	379.576	2	2.204	.113
	Unmarried	121	23.4298	9.25007	Within groups	19377.520	225		
	Widowed	27	25.9259	7.71076	Total	19757.096			
	Total	228	23.1276	9.32929					
Anxiety	Married	80	17.9250	8.01229	Between groups	94.640	2	.714	.491
	Unmarried	121	18.1736	8.105226	Within groups	14915.868	225		
	Widowed	27	20.0370	8.68456	Total	15010.509			
	Total	228	18.3070	8.13176					
Stress	Married	80	20.41	8.045	Between groups	4.200	2	.035	.966
	Unmarried	121	20.70	7.483	Within groups	13480.677	225		
	Widowed	27	20.61	7.961	Total	13484.877			
	Total	228	20.60	7.707					

One Way ANOVA were conducted to compare mean scores of married, unmarried and widowed internally displaced youths in depression, anxiety and stress scores. The result on table indicates depression; ($F(2,225) = 2.204, P=.113, P>.05$), anxiety; ($F(2,225) = .714, P=.491, P>.05$),

Stress; ($F(2,225) = .035, P=.996 P>.05$). The result indicates that the calculated P -value (Depression), $P=.113$, (Anxiety) $P=.491$, (Stress) $P=.996$) were greater than the critical p -value ($P=.05$). Therefore, the researcher concluded that there were no statistically mean differences in depression, anxiety, and stress scores between married, unmarried, and widowed internally displaced youths.

4.6 Relationship between Depression, Anxiety and Stress Scores of the Respondents

Pearson Correlation was used to examine the relationship between depression, anxiety and stress scores of the respondents. The results were analyzed as follows.

Table 11: Pearson Correlation result for relationship between depression, anxiety, stress scores of the respondents

Pearson Correlation			
Variables	Depression	Anxiety	Stress
Depression	—	.435**	.510**
Anxiety		—	.343
Stress			—

** $r < 0.01$

As indicated in the table above, Pearson Correlation was computed to examine the relationship between depression, anxiety, and stress scores internally displaced youths. Depression has shown positive correlation with anxiety ($r=.435^{**}$) and stress; ($r=.510^{**}$). Besides, anxiety has shown positive correlation with stress; ($r=.343^{**}$). It can be concluded that there were moderate positive relationship between depression and anxiety scores, as well as between depression and

stress scores. Also there was weak positive relationship between anxiety and stress scores (Based on Dancey & Reidy (2007) Guide to correlation coefficients, cited in Akoglu (2018)).

CHAPTER FIVE

Discussions

In this section, the results of the findings were discussed in relation to the literatures. The main aim of this study was to assess incidence of depression, anxiety and stress among internally displaced youths. The baseline results, however, also provided information about the traumatic events that experienced by the internally displaced youths, sex and marital status difference in depression, anxiety and stress among internally displaced youths, the relationship between depression, anxiety and stress scores of the respondents. The major findings were discussed as follows.

5.1 Trauma Events Experienced by the Respondents

The findings in this study indicated different kinds of trauma events which were experienced by internally displaced youths from Somali and Oromia regions border which is similar with what were reported by Jong et al. (2001) and Haruna et al. (2017). The most frequently experienced trauma events in this study were; forced hiding (74%), witnessing combat situation (68%), lack of food or water (60.1%), murder and death of family member or friend due to violence (56.6%). This result were also supported by Cardazo et al. (2000) which shows high prevalence of traumatic events among internally displaced peoples; 66.6% deprived of food and water, 66.5% witnessing combat situation, 64.1% forced isolation, 47.6% ill health without access to medical care, 41.8% forced to separation from family members, 26.4% murder of family or friend. 23.9% witnessing murder, 17.7% kidnapping; whereas, 4.4% rape.

Similar study conducted by Marshall et al. (2005) showed people who were affected by war and conflict were forced to labor (like animal or slave) (96%), 90% had a family member or friend

who were murdered, and 54% tortured. Moreover, 34% of them saw a dead body in their neighborhood, 28% were robbed and 17% were threatened by a weapon.

A study presented other supportive evidence by Feyera et al. (2015) which showed high prevalence of trauma events among population affected by conflict; 57.4 % experienced a combat situation, 45.1 % of the participants witnessed the murder of family or friends, and 53 % of them reported witnessing of unnatural death of family, (74.4 %) had ever lacked food or water, 44.4 % had seriously ill without access to medical care.

5.2 Incidence of depression, anxiety and stress

The high incidence of depression (89.9%); anxiety (94.3%) and moderate stress 78.1% in this study was similar to that reported by other studies. Housen et al., 2017 found high prevalence of depression (90%) and anxiety (71%); among internally displaced people. Other study conducted by Wiseman (2015) showed, among people experienced traumatic events; 58.7% had symptoms of anxiety above the normal range. Similarly, 54.3% had symptoms of stress above the normal range. However, inversely Husain et al. (2011) stated that the overall prevalence of anxiety and depression symptoms among internally displaced people were 32.6% and 22.2% below normal range.

This study showed high incidence of depression, anxiety in a sample internally displaced youths living in Dukem, Genda Koticha IDP site. Mild depression showed a score of 13(5.7%); moderate depression showed 43 (18.9%); severe depression showed 77 (33.8%) and extremely severe had a score of 72 (31.6 %). Regarding to anxiety scores, 39.9 % (91) of respondents were at extremely severe level of anxiety, whereas 23.7 % (54) were at severely anxious and 24.1 % (55) of respondents at moderate level of anxiety. Most of the respondents, 78 (34.2 %) were at

moderate level of stress; 58 (25.4 %) of them were at severe level of stress. Similar studies conducted in post-conflict settings found high incidence of depression, anxiety and stress. Roberts et al. (2008); Alkhafaji (2015); Morina et al. (2018); Nwoga et al. (2018); and Sabim et al., (2003) showed severe level of depression and anxiety among internally displaced and people who were affected by war and violence. Study conducted by Musau & Wasanga (2011) indicated that, levels of depressive symptoms among internally displaced people ranging from mild to severe. 41% severely depressed; 30% moderately depressed, and 11% had mild depression. Lumley et al., 2018 showed extremely severe range of depression (42%) and anxiety (57%) among population affected by violence & conflict.

5.3 Sex Difference in Depression, anxiety and stress scores of the respondents

This study's results indicated the absence statistically significant sex differences in depression anxiety and stress scores of the internally displaced youths. This means both males and females are equally affected by depression, anxiety and stress. This result were supported by Qeshta et al., 2019; showed absence of sex differences in depression scores among displaced people. Study conducted by Ayazie et al., (2014) showed absence of significant sex difference in anxiety among people who were affected by conflicts. Inversely, study conducted by Mujeeb (2015) showed significant gender differences in depression, anxiety, and stress among internally displaced people. Another study conducted by Farooqi & Habib (2010) showed significant gender difference in depression, anxiety, and stress between males and females who are survivors of violence.

5.4 Marital Status Difference in depression, anxiety and stress scores of the participants

Additionally, regarding the marital status of the participants of this study, 35% the participants were married. This finding may be due to the culture settings. One way ANOVA results showed that there is no statistically significance difference between married, unmarried, and widowed internally displaced youths in DASS score. From the results, it can be concluded that there were no difference in depression, anxiety, and stress scores among married, unmarried and widowed IDYs. Also the same as married, the unmarried, IDYs depression, anxiety and stress score is not higher than those who are widowed. Study conducted by Fan et al., 2011 showed the absence of statistically significant difference in DASS scores between married, unmarried, and widowed/separated among people affected by violence.

5.5 The relationship between depression, anxiety, and stress scores of the respondents

The results also pointed out significant relationship between depression and anxiety, and stress scores of the respondents (Depression & Anxiety; $r = .435$, Depression and Stress; $r = .510$, Anxiety and stress; $r = .343$). This result was similar with study conducted by Qeshta (2019) which showed significantly positive correlation between anxiety and depression among internally displaced people (anxiety and depression ($r = 0.60$), anxiety and stress ($r = 0.61$) stress and depression ($r = 0.47$). Study conducted by Jahanara (2015) indicated that depression, anxiety, and stress scores of people who affected by conflict were positively correlated to each other.

CHAPTER SIX

Summary, Conclusions and Recommendations

6.1 Summary

This study was conducted with the aim of examining the incidence of depression, anxiety and stress among internally displaced people in Genda Koticha, Dukem. The study also explored trauma events experienced by IDPs, sex differences in DASS, the relationship between DAS scores of IDPs. In order to deal with basic research questions, related literature was reviewed and three theoretical frameworks were utilized; Cognitive Theory, Reinforcement Theory, Psychoanalytic Theory, Emotional Processing Theory, General Adaptation Syndrome Theory, Appraisal Theory. The study involved the questionnaires that measures trauma events and DASS scores of IDYs. Before collection of main data, a pilot study was conducted to realize the reliability of the instruments and necessary improvement was made. Then after, the study involved IDY youth in the selected site that chosen purposefully in 2019. The scales were distributed to purposefully selected 228 IDY in Genda Koticha site one found in Dukem. Then, the data was collected through purposive sampling technique and 228 questioners, which were returned properly, were used for data analysis.

The collected data was analyzed using both descriptive and inferential statistical analysis. Descriptive statistics were used to describe the results of the study and inferential statistics were utilized to check the statistical significance of the tests. Hence, to calculate the relationship between variables Pearson correlation was used. One way ANOVA was used to determine the existence of significant difference among marital statuses and DASS scores. Independent sample t-test also used to calculate the DASS scores difference between IDYs males and females.

Based on the analysis the most experienced trauma events were forced hiding (74.6%), witnessing combat situation (68.0%). Rarely experienced events were; rape (4.8), witness rape and other sexual abuse (24.6). Concerning incidences of depression; 18.9% of the respondents' were at moderate, 33.8% severe, and 31.6% were extremely severe level of depression. There were no significant differences observed between sexes and marital statuses in depression scores. ($t(226) = .049; p=.961$), ($F(2,225) = 2.204, P=.113$).

The study also revealed that majority of IDYs (39.9 %) was at extremely severe level of anxiety. There were no significance difference in anxiety between males and females ($t(226) = .142; p=.858$). marital statuses; ($F(2,225) = .714, P=.491$). In addition, the results were also discovered that most of the internally displaced youth were at moderate level of stress (78.1%). There were no statistically significant mean difference between males internally displaced youth on their stress score with ($t(226) = .086; p=.932$) & marital statuses, Stress; ($F(2,225) = .035, P=.996$).

In addition Pearson correlation results for depression score has shown significant positive correlation with anxiety ($r=.435^{**}$) and stress; ($r=.510^{**}$). Besides, anxiety has shown significant positive correlation with stress; ($r=.343^{**}$). It can be concluded that there were moderate positive relationship between depression and anxiety scores, as well as between depression and stress scores. However, there were low positive relationship between anxiety and stress scores.

6.2 Conclusions

The majority of internally displaced youth were experienced violence and conflicts related trauma events. Most of them were forced to hide (74.6%), experienced combat situation, death of family members or friends due to violence. The prevalence of conflict and violence related traumatic events were high among internally displaced youths at Dukem Genda Koticha IDP site. According to DASS (65.4%) of the youths score showed a severe and very severe rate of depression and anxiety (63.8%). Therefore, the large numbers of internally displaced youths could be at high risk of depression and anxiety. According to the results of this study, there were non-significant differences found between DASS scores of IDY in sex and marital statuses. This may be because of experiencing same stressful events, living under the same condition. DASS scores of the participants were positively correlated to each other. The purposive sampling method that was used in present shows above results, but it may not useful for other study.

6.2 Recommendations

This study was conducted to assess the incidence of depression, anxiety and stress among internally displaced youth who are living in Dukem Genda Koticha IDP site. It also assessed traumatic events which experienced by the internally displaced youths at that area. As the findings and the conclusions drawn disclosed, there were high incidence of depression, anxiety and stress among internally displaced youths. Thus, based on the findings of the study and the conclusions, the following recommendations are forwarded to improve internally displaced youth mental health at Dukem, Genda Koticha IDP site.

All the internally displaced people at that site were displaced from their home due to war and conflict. As result, they experienced different traumatic events which may affect their

psychological wellbeing. At a national level, there was a need to prevent and manage displacement, and traumatic events and its impact following displacement. An organized body of educators, charity association, youth association, health related organization, different media, law enforcement bodies and other concerned bodies at national level have to be involved.

Government policy should also consider the effects of displacement on mental health. In resettlement policy, mental health and psychosocial support program should include improving mental health of internally displaced people through provision of resources, enhancing the capacity of the individual for resilience, and encouraging community supports.

Mental health awareness and resilience trainings should be given for internally displaced people in collaboration with government, mental health professionals, universities, NGO's, to increase understanding and treatment of psychological disorders among internally displaced people. In addition, the organized psychotherapy and counseling center should found around IDP camps and sites to support internally displaced people.

Furthermore, research should be conducted on the prevalence of psychological problems and psychological impact of forced internal displacement to enhance knowledge about the mental health needs of those in sustained displacement.

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Appendix A: English Questionnaire

ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES

SCHOOL OF PSYCHOLOGY

This study is designed to assess the incidence of Depression, Anxiety and Stress among internally displaced youth from Somali and Oromia regions border. The information to be collected through this questionnaire will be used only for academic purpose and are thus promisingly confidential. Hence you are kindly requested to fill the questionnaire honestly and carefully with confidence.

Thank you for your cooperation.

Part One: Background information of the respondents

Sex Male _____ Female _____

Age _____

Marital Status Married _____ Unmarried _____ Divorced _____ Widowed _____

Part Two: Traumatic events

Instruction I: Below statements show events that related to your experience when you displaced from your home. Please indicate whether you have experienced any of the following events (check Yes Or No) by putting ‘X’ mark on space provided under the response categories.

No.	Items	Responses	
		Yes	No
1	Witnessing killing/murder		
2	Forcing to hide		

3	Witness combat situation		
4	Kidnapped		
5	Witness torture		
6	Encounter Rape		
7	Witness rape or other sexual abuse		
8	Ill without healthcare		
9	Lack of food and water		
10	Forced evacuation under dangerous conditions		
11	Forced to betray family member, or friend placing them at risk of death or injury		
12	Murder or death due to violence of family member or friend		
13	Forced to separate from family members		
14	Enforced disappearance or kidnapping of family member/friend		

Part Three: Incidence of Depression, Anxiety, Stress

Instruction II: For each of the statements below, please circle the number which best indicates how much the statement applied to you OVER THE PAST WEEK. There are no right and wrong answers. Do not spend too much time on any one statement.

0-Did not applied to me at all

1-Applied to me to some degree, or some of the time

2-Applied to me to a considerable degree, or a good part of the time

3- Applied to me very much, or most of the time

No	Items	Responses			
		0	1	2	3
1	I felt down- hearted and blue				
2	I felt sad and depressed				
3	I could see nothing in the future to be hopeful about				
4	I felt that I have nothing to look forward to				
5	I felt that life was meaningless				
6	I felt that life wasn't worthwhile				
7	I felt I was pretty worthless				
8	I felt I wasn't worth much as a person				
9	I felt that I had lost interest in just about everything				
10	I was unable to become enthusiastic about anything				
11	I couldn't seem to experience any positive feeling at all				
12	I couldn't seem to get any enjoyment out of the things I did				
13	I just couldn't seem to get going				
14	I found it difficult to work up the initiative to do things				
15	I was aware of the action of my heart in the absence of physical exertion (e. g. , sense of heart rate increase, heart missing a beat).				
16	I Perspired noticeably (e.g. , hands sweaty) in the absence of high temperatures or physical exertion.				

17	I was aware of dryness of my mouth				
18	I experienced breathing difficulty (e.g., excessively rapid breathing, breathless in the absence of physical exertion)				
19	I had difficulty in swallowing				
20	I had feelings of shakiness (e.g., legs going to give away)				
21	I experienced trembling (e.g., in the hands)				
22	I was worried about situations in which I might panic and make fool of my self				
23	I found myself in situations which made me anxious I was most relieved when they ended				
24	I feared that I would be “thrown by some trivial but unfamiliar task.				
25	I felt I was close to panic				
26	I felt terrified				
27	I felt scared without any good reason				
28	I had feeling of faintness				
29	I found it hard to wind down				
30	I found it hard to calm down after something upset me				
31	I found it difficult to relax				
32	I felt that I was using a lot of nervous energy				
33	I was in a state of nervous tension				
34	I found myself getting upset rather easily				
35	I found myself getting upset by quite trivial things				
36	I found myself getting agitated				

37	I tended to over react to situations				
38	I found that I was very irritable				
39	I felt that I was rather touchy				
40	I was intolerant of anything that kept me from getting on with what I was doing				
41	I found myself getting impatient when I was delayed in any way (e.g., lifts, traffic lights, being kept waiting)				
42	I found it difficult to tolerate interruptions to what I was doing				

Appendix B: Afan Oromo Questionnaire

YUUNIVERSITII FINFINNEE/ADDIS ABABAA

COLLEEJII BARNOOTAA FI SAAYINSII AMALAA

MUUMMEE BARNOOTA SAAYIKOOLAJII

Gaaffileen kun kan qopha'aniif sadarkaa mukaa'uu, muddama/ yaaddoo fi dhiphina dargaggoota fi ga'eessota daangaa naannolee Somaalee fi Oromiyaa irraa buqqa'anii qorachuufi. Odeeffannoowwan qorannoo kanarraa argaman dhimma barnootaa qofaaf kan fayyadan ta'uusaa bartee bilisummaadhaan akka guuttun si jajjabeessa.

Hirmaannaa keetiif guddaa galatoomi.

Kutaa Tokkoffaa: Gaaffii waa'ee deebiftootaa

1. Saala: Dhiira_____ Dubara_____
2. Umrii: _____
3. Sadarkaa gaayilaa
Kan hinfuune/heerumne_____ Kan fuudhe/ heerumte _____ Kangadhiise/ste_____
Du'aan kan adda bahe/baate_____

Kutaa Lammaffaa: Gaaffii waa'ee haalota miidhaa xiinsammuu namarraan gahanii.

Qajeelfama Tokkoffaa: Himootni armaan gadii kun rakkoollee yeroo naannoo kee irraa buqqifamte si mudatan agarsiisu. Himicha sirriitti dubbisiitii, filannoo kee EEYYEE ykn LAKKII jechuun iddoo filannoo jalatti mallattoo 'X' barreessudhaan ibsi.

Lak	Gaaffilee	Deebiwwan	
		Eeyyee	Lakkii
1	Nama ajjeefame ykn qalame arguu		
2	Dhokachuuf dirqamuu		
3	Haala baay'ee nama miidhuu danda'u(fknf: nama meeshaa waraanaa ykn kan biraa qabatee si miidhuuf deemu, abidda boba'u) arguu		
4	Ugguramuu/ukkaamfamuu		
5	Utuu namni dararamuu arguu		
6	Akka tasaa gudeedamuu		
7	Utuu namni gudeedamuu ykn miidhaa saalaa irra		

	gahuu arguu		
8	Dhukkubsatanii yaalamuu/yaala gahaa dhabuu		
9	Nyaata fi bishaandhabuu		
10	Bakka miidhaan sirra gahuudanda'u turuuf dirqamuu		
11	Humnaan maatii ykn hiriya kee iddoo miidhaan irra gahuu danda'u (du'u ykn madaa'u) akka keessuuf dirqisiifamuu		
12	Du,uu miseensa maatii ykn hiriya keetii(sababii jeequmsaatiif)		
13	Dirqisiifamuun/ humnaan miseensota maatiiirraa ykn hiriya irraa addaan bahuu		
14	Dhabamuu ykn ugguramuu miseensa maatii ykn hiriya keetii		

Kutaa 3ffaa: Gaaffii waa'ee sadarkaa mukaa'uu/ of jibbuu, muddamaa/yaaddoo fi dhiphinaa

Qajeelfama Lammaffaa: Himoota armaan gadii dubbisiitii, sadarkaa isaan jireenya kee torban darbee ibsuu danda'an irratti hundaa'uudhaan lakkoofsota tarreeffaman jalatti mallattoo 'X' barreessuun deebisi. Deebii sirriin yookaan sirrii hin taane hinjiru. Hima tokkicharratti yeroo dheeraa hingubin.

- 0- Na hin ilaallatu
- 1- Haga tokko na ilaallata
- 2- Sadarkaa murtaawaa ta'een na ilaallata
- 3- Baay'ee na ilaallata yookaan yeroo baay'ee na ilaallata

Lak.	Gaaffilee	Deebiiwwan			
		0	1	2	3
1	Hamileen koo baay'ee na cabaadha				
2	Nan gadda nan muddama				
3	Jireenya egeree kootiif wanti ani abdadhu tokkollee hinjiru				

4	Gara fuulduraatti waanan abdadhu tokkollee waanan hinqabne natti fakkaata				
5	Jireenyi koo waan abdii fi hiika hin qabne natti fakkaata				
6	Jireenyi waan gatii hinqabne natti fakkaata				
7	Ani nama gatii hin qabne waanan ta'e natti fakkaata				
8	Akka namoota kaanii waanan gatii qabu natti hin fakkaatu				
9	Wantoota hundumaa irratti fedhiin koo baay'ee gadi bu'aadha				
10	Waan kamiif iyyuu kaka'umsa hinqabun ture				
11	Miira gaarii keessa kootti uumuu gonkumaa hin dandeenye				
12	Wantootan hojjedhee darbetti gonkumaa gammachuu hinqabu				
13	Fuulduratti tarkaanfachuun waan salphaa natti hin fakkaatu				
14	Kaka'umsa waa tokko hojjechuu argachuun baay'ee natti ulfaata				
15	Wayita waanti qaamakoo irratti dhiibbaa godhu hinjirretti dhahannaan onnee kootii natti dhagahama: fakkeenyaaf dhahannaan onnee koo nidabala, dhahannaan onnee dhaabbachuu				
16	Yoo ho'I olka' aan hin jiraanne illee, yookaan sochii qaamaa wayitan godhu akka salphaatti na dafqisiisa (fakkeenyaaf harka koo na dafqisiisa)				
17	Afaan koo akkuma salphaatti na goga				
18	Rakkoon hargansuu yeroo baay'ee na mudata, fakkeenyaaf garmalee aritiidhaan harganuu, hafuura dhabuu				
19	Wantoota garaagaraa liqimsuun natti ulfaata				
20	Miirri laamsha'uu yeroo baay'ee natti dhagahama (fakkeenyaaf miillikoo hadoodee na jalaa sigigaata)				
21	Hollannaan yeroo baay'ee na mudata (fakkeenyaaf harkakoo)				
22	Waa'ee haalota na sodaachisanii yaadee dhiphadheen of gowwomsa				
23	Yeroo baay'ee haalota baay'ee na aarsanii fi na dhiphisan keessattan of arga. Wayita miironni kunnin nagadhiisan keessi koo ni tasgabba'a				
24	Humni ta'e waan darbatee na kuffisu natti fakkaata, garuu humna hin beekammedha				

25	Keessikoo baay'ee na jeeqama				
26	Baay'ee na naasisa/ rifaasisa				
27	Sababa tokko malee na sossodaachisa				
28	Yeroo baay'ee of na wallaalchisa				
29	Of tasgabbeessuun baay'ee natti ulfaata				
30	Wayita wanti tokko na aarsu salphaatti of tasgabbeessuu hindanda'u/ natti ulfaata				
31	Keessa koo tasgabbeessee of bohaarsuun baay'ee natti ulfaata				
32	Anniisaa narvii kootii baay'ee waanan itti fayyadamaa ture natti fakkaata				
33	Narviin/buusaan qaama kootii haalaan muddamaa ture				
34	Salphaattan / dafeenaara				
35	Wantootuma salphootattan aaree finiina				
36	Miirikoo salphaatti jeeqamuu danda'a				
37	Miirri koo haalota kamiyyuu keessatti salphaatti hubamuu danda'a				
38	Dafeen mufadha				
39	Baay'een dheekkama				
40	Wanta waanan hojjecha ture na danqu kamiif iyyuu obsa hinqabu				
41	Wayita ani waa tokko of boodatti hafu obsaan dhaabadhee eeguu hindanda'u (fakkeenyaaf liiftii, ibsaa tiraafikii, bakka ta'e akkan turuuf wayitan godhamu)				
42	Wayita ani waa tokko hojjechaa jirutti yoo wanti yookaan namni biraan dhufee gidduu seene obsa hinqabu				

Approval Paper

**“Depression, Anxiety, and Stress among Internally Displaced People (IDPs)
from Somali and Oromia Regions Border in Genda Koticha, Dukem”**

By: Dabale Eliyas

Approved by the board of examiners

_____	_____	_____
Chair person name	Signature	Date
_____	_____	_____
Advisor	Signature	Date
_____	_____	_____
Internal examiner	Signature	Date
_____	_____	_____
External examiner	Signature	Date
_____	_____	_____
Graduate program Coordinator	Signature	