ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICINE

DEPARTMENT OF PSYCHIATRY

TRAUMA EXPOSURE AND ITS ASSOCIATION WITH MENTAL HEALTH OUTCOME AND PSYCHOSOCIAL WELLBEING AMONG RESIDENTS AND IDPS IN AXUM DURING THE NORTHERN ETHIOPIAN CONFLICT

PRINCIPAL INVESTIGATOR: HAILELEUL MEKONNEN TILIINTY
(THIRD YEAR PSYCHIATRY RESIDENT)

MAY, 2026



ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICINE

DEPARTMENT OF PSYCHIATRY

TRAUMA EXPOSURE AND ITS ASSOCIATION WITH MENTAL HEALTH OUTCOME AND PSYCHOSOCIAL WELLBEING AMONG RESIDENTS AND IDPS IN AXUM DURING THE NORTHERN ETHIOPIAN CONFLICT

PRINCIPAL INVESTIGATOR: HAILELEUL MEKONNEN TILINTY
(THIRD YEAR PSYCHIATRY RESIDENT)

A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE SPECIALITY CERTIFICATE IN PSYCHIATRY

Acronyms

AAU: Addis Ababa university

CHS: College of Health Sciences

CO-I: Co-investigator

DSM-V: Diagnostic and statistical manual for mental disorder fifth edition

FGD: Focused group discussion

GBV: Gender based violence

GHQ-12: General Health Questionnaire

HESPER: Humanitarian Emergency Settings Perceived Needs Scale

HPRT: Harvard program in refugee trauma

HTQ: Harvard Trauma Questionnaire

IASC: Inter-agency Standing Committee

IDP: Internally displaced people

IRB: Institutional review board

LMIC: Low- and middle-income country

MDD: Major depressive disorder

MHPSS: Mental health and psychosocial support

NGO: Non-governmental organization

OSSS-3: Oslo Social Support Scale

PI: Principal investigator

PTSD: Post traumatic stress disorder

SGBV: Sexual and gender-based violence

SPIESS: Skills, Physical, Intellectual, Emotional, Social, and Spiritual/Existential functioning

SPSS: Statistical package for the social sciences

TIC: Trauma informed care

UN: United nation

UNHCR: United nations high commissioner for refugees

UNICEF: United nations international children's emergency fund

USAID: United states agency for international development

WASSS: WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings

WHO: World health organization

ACKNOWLEDGMENT

I would like to thank my advisors Dr. Engida Girma, Dr. Wubalem Fekadu, and Dr. Azeb Asaminew, for their incredible guidance and mentorship.

A special thanks to psychiatry department of Addis Ababa University for facilitating this opportunity and supporting my research efforts.

I also express my gratitude to the Joint European Initiative to Strengthen Medical Specialization in Ethiopia for their financial support in making this project possible.

Table of Contents

Acronyms ..... *i*

ACKNOWLEDGMENT ..... *iii*

Lists of Tables ..... *vi*

List of figures ..... *vii*

List of Appendices ..... *viii*

ABSTRACT ..... *ix*

1. INTRODUCTION *1*

1.1 BACKGROUND OF THE STUDY 1

1.2 Statement of the problem 4

2. Significance of the study *5*

3. LITERATURE REVIEW *6*

3.1 Introduction 6

3.2 Trauma Exposure in Conflict Zones 7

3.3 The Impact of Traumatic Events on Mental Health 9

3.4 Psychosocial Consequences of Trauma 12

3.5 The Role of Social Support in Trauma Recovery 13

3.6 Coping Strategies in Response to Trauma 15

4. Conceptual framework *18*

5. Research Question *19*

6. OBJECTIVE *20*

6.1 General objective: 20

6.2 Specific objectives: 20

7. METHODOLOGY *21*

7.1 Study setting 21

7.2 Study design and period 21

7.3 Study Population 21

7.4 Eligibility criteria 21

7.5 Sample Size Determination 22

7.6 Sampling procedure 22

7.7 Data Collection Instruments 24

7.9 Data processing and analysis 30

8. Ethical considerations 31

9. Results *32*

9.1. Sociodemographic characteristics 32

9.2. Exposure to traumatic events 33

9.3 Mental health outcomes 35

9.3.1 PTSD severity 35
9.3.2 Culturally recognized symptoms of suffering 37
9.3.3 Severe symptoms and functional impairment 38
9.3.4 Perceived needs in humanitarian settings 38
9.3.5 General psychological distress 39
9.3.6 Social support 40
9.3.7 Coping strategies 40

9.4 Factor affecting PTSD 41

9.4.1 Factors associated with PTSD 41
9.4.2 Multiple analysis of factors associated with PTSD 45

10. Discussion 47

10.1 Trauma Exposure 47

10.2 Mental Health Outcomes 48

10.3 Factors associated with PTSD 53

11. Strengths and limitations 56

11.1 Strength 56

11.2 Limitations 57

12. Conclusion 58

13. Recommendations 58

14. REFERENCES 60

11. Appendix 71

ANNEX 1 : Participants' Information Sheets 71

Annex 2-Informed Consent Form 72

ANNEX 3 : Demographic Information 73

Annex 4- HTQ Cambodian Version 75

ANNEX 5: WHO-UNHCR ASSESSMENT SCHEDULE OF SERIOUS SYMPTOMS IN HUMANITARIAN SETTINGS (WASSS) 89

ANNEX 6: THE HUMANITARIAN EMERGENCY SETTINGS PERCEIVED NEEDS SCALE (HESPER) 93

Annex 7: The General Health Questionnaire (GHQ) 12 99

ANNEX 8: Oslo Social Support Scale (OSSS-3) 102

ANNEX 9: Brief COPE 104

ANNEX 10: Tigrigna version of all instruments 107

12. Assurance of principal investigator 124

Declaration of original work 124

Lists of Tables

Table 1. Sociodemographic characteristics of participants

Table 2. Trauma events experienced by participants

Table 3. Traumatic event count among participants

Table 4. Trauma symptoms (DSM-5) mean scores

Table 5. Culturally recognized symptoms of suffering

Table 6. Severe symptoms and functional impairment

Table 7. Prevalence of psychological distress

Table 8. Coping Strategy Scores

Table 9. Association between selected variables and PTSD symptom severity (non-parametric tests

Table 10. Multivariable linear regression predicting PTSD symptom severity

List of figures

Figure 1. Conceptual framework

Figure 2. Sampling method of permanent residents

Figure 3. Sampling method of IDP sites

Figure 4. Bar chart of frequency of traumatic events

Figure 5. Histogram with kernel density estimate of PTSD symptom severity

Figure 6. Distribution of PTSD status among participants

Figure 7. Horizontal bar chart of perceived need severe problems

Figure 8. Heatmap with correlation coefficients and color intensity

Figure 9. Median score of coping strategies by PTSD Status

Figure 10. Forest plot of independent predictors of PTSD symptom severity

List of Appendices

ANNEX 1: Participants' information sheet

ANNEX 2: Informed consent form

ANNEX 3: Demographic information

ANNEX 4: HTQ Cambodian version

ANNEX 5: WASSS

ANNEX 6: HESPER

ANNEX 7: GHQ-12

ANNEX 8: OSSS-3

ANNEX 9: Brief COPE

ANNEX 10: Tigrigna version of all instruments

ANNEX 11: Declaration of original work

ABSTRACT

Background:
Traumatic events have a well-established impact on mental health which often leads to psychological distress and impairment. However, in the context of the northern Ethiopian conflict (November 2020–November 2022 G.C), the mental health consequences for affected communities particularly in Axum is not studied well.
Objectives:
This study assessed the association of trauma exposure with mental health outcomes and psychosocial well-being among residents and IDPs in Axum during the northern Ethiopian conflict.
Methods:
A community-based cross-sectional study was conducted in August 2025 with 515 participants (340 permanent residents and 175 internally displaced persons) selected through multi-stage systematic sampling. Data were collected using standardized instruments, including the Harvard Trauma Questionnaire (HTQ), GHQ-12, WASSS, HESPER, Brief COPE, and the Oslo Social Support Scale, all translated into Tigrigna. Multiple linear regression analysis was used to identify factors associated with PTSD severity.
Results:
Trauma exposure was nearly universal (99.8%), with 54% of participants reporting eight or more traumatic events. The prevalence of probable PTSD was 41.9%, and 74.6% reported significant psychological distress. Functional impairment due to emotional distress was reported all or most of the time by 31.5% of participants. Culturally recognized symptoms such as hopelessness, inability to help others, and meaning-making struggles were showed the strongest statistical association with PTSD severity ($\beta = 0.586$, $p < 0.001$). Social support was poor in 77.5% of participants. Avoidant coping was strongly associated with worse outcomes ($\beta = 0.191$, $p < 0.001$), whereas emotion-focused coping showed a protective effect. Internally displaced persons had significantly higher PTSD scores than permanent residents. Food related problem (67.6%) and inadequate shelter (59.0%) were the most frequently reported serious needs.
Conclusions:
The findings show a considerable burden of trauma and significant mental health consequences among the study population in Axum. Culturally recognized symptoms of distress are found to be fundamental to the expression of distress and require specific focus in both assessment and intervention. Any community interventions should include psychosocial care and address basic needs assessment and prioritize internally displaced populations.

Keywords:
Cultural symptoms of trauma, Northern Ethiopian conflict, trauma, psychological distress, IDPs

1. INTRODUCTION

1.1 BACKGROUND OF THE STUDY

In November 2020 conflict started in the Tigray region which leads to violence, displacement, and humanitarian crises and the conflict has resulted in destruction of properties, displacement, mass killings and sexual violence (1). According to reports, thousands have lost their lives and millions have been displaced both internally and across borders. The ongoing instability has disrupted livelihoods, healthcare services, and social structures, leaving a lasting impact on the population's mental and physical well-being (1,2).

According to reports from the UN and USAID, more than 2.1 million people were internally displaced with over 71,000 seeking refuge in neighboring country (3). The psychological impact of the conflict in Tigray was profound and war survivors, including those affected by gender-based violence (GBV), internally displaced persons (IDPs) and other vulnerable groups have experienced extreme trauma and stress. Most commonly reported mental health issues among these populations include depression, anxiety, PTSD and other forms of mental distress (4).

Though peace agreement was signed in November 2022, the long-term effects of the war on affected population's mental health and psychosocial wellbeing remain important areas of study especially regarding coping mechanism and availability of social support in post conflict environments (5).

Trauma from armed conflict is known to have significant effect on mental health and psychosocial functioning (6). Anxiety, PTSD, and depression are commonly reported among affected population of conflict (7–9). Trauma also have the potential to affect beyond individual level such as families, community and society disrupting the social bonding and economic recovery (10). Despite having such effects, there remain a signficant research gap in understanding about the effect of trauma on mental health faced by affected population of the northern conflict especially in Axum.

.

A research analysis done in Tigray region to examine the extend of health facility dysfunction between November 2020 and June 2021, 27.5% of hospitals, 17.5% of health centers and none of the 712 health posts were functional. The analysis also documented that basic and essential health services such as antenatal care, vaccinations and deliveries were affected significantly. The report also documented that over 5.2 million affected individuals need emergency food assistance. the disruption of healthcare service and lack of basic need has affected mental health and psychosocial functioning of the affected individuals (11).

Trauma exposure severity and frequency can significant affect the mental health and also psychosocial outcome of individuals (12,13). Global researches have shown that severe trauma like witnessing violence, and sexual trauma can overwhelm an individual's coping capacity and might leads to significant psychological distress (14). Multiple traumatic events also have significant impact on the recovery process and leading to a sense of chronic threat (15). Due to this, pattern and severity of trauma exposure determine both the psychological impact and also the recovery journey.

The mental health outcomes of affected populations during the northern conflict were compounded by displacement, loss of social support and limited access to mental health services (11). In such conditions, the ability of individuals to cope with trauma is important. Coping strategies may vary from person to persons and understanding the way how the affected individuals cope during the conflict is crucial in addressing their needs and designing specific interventions.

Additionally, studies have shown that social support is one of the most protective factors against the adverse effects of trauma especially in armed conflict related traumatic events (16). Social support provide emotional support, enhance resilience among the community and restores the social bonding (17). However, in conflict affected population social support may be disrupted due to loss of family member or close person, destruction, and displacement.

This study aimed to explore the impact of traumatic events on mental health and psychosocial well-being, coping strategies, and social support among survivors of the Axum conflict. By examining the types, severity, and frequency of traumatic experiences, as well as the mental health consequences this research seeks to

identify the specific needs of survivors. Additionally, it aimed analyzing the coping strategies employed by survivors and the role of social support in their recovery process. This research provide insight into how trauma affects survivors of the northern conflict and offer valuable information for the design of effective mental health and psychosocial support interventions.

By addressing these gaps, this study contributes to the growing body of literature on mental health and psychosocial support in conflict affected regions. More importantly, it provides evidence-based recommendations for humanitarian and government bodies to enhance their response to the mental health needs of survivors.

This research is not significant for Axum town only but also for similar conflict-affected areas, as it provides insights that can inform broader interventions aimed at addressing mental health and psychosocial issues in the post conflict areas. Understanding the patterns of trauma, the coping strategies of survivors, and the role of social support can also help in designing interventions that are both culturally sensitive and contextually appropriate.

Additionally, this study aimed at generating evidence that will serve as the foundation for developing and adapting culturally sensitive, trauma-informed mental health and psychosocial support (MHPSS) care.

1.2 Statement of the problem

The Tigray conflict has resulted in suffering, including displacement, loss of life, and destruction of property (11). The city of Axum which is home to both long term residents and IDP population has become an example for mental health struggles caused by the Northern Ethiopian conflict.

A book published in 2024 titled Tigray: The Hysteresis of War documented that satellite images showed mass graves near Axum churches (18). Though the extend and magnitude of the conflict on infrastructure and mortality burden has been documented, the impact of the conflict on mental health of affected population remains under studied.

In previous studies exposure to any traumatic events have been linked to severe mental health outcomes including PTSD, depression, anxiety and to the extent of psychosis (6). The psychosocial effect of trauma is beyond clinical mental health disorders. Affected individuals may face difficulty in rebuilding their lives, reconnecting socially and returning back to their premorbid functionality (16). These conditions can also affect individuals' capacity to function well and recover in the aftermath of war. In Axum, affected populations have experienced multiple traumatic events. however, there is limited data on the patterns, type and severity of these experiences (18). This knowledge gap may delay in designing targeted mental health interventions for those affected during the conflict.

Additionally, coping strategies also play an important role in how individuals respond to and recover from trauma (19). However, in conflict affected settings like Axum, survivors may use maladaptive coping strategies that exacerbate their mental health condition. This might require a detail study on the coping strategies employed by the affected population and their relationship to mental health outcomes. Such evidence can guide the development of contextually appropriate interventions that promote adaptive coping mechanisms.

This study aimed to fill gaps by examining the patterns of trauma, the mental health and psychosocial consequences of trauma exposure, the coping strategies of affected population, and the role of social support on affected individuals in Axum during the northern Ethiopian conflict to have evidence-based interventions.

2. Significance of the study

This study provides an extensive assessment of the patterns, types, frequency and severity of trauma experienced by affected population of Axum during the northern Ethiopia conflict. By identifying the specific traumatic events experienced by the affected population in Axum, the study helps in understanding the unique challenges faced by those affected and this is important for creating mental health and psychosocial support strategies that meet the specific needs of those affected.

This study also provide evidence on coping strategies applied by the Axum community during the conflict which provide insights into which mechanisms are adaptive and which may be maladaptive that may exacerbate distress. This evidence can guide practitioners in developing programs that supports resilience and adaptive coping among survivors.

Additionally, this research contributes to an understanding of the mental health outcomes and psychosocial consequences associated with trauma which is unique to Axum community and this will help for designing community specific interventions.

this research also examines the availability of social support and how this support helped during the conflict. understanding the role of social support will help in strengthen the support system and also trying to design intervention in a way to help them have more social support if the affected population lack support.

After examining the relationship between trauma exposure, mental health outcome, social support and coping strategies, this research provide evidence-based intervention and recommendations for the design and implementation of trauma informed MHPSS for aid organizations, government body and other stakeholders in Axum and similar settings.

Though the focus of this research was on Axum community, the findings help to other conflict affected region of Tigray that shared the similar culture and context and the insights gained from this research can serve as a model for addressing mental health in culturally oriented way.

3. LITERATURE REVIEW

3.1 Introduction

The impact of armed conflict on mental health and psychosocial well-being has become an area of research, given the growing recognition of its long term consequences on individuals and communities. Traumatic experiences, such as exposure to violence, forced displacement, and loss of loved ones, result in complex mental health and psychosocial challenges, including post-traumatic stress disorder, depression, anxiety, and disruption of social structures (6,9). Global studies, particularly in regions affected by protracted conflicts, have consistently highlighted the multifaceted effects of trauma, emphasizing the urgent need for evidence-based mental health and psychosocial support interventions (20–24).

In Africa, conflict-affected populations have faced unique challenges due to the interplay of cultural, economic, and systemic factors. Countries like Rwanda, Sierra Leone, and South Sudan have provided valuable insights into the patterns and consequences of trauma on mental health and psychosocial wellbeing within resource-limited settings (25–28).

The Northern conflict in Ethiopia has profoundly impacted the city of Axum, where both long-term residents and internally displaced persons (IDPs) have endured significant atrocities (5). Report have shown that Axum population have been through mass killings, people forced from their homes, and the destruction of cultural landmarks (18) . Despite these events, there remains a critical gap in understanding the specific mental health and psychosocial consequences of trauma in Axum and how survivors cope in such challenging circumstances.

Mental health services in the Tigray region are limited, both in terms of availability and accessibility (11). The conflict has further strained these services, with many healthcare facilities damaged or destroyed. There is a critical shortage of trained mental health professionals, and existing services often lack the capacity to address the complex and widespread needs of the population. Additionally, cultural barriers and stigma associated with mental health issues hinder individuals from seeking help (4).

Numerous studies have been conducted in the Tigray region concerning the impact of the ongoing conflict on healthcare systems, medical facilities, and common medical conditions such as tuberculosis (TB), diabetes mellites and hypertension (29–31). These studies have highlighted the severe disruption of healthcare infrastructure, the burden on medical staff, and the exacerbation of pre-existing health conditions due to the conflict. However, despite the extensive research in these areas, there remains a notable gap in the literature regarding the mental health and psychosocial impact of the conflict on affected populations. The psychological effect of the war, including trauma-related disorders such as PTSD, depression, and anxiety, has not been adequately explored in the context of the Tigray conflict.

Therefore, while existing research has provided valuable insights into the healthcare challenges arising from the conflict, it is crucial to address the mental health consequences, psychosocial effects, and the dynamics of social support in these populations. These aspects are vital for developing a holistic understanding of the long-term impact of the conflict and for designing effective mental health and psychosocial support (MHPSS) interventions that are culturally sensitive and context-specific.

3.2 Trauma Exposure in Conflict Zones

Trauma refers to events or experiences that trigger severe physical and psychological stress. It occurs when an individual encounters an event, series of events, or circumstances perceived as harmful or threatening, leading to long-term negative impacts on their functioning and overall well-being, including physical, emotional, social, or spiritual aspects (32).

Armed conflicts are organized violent clashes between armed groups that affect people physically, mentally, emotionally, and spiritually (33). According to The War Report from 2019, there were at least 69 active conflicts in 30 countries in 2018. These conflicts lead to more violence and disrupt the social fabric of the affected communities (34).

Traumatic events during armed conflicts can vary widely, encompassing physical violence, psychological abuse, displacement, and loss of loved ones (35). Globally, studies highlight common forms of trauma such as extrajudicial killings, sexual

violence, torture, and destruction of property (36,37). These experiences are often compounded by forced migration, leading to prolonged uncertainty and insecurity (38,39). In African conflict zones survivors have reported widespread exposure to mass violence, family separation, and systemic abuse (40).

The frequency of trauma exposure is a critical factor influencing its psychological and social impact. A substantial body of literature suggests that experiencing multiple traumatic events significantly increases the risk for severe and chronic PTSD symptoms compared to a single traumatic event (41,42). A study explored the cognitive link between multiple traumatic events and PTSD symptom severity by focusing on dysfunctional cognitions and the findings suggest that repeated trauma may exacerbate PTSD severity through the development of maladaptive cognitions and expectations, emphasizing the need for targeted interventions addressing these cognitive patterns (43).

A large-scale survey involving 68,894 adults from 24 countries across six continents examined exposure to 29 types of traumatic events. Over 70% of participants reported experiencing at least one traumatic event, while 30.5% had been exposed to four or more. Five specific types of traumas, witnessing death or serious injury, the unexpected death of a loved one, being mugged, involvement in a life-threatening automobile accident, and experiencing a life-threatening illness or injury—accounted for more than half of all reported exposures. The study found that trauma exposure varied by country, sociodemographic factors, and prior trauma history (36). Another study conducted in central Vietnam, highlights the significant impact of frequent trauma exposure on mental health. The findings revealed that 47% of participants had experienced at least one traumatic event in their lifetime, with about half of these individuals exposed to multiple traumas. Among the total sample, the prevalence of depression, anxiety, and PTSD symptoms was 12.7%, 15.5%, and 6.9%, respectively, while PTSD prevalence among those reporting trauma exposure was 14.8%. Furthermore, exposure to a higher number of trauma types was associated with an increased risk of depression, anxiety, and PTSD symptoms (44).

Another study done on Vietnamese ex-political detainees has demonstrated a dose-effect relationship between cumulative torture experiences and psychiatric symptoms, specifically post-traumatic stress disorder and major depression. A positive correlation

was found between cumulative torture experiences and psychiatric symptoms (45). These findings highlight the compounding impact of repeated traumatic experiences on mental health outcomes.

The severity of trauma in conflict settings is determined by factors such as proximity to violence, direct involvement, and the extent of personal loss (46). Globally, severe trauma is often associated with experiences that threaten life, such as sexual violence, physical assault, or witnessing mass killings (37,47). Studies indicate that individuals exposed to more severe trauma are at a significantly higher risk of developing complex mental health disorders and experiencing prolonged psychosocial difficulties (15,45).

Understanding the types, frequency, patterns, and severity of trauma in Axum is essential for developing targeted mental health and psychosocial support interventions. By analyzing the trauma dimensions, this study aims to bridge global knowledge with the local realities of Axum's population.

3.3 The Impact of Traumatic Events on Mental Health

Traumatic events, particularly armed conflicts, can have profound and long-lasting effects on mental health. Across the world, conflict survivors frequently experience mental health disorders such as post-traumatic stress disorder, depression, anxiety, and substance use disorders (38,47,48). Global research has shown that trauma related to violence, displacement, and loss leads to heightened rates of psychological distress. For instance, studies from conflict zones such as Syria, Iraq, Ukraine and Afghanistan have found that civilians exposed to war-related trauma exhibit higher rates of PTSD, depression, and anxiety (49–51).

A meta-analysis estimated the prevalence of post-traumatic stress disorder and depressive symptoms among civilians living in regions affected by armed conflict. Out of 38,595 articles identified, 57 met the inclusion criteria, encompassing data from 64,596 participants. The analysis found a PTSD prevalence of 23.70% and a prevalence of depressive symptoms at 25.60% among war-affected civilians (47). These findings provide strong evidence of the significant negative impact of armed conflict on mental health, highlighting the urgent need for mental health interventions in conflict-affected populations.

Another systematic review and meta-analysis investigated the global burden of post-traumatic stress disorder and major depression in countries affected by war from 1989 to 2019. Random-effects meta-analyses revealed point prevalences of 26.51% for PTSD and 23.31% for MDD. Among those affected by PTSD, 55.26% also had comorbid MDD. The analysis found no significant association between prevalence rates and factors such as war intensity and duration, time since the war, response rate, or survey quality. Notably, war survivors were predominantly from low- and middle-income countries (7).

In conclusion, the findings from these meta-analyses consistently highlight the substantial mental health burden of armed conflict, with elevated prevalence rates of PTSD, depression, and anxiety with emphasize the disproportionate mental health burden experienced by survivors in low- and middle-income countries.

A recent longitudinal study examining the mental health effects of the October 7, 2023, attack and subsequent war in southern Israel focused on clinical symptoms of anxiety, depression, and PTSD. The study included 1,052 individuals, aged 18-40, from conflict zones in Israel, and assessed mental health symptoms through three waves of surveys from February to May 2024. The study found that individuals who experienced traumatic loss, forced displacement, or economic hardship, as well as women and ethnic minorities, consistently exhibited higher rates of anxiety, depression, and PTSD symptoms. Specifically, participants who suffered traumatic losses, such as the death or kidnapping of family members, or faced displacement, showed significantly more severe symptoms compared to those without these experiences. Ethnic minorities, particularly Arabs, also demonstrated higher levels of anxiety and depression across all time points compared to Jewish individuals (52). This study highlights the significant mental health impact of traumatic experiences.

In LMIC conflict-induced trauma has been widely studied, particularly in countries such as Rwanda, Sierra Leone, Liberia, and South Sudan (28,53–56). The mental health consequences of armed conflict in these regions evidenced the global patterns of trauma.

A systematic review and meta-analysis examining the prevalence of post-traumatic stress disorder among displaced people in Africa included 10 studies with 5287

participants. The pooled prevalence of PTSD was found to be 55.64%. Subgroup analysis revealed similar high prevalence rates among internally displaced people (56.35%) and refugees (54.04%). Significant factors associated with PTSD included being female, unemployed, and experiencing depression (10,56). These findings highlight the high burden of PTSD among displaced populations in Africa. When comparing this systematic review and meta-analysis with the earlier global meta-analysis on PTSD prevalence in conflict-affected populations. both studies highlight the significant prevalence of PTSD in conflict-affected populations, with the African study revealing notably higher rates of PTSD (55.64%) among displaced people compared to the global estimate of 23.70%.

A recent study on war-related trauma and posttraumatic stress disorder in Sudan assessed 642 participants, including internally displaced people (IDPs), refugees, and non-displaced individuals. The study found that 36.6% of participants experienced PTSD, with refugees at a 1.4 times higher risk of developing PTSD compared to IDPs and non-displaced individuals. Traumatic events were moderately correlated with PTSD symptoms, although non-displaced individuals had higher exposure to such events. This aligns with most of the previous studies (53).

A systematic review and meta-analysis examined the prevalence and factors associated with PTSD among the Ethiopian population living in war-affected communities. Nine studies involving 6,107 participants were analyzed, revealing a pooled PTSD prevalence of 48.4%. The findings highlight a high prevalence of PTSD in these communities, with notable disparities showing women at greater risk. Key risk factors identified include witnessing the murder of a loved one, experiencing depression and anxiety, and perceiving a direct threat to life (10).

A community-based study on war-related sexual and gender-based violence (SGBV) in Tigray, Northern Ethiopia, conducted in 52 districts, found that 43.3% of women of reproductive age experienced at least one type of gender-based violence. The prevalence of different forms of violence included 9.7% for sexual violence, 28.6% for physical violence, 40.4% for psychological violence, and 7.9% for rape. Among sexual violence survivors, 82.2% of cases involved rape, with 68.4% of these survivors reporting gang rape. Young women aged 15–24 was most affected by sexual violence, with a prevalence of 29.2%. Common SGBV-related issues included physical trauma

(23.8%), sexually transmitted infections (16.5%), HIV infection (2.7%), unwanted pregnancy (9.5%), and depression (19.2%). Notably, 89.7% of survivors did not receive any post-violence medical or psychological support (57). This study highlights the significant impact of war-related sexual and gender-based violence on the mental and psychosocial well-being of women in Tigray.

One significant issue in Tigray, as in other conflict zones, is the lack of adequate mental health services. Mental health services in the Tigray region are limited, both in terms of availability and accessibility. The conflict has further strained these services, with many healthcare facilities damaged or destroyed (11). There is a critical shortage of trained mental health professionals, and existing services often lack the capacity to address the complex and widespread needs of the population. Additionally, cultural barriers and stigma associated with mental health issues hinder individuals from seeking help (4).

The global and regional understanding of how trauma affects mental health, especially in conflict areas, helps us understand what is happening in Axum. This comparison highlights the need to address both mental health symptoms and the psychosocial impacts of trauma.

3.4 Psychosocial Consequences of Trauma

The psychosocial consequences of trauma in conflict settings are profound, affecting individuals' ability to function socially, emotionally, and psychologically (58,59).

Trauma has a profound impact on psychosocial well-being, with effects ranging across a spectrum of severity. For many, trauma results in mild distress responses, such as temporary anxiety, sleep disturbances, or behavioral changes like increased substance use. These reactions often resolve without clinical intervention but can benefit from community level support. For others, trauma leads to more persistent and moderate symptoms, including chronic anxiety and insomnia, requiring psychological and medical interventions. In the most severe cases, trauma can result in diagnosable psychiatric disorders such as PTSD or major depressive disorder, significantly impairing daily functioning and necessitating specialized treatment (60).

A study conducted in Ardabil, Iran, in 2022, investigated the relationship between emotional inhibition, rejection sensitivity, and social isolation in 300 veterans with PTSD. The findings highlighted that emotional suppression and heightened sensitivity to rejection directly contributed to social isolation in this population (61). This shows how war related trauma can disrupt cognitive and emotional processes, leading to difficulties in forming and maintaining social connections, which further worsens the psychosocial challenges faced by those affected by conflict.

Another study examining the long-term effects of psychological trauma on psychosocial functioning analyzed 115 young adults who survived a shipping disaster (the sinking of the Jupiter in 1988) 5 to 8 years earlier, compared with 50 control participants (62). The findings supported the idea that trauma impacts psychosocial functioning primarily through its influence on psychopathology.

In Africa, the psychosocial consequences of trauma are especially visible in the aftermath of conflicts like those in Rwanda, South Sudan, and Sierra Leone. In these settings, survivors report a range of negative emotional states, including fear, anger, distrust, and isolation (63).

Understanding the psychosocial consequences of trauma is crucial for developing effective mental health interventions in Axum.

3.5 The Role of Social Support in Trauma Recovery

Social support plays a vital role in the recovery process for trauma survivors, and its importance is universally recognized in mental health research (64–66). Numerous studies highlight that the presence of supportive relationships can significantly mitigate the negative psychological effects of trauma. Social support provides emotional comfort, practical assistance, and a sense of belonging, which can help individuals feel more resilient in the face of adversity (16,67).

Research on trauma recovery demonstrated that social support can serve as a protective factor, reducing the risk of developing mental health disorders such as post-traumatic stress disorder, depression, and anxiety (65,66). Positive social relationships act as a buffer against stress and provide individuals with the opportunity to share their experiences, express emotions, and receive validation (68–70). These

factors are essential for emotional healing after trauma. Conversely, a lack of social support or social isolation can exacerbate mental health issues, contributing to feelings of loneliness, hopelessness, and an increased risk of chronic psychological distress (67).

A recent study explored the connection between PTSD and social support, focusing on causal pathways over time. The sample consisted of 151 individuals who had experienced trauma within the last six months. Participants were assessed for PTSD and social support from intimate partners, friends, and relatives at four different points throughout a year (71). The findings resulted the bidirectional relationship between PTSD and social support, with a particular emphasis on the role of perceived social support from friends being crucial during trauma recovery.

The role of social support in trauma recovery is widely documented across various global contexts. Survivors in these areas have reported that while trauma was often overwhelming, their ability to rely on family members, friends, and communities played a crucial role in coping and healing (67,69).

In African, social support systems are typically centered around communal living, where people share experiences, resources, and responsibilities (72). For instance, community-based organizations often step in to provide psychosocial support services, while religious leaders offer spiritual care to help individuals process trauma (73). The African tradition of "ubuntu," which emphasizes interconnectedness and mutual support, is an important cultural aspect that strengthens the role of social support in recovery (74).

In Ethiopia, similar to global trends, research has shown that higher levels of social support are associated with lower rates of mental illness, including depression and PTSD. Conversely, individuals with limited social support are more vulnerable to developing mental health issues. for instance, a cross-sectional study conducted in 2022 among 785 participants in Northeast Ethiopia examined factors associated with depression in a war-affected population. The study found that the prevalence of depression among participants was 24.5%, with low social support being a significant factor associated with increased depression levels (75).

3.6 Coping Strategies in Response to Trauma

Coping strategies are the various behavioral and psychological efforts individuals use to manage, endure, alleviate, or diminish stressors. While coping theories have categorized these strategies in different ways over time, they generally divide them into two main types: emotion-focused strategies and problem-focused strategies (76).

Globally, survivors of trauma, particularly those in conflict zones, employ a range of coping mechanisms to deal with the emotional and psychological impact of violence and displacement. These strategies can be broadly categorized into adaptive and maladaptive coping mechanisms. Adaptive coping strategies include seeking social support, engaging in spiritual practices, and utilizing problem-solving skills. These strategies help individuals process their emotions, maintain a sense of control, and find meaning in their experiences. On the other hand, maladaptive coping strategies such as substance abuse, avoidance, and denial can have long-term negative effects on mental health and hinder the recovery process (76).

A study examining coping strategies and psychological distress among 1,598 participants in Ukraine, Poland, and Taiwan during the early stages of the 2022 War in Ukraine found differences across populations. Among Taiwanese and Polish respondents, avoidant coping strategies showed the strongest association with psychological distress compared to problem- and emotion-focused strategies. In contrast, Ukrainian respondents demonstrated less pronounced differences in the associations between coping strategies and distress. Additionally, problem-focused and emotion-focused coping strategies exhibited similar levels of association with psychological distress across all three populations (77).

In the context of the Syrian civil war, encouraging survivors to engage in self-help strategies, promote recovery, and focus on social inclusion has been shown to enhance their confidence and well-being. Such involvement not only reduces the risk of learned helplessness but also mitigates the development of psychiatric disorders, paving the way for more satisfying and sustainable recovery outcomes (78).

Another study conducted in Gaza Strip following the 2012 war found that children exposed to higher levels of war trauma were at greater risk for developing PTSD, emotional disorders, and neuroticism, with approximately 30% of participants showing

symptoms of PTSD. In addition, coping strategies played a critical role in the manifestation of these symptoms, with emotion-focused coping being linked to higher levels of emotional and behavioral problems, neuroticism, and PTSD, while problem-focused coping showed a protective effect, reducing neuroticism and PTSD symptoms (79).

A cross-sectional study conducted among 205 adults in Beirut explored coping mechanisms and their relationship with stress during times of crises. The findings showed that 95.4% of participants experienced moderate to high levels of perceived stress. Problem-focused coping emerged as the most commonly adopted strategy and was significantly associated with lower stress levels. In contrast, avoidant coping strategies were linked to significantly higher stress levels, highlighting the critical role of coping mechanisms in managing stress during challenging circumstances (80).

Another study on coping with post-war mental health problems among youth survivors of violence in Northern Uganda, as part of the WAYS study, explored the impact of cognitive emotion regulation strategies on mental health. The findings revealed that maladaptive strategies, such as rumination, were significantly linked to higher levels of mental health problems. Conversely, adaptive strategies, such as putting experiences into perspective, were associated with fewer mental health symptoms. Youth scoring in the 85th percentile or higher for mental health issues reported more frequent use of maladaptive strategies compared to adaptive ones (19).

During the Tigray war, various coping strategies were employed to navigate the prolonged challenges of the conflict. A study examining the impact of the war on food security among urban households in Tigray revealed that 39% of households experienced hunger in the post-conflict period. Stress-level coping mechanisms, such as reducing food portion sizes or skipping meals, were the most commonly adopted strategies (81).

While these global and regional studies provide a foundation, there is absence of adequate research examining the specific coping strategies used by survivors of the Tigray conflict, and how these strategies relate to mental health outcomes and the availability of social support in a post-conflict, resource-limited setting. This study aims to address this gap

Understanding the coping strategies employed by survivors of the Axum conflict is important for developing effective mental health interventions. By understanding the specific coping mechanisms that survivors use, this study will provide insights into how best to support recovery in the context of the ongoing challenges in Axum.

4. Conceptual framework

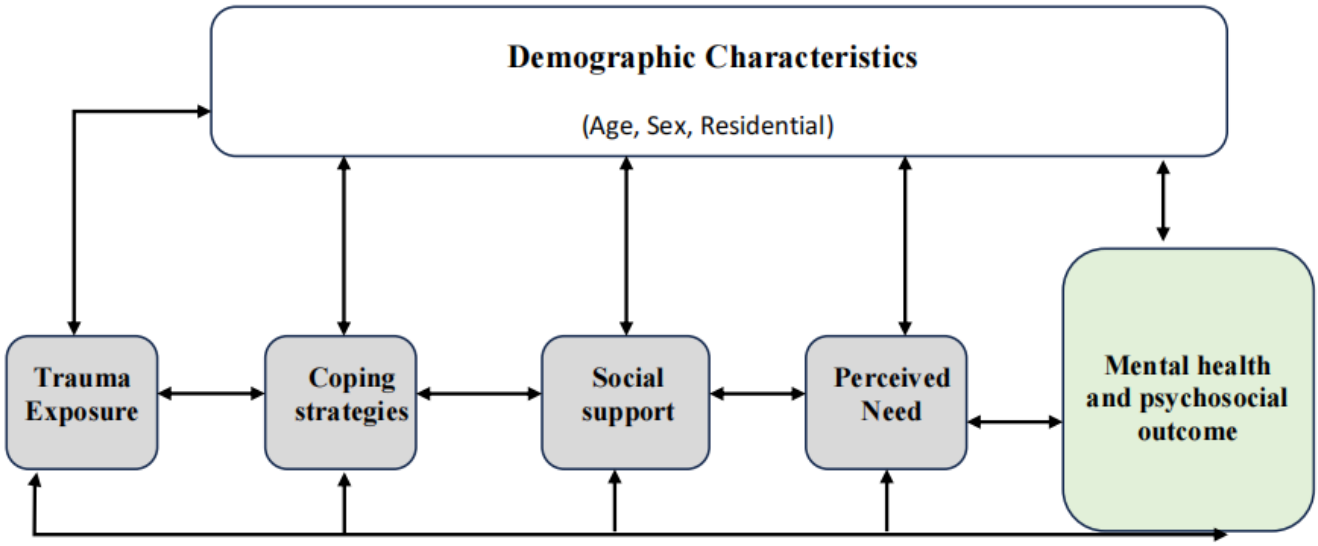


Figure 1: Conceptual framework

5. Research Question

The research questions are:

1. What are the patterns, types and severity of traumatic events experienced by survivors of the Axum conflict?

2. How does trauma exposure influence mental health outcomes among survivors of the Axum conflict?

3. What coping strategies are employed by participants in response to trauma, and how do these strategies associate with their mental health and psychosocial well-being?

4. How does social support relate to mental health and psychosocial consequences of trauma among the affected population in Axum?

6. OBJECTIVE

6.1 General objective:

The aim of this research was to assess the association of trauma exposure with mental health outcomes and psychosocial well-being among residents and internally displaced persons in Axum during the northern Ethiopian conflict.

6.2 Specific objectives:

1. To assess the patterns, types, and severity of traumatic events experienced by residents and internally displaced persons in Axum.
2. To examine the relationship between trauma exposure and mental health outcomes and psychosocial consequences.
3. To assess perceived needs, coping strategies, and level of social support among residents and internally displaced persons in Axum in response to trauma.
4. To examine the association between coping strategies and social support with mental health outcomes.

7. METHODOLOGY

7.1 Study setting

The study was conducted in Axum town which is located in the central zone of the Tigray Region in northern Ethiopia at an elevation of approximately 2,131 meters above sea level. It is historically recognized as the capital of the ancient Aksumite Empire and it is a center of culture and religion (82).

The town is divided into eight kebeles. According to the Ethiopian Statistical Service, a report released on July 2023, Axum has an estimated population of 99,114 (83). The town has one comprehensive specialized hospital, one general hospital, and two health centers.

The armed conflict in northern Ethiopia began in November 2020 and lasted in November 2022 after the signing of Pretoria peace agreement (5). Axum was one of the most affected areas during the conflict experiencing violence, destruction of property and displacement (18). As a result, six IDP sites currently exist in Axum, accommodating 51,871 individuals, according to data from the Tigray health bureau.

7.2 Study design and period

Community based cross-sectional study was conducted on August, 2025.

7.3 Study Population

The study population were permanent residents of Axum who lived in the town during the conflict period (November 2020 to November 2022) and internally displaced persons (IDPs) residing in the camps at the time of data collection.

7.4 Eligibility criteria

Inclusion Criteria:

- Age greater than 18.
- Residing during wartime (November 2020 to November 2022)
- Willing to participate and provide informed consent.

Exclusion Criteria:

- Individuals who are unable to communicate effectively.
- Visitors or temporary residents not permanently residing in the area.
- Those who are having severe illness which impairs them to fill the data were excluded.

7.5 Sample Size Determination

The sample size was determined using the single population proportion formula assuming the PTSD prevalence of 58% taken from prior research conducted in Tigray (57). Confidence interval of 95% and a 5% margin of error was assumed.

$$N=\frac{Z^2 \times p(1-p)}{d^2}$$

Where:

- N is sample size
- Z is value based on confidence interval
- P is sample proportion
- D is margin of error

By adding a 20% non-response rate and to improve statistical power a total sample of the final target sample size was set at 500 participants. At the end a total 528 data was collected. Of these, 515 interviews were successfully completed with a response rate of 97.5%. seven interviews were incomplete and eleven participants didn't complete the interview.

7.6 Sampling procedure

7.6.1 Sampling strategy

Multi stage systematic sampling technique was used. The total sample was proportionally allocated based on population size:

- Permanent residents: 328 participants
- IDPs: 172 participants

7.6.2 Sampling of permanent residents

From the eight kebeles, three were selected randomly by lottery method. The selected kebeles were Hawelti (ሓወልቲ), Hayelom (ሓየሎም) and Nigist Saba (ንግሥት ሳባ) with a total of 14,262 households.

Systematic sampling was applied within each kebele. A sampling interval (k) of 43 was calculated and used across all selected kebeles. A random starting point was determined for each kebele after which every 43rd household was selected. Afterward data collectors began from prominent location within each kebele. Within each selected household, one participant was chosen for interview. In the households with multiple individuals, the most recent birthday method was used to select the participant (Figure 2).

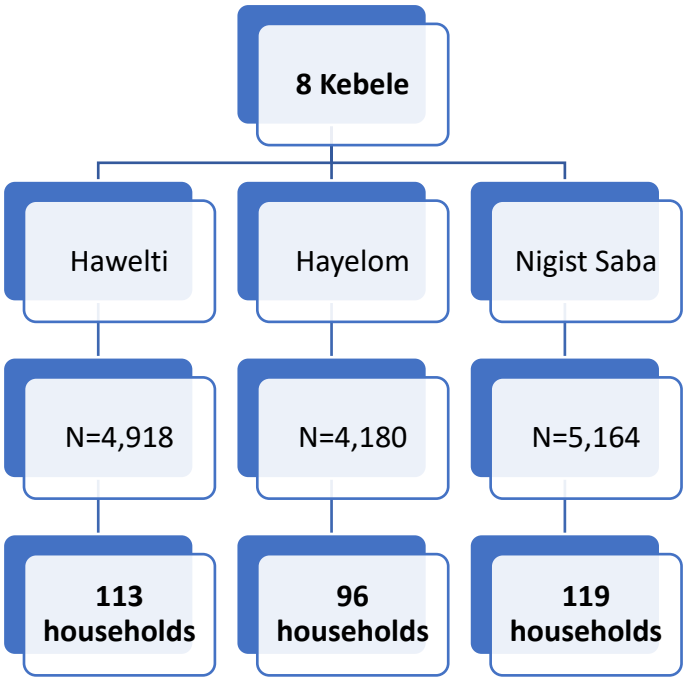


Figure2: Sampling method of permanent residents

7.6.3 Sampling of IDP sites

Two IDP sites were selected by lottery method. A total of 172 households were proportionally allocated for the two sites. Systematic sampling was used with a

sampling interval (k) of 23. The same procedure was applied as in the kebeles (Figure 3).

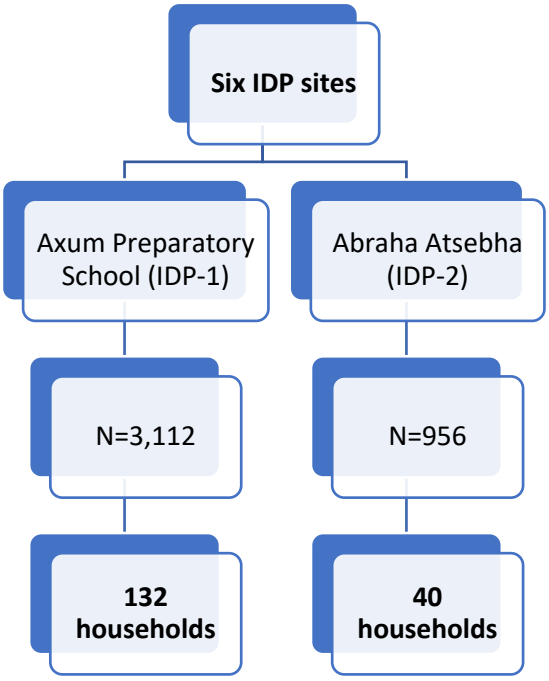


Figure 3: Sampling method of IDPs sites

7.7 Data Collection Instruments

Data was collected using seven standard and validated questionnaire which assess trauma exposure, trauma pattern and type, PTSD symptoms, psychological distress, coping strategies, social support, functional impairment, and perceived needs. The first section of the questionnaire is related to demographic characteristics of participants.

7.7.1 Harvard Trauma Questionnaire (HTQ)

The Harvard Trauma Questionnaire (HTQ) is a trauma screening instrument initially developed by the Harvard program in refugee trauma to assess trauma exposure and trauma related symptoms in refugee and also conflict-affected populations (84).

HTQ has six parts. The first part has 42 potentially traumatic events common in war settings and part 4 has 25 items which assess DSM 5 based PTSD symptoms and part 6 assess culture specific expressions of trauma which capture how traumatic event resulted culture specific description.

Each item is rated on a 4-point Likert scale ranging from “not at all” (1) to “extremely” (4). The HTQ has showed good psychometric properties across different cultural settings. The original validation among Indochinese refugees resulted a Cronbach’s alpha above 0.85 (84).

The HTQ has different versions and in the updated HTQ-5, which this study used, aligns with DSM-5 criteria and the symptom section was expanded from 16 items to 25 items including additional two items for the dissociative specifiers (depersonalization and derealization) (85). To identify probable PTSD, a mean score of 2.5 or higher is the most widely used cut-point and this cut point is originally established in a clinic-based sample (84,85). The HTQ-5 authors stated that while this cut-point is recommended provisionally, validation studies in new populations may establish context-specific thresholds (85).

the last part of HTQ is SPIESS which assess skills, physical, intellectual, emotional, social and spiritual or existential functioning. SPIESS has 30 items and this symptom score captures culturally specific expressions of distress and PTSD such as “thinking too much,” physical complaints, or spiritual suffering which may not be fully captured by the DSM diagnostic concepts of PTSD (86).

A study among Eritrean refugees in Ethiopia using a Tigrigna adaptation reported an alpha of 0.72 for the trauma event checklist. But this study only used the first items from the questionnaire which is trauma exposure item only (87).

Since there was no previously validated Tigrigna version of the full HTQ, the tool was translated to Tigrigna using forward-backward translation.

In this study the psychometric property of trauma exposure item, DSM 5 symptoms of HTQ and culturally recognized symptoms of suffering (SPIESS) were assessed and the Cronbach’s alpha resulted 0.81, 0.93 and 0.943 respectively.

7.7.2 General Health Questionnaire (GHQ-12)

General Health Questionnaire (GHQ-12) is a 12 item and brief self-administered screening tool to assess recent mental well-being and it detect non-psychotic psychiatric disorders such as depression and anxiety (88). It measures recent psychological state compared to their usual state and it captures three core dimensions: psychological distress, social dysfunction, and loss of confidence. GHQ 12 often used as identifying individuals at risk for a disorder, research has shown that a three-factor model (anxiety/depression, social dysfunction, and loss of confidence) fits the data better (89). In line with this, this study calculated not only a total distress score but also scores for each subscale, as recommended by studies conducted in similar settings (90,91).

The GHQ-12 consists of six positively and six negatively phrased items. This study used the Likert scoring method (0-1-2-3) because it captures the intensity of symptoms and is widely preferred in research. For negatively phrased items, responses are scored 0 (not at all) to 3 (much more than usual); for positively phrased items, they are reverse-scored so that higher scores always indicate greater distress. This yields a total score ranging from 0 to 36. This study used the three subscales: Anxiety/Depression (items 2, 5, 6, 9; range 0-12), Social Dysfunction (items 1, 3, 4, 7, 8, 12; range 0-18), and Loss of Confidence (items 10, 11; range 0-6).

A total Likert score of 12 or higher is the most commonly used cut-off for identifying individuals with significant psychological distress, a score of 16 to 20 interpreted as having high probability of a mental disorder and a score of 20 and above interpreted as Severe psychological problems (91). A study done in Ethiopia has shown validation result for the cutoff (90).

In this study, the GHQ-12 was translated into Tigrigna following the WHO guidelines for cross-cultural adaptation and pretested with community members to ensure clarity. The instrument's reliability in this study was excellent with Cronbach's $\alpha = 0.94$.

7.7.3 WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS)

The WASSS was developed by the World Health Organization and UNHCR to identify people in humanitarian settings who are experiencing severe psychological distress and need mental health care. It has two in two parts, a household screening section and an individual interview section. Each symptom is rated on a 5-point scale: 1 = none of the time to, 5 = all of the time (92). The total score ranges from 6 to 30 with higher score means more frequent and severe distress.

The tool was originally tested in a large study done in a Palestinian refugee camp in Beirut, Lebanon (Llosa et al., 2017). In that study, the internal consistency of the WASSS-I was moderate (Cronbach's α = 0.78). it's sensitivity and specificity were 50.0%, 83.4% respectively (93).

In this study the individual section (WASSS-I) was used which asks about six specific symptoms the person may have felt over the past two weeks: intense fear, anger, loss of interest, hopelessness, avoidance of reminders, and functional impairment (being unable to carry out essential daily activities).

The instrument was translated to Tigrigna following the same WHO-recommended process used for all instruments. In this study the internal consistency was excellent (Cronbach's α = 0.906).

7.7.4 Humanitarian Emergency Settings Perceived Needs Scale (HESPER)

The HESPER was developed by WHO and King's College London to help humanitarian workers to find out what people in emergencies see as their most serious needs (94).HESPER don't focus on symptoms but it assesses people directly about the practical problems they are facing. It covers 26 domains that are commonly affected in emergencies and for each item there is a yes or no answer. HESPER has been tested in different humanitarian contexts including Ethiopia, Haiti, Philippines and Jordan (94,95). In this study, the full HESPER was used after translated to Tigrigna and also asked participants to rank their top three problems to better guide future interventions.

7.7.5 Oslo Social Support Scale (OSSS-3)

The Oslo Social Support Scale is widely used questionnaire that asks three questions that assess a person's social support network (96). It was developed in the 1990s in a large population survey in Norway and has been used in other counties (96,97).

The three questions are: (1) "How many people are so close to you that you can count on them if you have great personal problems?" with answers ranging from "none" to "5 or more"; (2) "How much interest and concern do people show in what you do?" with answers from "none" to "a lot"; and (3) "How easy is it to get practical help from neighbors if you should need it?" with answers from "very difficult" to "very easy." The three scores are added to give a total between 3 and 14. Based on the total score it will be grouped into three categories: poor support (3–8), moderate support (9–11), and strong support (12–14) (96).

In this study, the tool was translated to Tigrigna and the internal consistency was low with a Cronbach's alpha coefficient of 0.63.

7.7.6 Brief COPE

The Brief COPE is a 28-item questionnaire that measures how people respond to stressful events. It was developed as a shorter version of the original COPE inventory and has become the most widely used tools for understanding coping strategies (98). The scale grouped into 14 different coping strategies, each measured by two items. In most studies these 14 strategies grouped into three coping styles with problem-focused coping (active coping, instrumental support, and planning), emotion-focused coping (acceptance, emotional social support, humor, positive reframing, and religion), and avoidant or dysfunctional coping (behavioral disengagement, cognitive disengagement, denial, self-distraction, self-blame, substance use, and venting) (98).

The instrument rated on a 4-point scale: 1 = "I haven't been doing this at all," 2 = "a little bit," 3 = "a medium amount," and 4 = "I've been doing this a lot."

The Brief COPE has been used in many cultural contexts and has shown good psychometric properties in diverse populations (98,99). In Ethiopia, the scale has been validated in two studies. In one study with women experiencing postpartum depression in rural areas and another study with Ethiopian migrant returnees who were in quarantine during the COVID-19 pandemic (100,101). In the study with migrant returnees, the internal consistency coefficients were 0.74 for problem-focused coping, 0.70 for emotion-focused coping, and 0.71 for dysfunctional coping (101).

In this study the Brief COPE was translated into Tigrigna since no publication had been presented and the internal consistency was good with Cronbach's α of 0.726.

7.7.7 Pilot testing and adaptation process

All instruments were translated into Tigrigna by following the WHO's recommended adaptation process. One psychiatry resident who is fluent in Tigrigna and English translated the tool into Tigrigna and then backward translation by another mental health expert. One academician who is not a mental health expert translated into Tigrigna and backward translated by professional translator. Finally, the translated versions were evaluated by a meeting among translators and in the presence of mental health experts and psychiatry residents. Following the discussion, pilot testing was done on 50 individuals who are living in Axum but not from the selected kebele and IDPs. After another round of revision based on the feedback from the pilot testing, the questionnaire was finalized and used to collect data.

7.8 Data collection procedure

All the structured questionnaires were entered into kobo toolbox application. Ten data collectors and 2 supervisor/facilitators recruited for the data collection procedure. All data collectors and supervisors had experience in kobo toolbox usage and were all master's degree holders. After the recruitment, two full day training sessions were held about the data collection instrument and trauma informed data collections.

Data collection was conducted over a period of two weeks. Each day, data collectors received went to their assigned site with supervisors. The questionnaire was administered face-to-face in a private setting within or near the household where data

collectors entered the responses directly into the application. Each interview lasted approximately 45-60 minutes.

All data were collected using the Kobo toolbox application on smart phone. Two field supervisors conducted daily site visits and observing interviews. Supervisors reviewed all submitted data each evening, checking for completeness, consistency, and location where it was filled.

During the data collection, participant who showed distress and requesting mental health support were offered breathing and relaxation exercise by the data collector and then referred to Axum comprehensive specialized hospital with a prepared referral slip.

7.9 Data processing and analysis

After cleaning the data, entered into SPSS version 27 and coded. Both descriptive and inferential statistics analysis was done. The descriptive statistics measured frequencies and percentages for categorical variables, for continuous and normally distributed variables, means and standard deviations (SD) were done. For non-normally distributed continuous variables, medians and interquartile ranges (IQR) were done.

After analyzing the descriptive statistics, normality assessment was done to check whether the variables are normally distributed or not. Since the primary outcome which is PTSD symptom severity was not normally distributed, non-parametric tests were used for bivariate analysis. Spearman's rank correlation was done for associations with continuous or ordinal variables, Mann–Whitney U test was done for binary categorical variables and Kruskal–Wallis test was done for categorical variables with more than two groups.

All variables with a p-value ≤ 0.25 in the bivariate non-parametric tests were entered into the multiple linear regression model. Additionally, a prior selected variables of clinical importance were also included regardless of their bivariate p-value. The cut off 0.25 was selected to allow for the exploration of potentially relevant associations that may not reach traditional levels of statistical significance, which is 0.05 (102).

Multicollinearity was checked and all variables had a VIF values range from 1.12 to 3.45.

8. Ethical considerations

Ethical clearance was obtained from the Department of Psychiatry, College of Health Sciences, Addis Ababa University with a meeting number PSY/REC/0? /25. Additionally, support letter from Tigray health bureau and Axum town administration was obtained.

After the participant provided detail information about purpose of the study, potential risks, benefits, voluntary participation and the issue of confidentiality, informed consent was obtained.

The data was anonymized and no personally identifiable information was linked to their responses. The collected data was securely stored.

Given the sensitive nature of the study, measures were taken to minimize risks of re-traumatization. Data collectors were trained in trauma-informed data collection and to create a supportive environment during data collection. Participants had the option to skip question and in cases where significant psychological distress was observed, they were referred to Axum comprehensive specialized hospital. Additionally, all participants received information about available mental health support services in Axum, regardless of their distress level.

9. Results

9.1. Sociodemographic characteristics

A total of 515 participants were included in the study. Of these, 53.8% were female. The median age of participants was 38 years (IQR: 31, 46). 80.4% of the participants have attended formal education. Two-thirds of participants were permanent residents, and the remaining were internally displaced persons (IDPs). The mean family size was 4.71 (±2) (Table 1).

Table 1. Sociodemographic characteristics of participants (N=515)

Variable	Category	Frequency	Percent (%)
Sex	Male	238	46.2
	Female	277	53.8
Marital Status	Single	63	12.2
	Married	367	71.3
	Widowed	38	7.4
	Divorced/Separated	47	9.1
Education	No formal	101	19.6
	Primary	128	24.9
	Secondary	175	34.0
	Bachelor	73	14.2
	Master	24	4.7
	Other	14	2.7
Employment	Employed	266	51.7
	Unemployed	249	48.3
Residential status	Permanent	340	66.0
	IDP	175	34.0
Living situation	Own home	126	24.5
	Rental	223	43.3
	IDP shelter	166	32.2
Religion	Orthodox	505	98.1
	Muslim	8	1.6
	None	2	0.4
Family size	Mean ± SD	4.71 ± 2.23	-

Median Age (Q1–Q3)		38 (31–46)	-
Median income (Q1–Q3)		500 (0–5000)	-

9.2. Exposure to traumatic events

From the participant 92.0% reported lack of food, inability to access medical care (76.7%), exposure to war conditions (74.8%), forced displacement or evacuation (68.0%), and lack of shelter (59.4%). Physical assault or beating was reported by 34.6% of participants. From the participant 3.5% reported experiencing rape (Table 2).

Table 2: Trauma events experienced by participants (N=515)

Trauma Event	**Yes, n (%)**	**No, n (%)**
Exposure to war conditions (combat situation)	385 (74.8%)	130 (25.2%)
Forced displacement (forced evacuation under dangerous conditions)	350 (68.0%)	165 (32.0%)
Physical assault/beating	178 (34.6%)	337 (65.4%)
Sexual violence (rape)	18 (3.5%)	497 (96.5%)
Other types of sexual violence	96 (18.6%)	419 (81.4%)
Injury from stick/club/knife/stabbing	23 (4.5%)	492 (95.5%)
Torture	104 (20.2%)	411 (79.8%)
physical injury	63 (12.2%)	452 (87.8%)
Imprisonment / Detention	121 (23.5%)	394 (76.5%)
Forced labor	37 (7.2%)	478 (92.8%)
Forced to hide	416 (80.8%)	99 (19.2%)
Kidnapping / Abduction	54 (10.5%)	461 (89.5%)
Witnessed death of spouse due to conflict	26 (5.0%)	489 (95.0%)
Witnessed death of child due to conflict	40 (7.8%)	475 (92.2%)

Witnessed death of family member or friend	298 (57.9%)	217 (42.1%)
Disappearance or kidnapping of spouse	46 (8.9%)	469 (91.1%)
Disappearance or kidnapping of child	47 (9.1%)	468 (90.9%)
Disappearance or kidnapping of family member or friend	170 (33.0%)	345 (67.0%)
Severe injury to family member/friend due to war or explosives	154 (29.9%)	361 (70.1%)
Saw someone being beaten	268 (52.0%)	247 (48.0%)
Witnessed killing (murder)	308 (59.8%)	207 (40.2%)
Witnessed sexual violence against others	41 (8.0%)	474 (92.0%)

The majority of participants reported exposure to a high number of traumatic events, with 54.0% experiencing eight or more events and 24.1% reporting 17 or more.

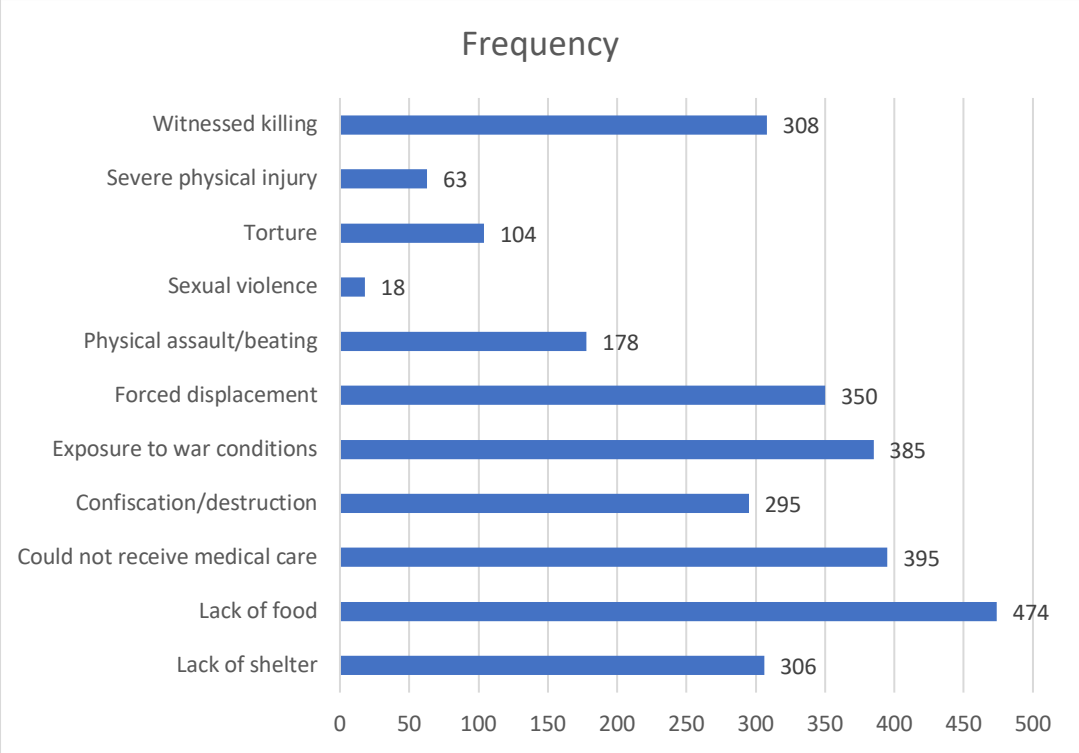


Figure 4. Bar chart of frequency of traumatic events

From the 515 respondents, (99.8%) reported exposure to at least one traumatic event. The cumulative traumatic event exposure using percentile cutoffs of 25th, 50th (median), and 75th percentile trauma scores were 7, 12, and 16, respectively.

Accordingly, 135 participants (26.2%) reported exposure to seven or fewer traumatic events, while 156 (30.3%) experienced 8 to 12 events (Table 3).

Table 3: Frequency of traumatic event among participant (N=515)

		Frequency	Percent
Traumatic Event	≤ 7	135	26.2
	8 to 12	156	30.3
	13 to 16	100	19.4
	17 to 36	124	24.1
	Total	515	100.0

9.3 Mental health outcomes

9.3.1 PTSD severity

The mean DSM-V trauma symptom score was 59.36 (SD = 15.31). The total possible score ranges from 25 to 100. Percentile scores were 48 at the 25th percentile, 59 at the median, and 69 at the 75th percentile (Figure 5).

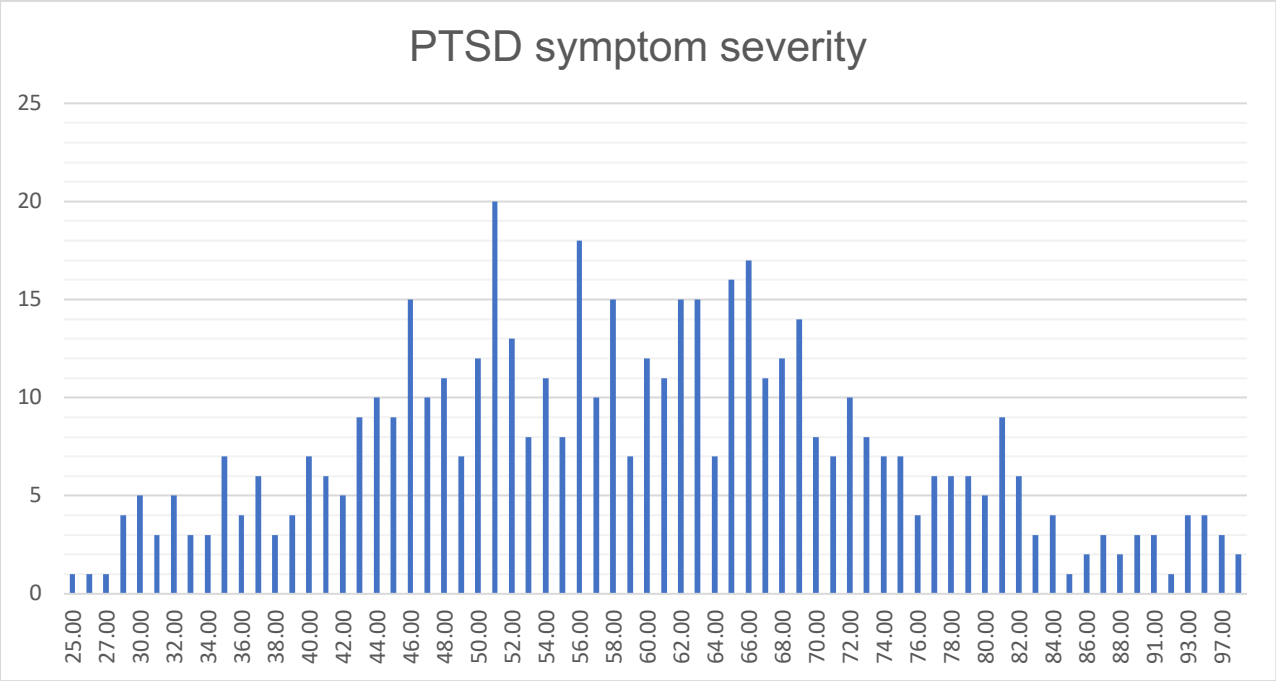


Figure 5. Historgram with kerner density estimate of PTSD symptom severity

The prevalence of probable PTSD among participants was 41.9% (95% CI: 37.6%–46.3%). More than two in five individuals in the study population met the threshold for probable PTSD based on the Harvard Trauma Questionnaire cut-point of ≥2.5.

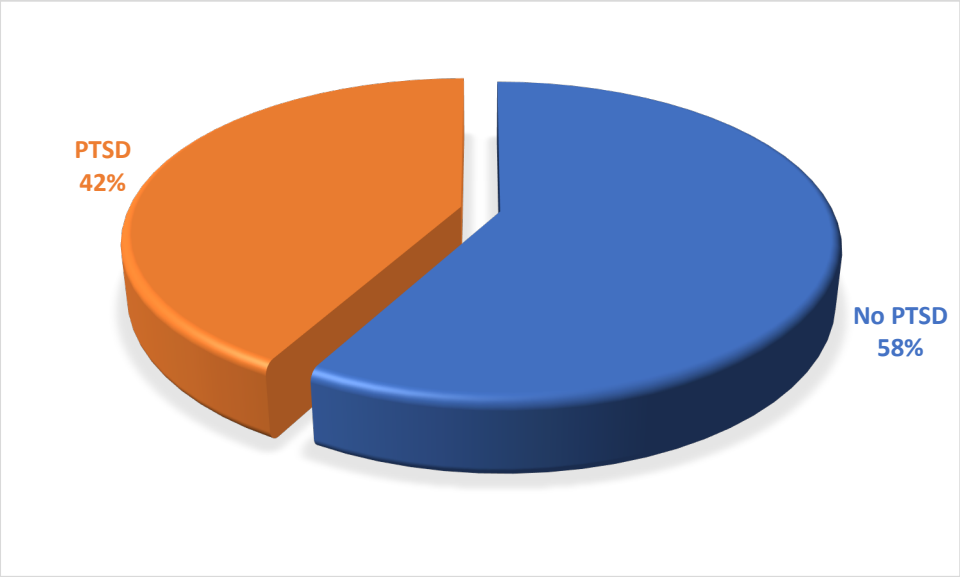


Figure 6. Distribution of PTSD status among participants

The distribution of PTSD symptoms includes intrusive memories, 3.7% of participants reported never experiencing the symptom, while 27.0%, 29.5%, and 39.8% reported experiencing it a little, moderately, and extremely, respectively. For hypervigilance, 27.4% reported never experiencing the symptom, while 33.4%, 25.4%, and 13.8% reported a little, moderate, and extreme levels, respectively (Table 4).

Table 4. Trauma symptoms (DSM-5) mean scores

Symptom	Never	A little	Moderately	Extremely
Intrusive memories	3.7%	27.0%	29.5%	39.8%
Flashbacks	21.9%	27.0%	28.0%	23.1%
Nightmares	28.9%	28.3%	26.8%	15.9%
Emotional numbing	35.0%	41.0%	15.3%	8.7%
Hypervigilance	27.4%	33.4%	25.4%	13.8%

9.3.2 Culturally recognized symptoms of suffering

The mean score for culturally recognized symptoms or how trauma is experienced within Axum was 63.85 (SD = 19.12), with scores ranging from 29 to 116. Hopelessness or despair was reported by 66.0% of participants at moderate to extreme levels (25.8% moderate, 40.2% extreme). Feeling unable to help others affected 67.2% at moderate to extreme levels. Participants reported spending significant time wondering why these events happened, with 55.9% experiencing this at moderate to extreme levels (Table 5).

Table 5: Culturally recognized symptoms of suffering

Cultural recognized symptom	**Never %**	**A little bit %**	**Moderately %**	**Extremely %**
Skills now feel useless	21.6	28.7	28.5	21.2
Coping ability less than before	9.3	24.3	34.4	32.0
Difficulty adjusting to new situations	26.8	34.0	21.2	18.1
Work brings up bad memories	59.8	17.7	13.6	8.9
Colleagues being near disturbs you	73.4	12.0	9.7	4.9
Fatigue/exhaustion	25.0	30.3	27.8	16.9
Weak memory / poor concentration	11.2	36.9	28.2	23.7
Feeling stressed by work	44.5	19.2	20.8	15.5
Hopelessness / despair	12.8	21.2	25.8	40.2
Feeling unable to help others	9.7	23.1	22.9	44.3
Spending time wondering why events happened	12.8	31.3	24.1	31.8
Feeling isolated / no one to turn to	29.3	21.4	17.5	31.8
Survivor's guilt	66.8	12.4	11.8	8.9
Feeling shame about events	70.9	14.8	7.8	6.6

Feeling betrayed	35.9	21.7	20.4	21.9
Urge for revenge / retaliation	50.3	9.9	14.2	25.6

9.3.3 Severe symptoms and functional impairment

The mean severe symptom score was 17.36 (SD = 6.33), with a range of 3 to 30. Across items assessing intense fear, anger, loss of interest, hopelessness, and functional impairment over the previous two weeks, between 11% and 16% of participants reported experiencing these symptoms all of the time. Functional impairment due to emotional distress was reported all or most of the time by 31.5% of participants (Table 6).

Table 6. Severe symptoms and functional impairment (N=515)

Symptom	All of the time	Most of the time	Sometimes	A little	Never
Fear nothing could calm	11.3%	23.5%	28.5%	17.7%	18.1%
Intense anger	13.8%	23.9%	27.0%	17.7%	16.5%
Hopelessness	15.5%	26.4%	26.4%	14.0%	17.3%
Loss of interest	7.2%	21.2%	32.2%	19.4%	19.2%
Functional impairment	7.8%	23.7%	30.7%	19.4%	16.7%

9.3.4 Perceived needs in humanitarian settings

Of the participants 41.2% reported having lack of clean water, 67.6% reported having severe problem of lack of food. Lack of shelter was reported as severe problem by (59.0%) (Figure 7).

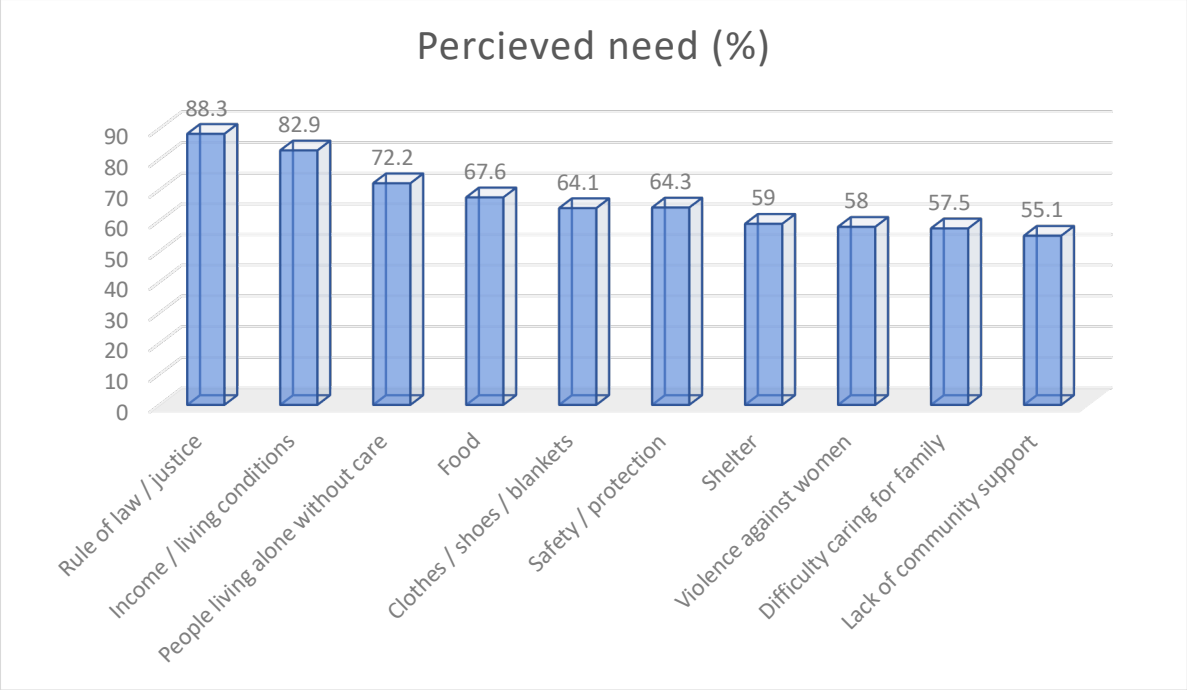


Figure7. Horizontal bar chart of percieved need severe problems

9.3.5 General psychological distress

From the 515 participants, 25.4% (n = 131) scored below the cutoff of 12 and showed no significant psychological distress. In contrast, 74.6% of participants scored 12 or higher. Specifically, 23.1% (n = 119) demonstrated a high probability of a mental disorder, and 34.0% (n = 175) experienced severe psychological problems (Table 7).

Table 7. Frequency of psychological distress

		Frequency	**Percent**
General psychological distress	No significant distress	131	25.4
	Evidence of psychological distress	90	17.5
	High probability of a mental disorder (Severe)	119	23.1
	Severe psychological problems	175	34.0
	Total	515	100.0

The median (IQR) scores for the GHQ subscales were 6 (4–8) for anxiety and depression, 8 (6–12) for social dysfunction, and 2 (1–4) for loss of confidence.

9.3.6 Social support

Most participants reported low social support. 399 participants (77.5%) were classified as having poor social support, 22.3% had moderate support, and only one participant (0.2%) reported strong support. The mean score of social support was 6.17 (SD = 2.51).

9.3.7 Coping strategies

From the coping strategy used by the participants, self-distraction had a mean score of 4.70 ± 1.58. The median scores were 4 (IQR: 4–6) for planning and 2 (IQR: 2–5) for substance use (Table 8).

Table 8. Coping strategy scores (N=515)

Self-Distraction	Mean ± SD	4.7 ±1.58
Active Coping	Medina (IQR)	4(4,6)
Denial	Medina (IQR)	4(2,5)
Substance Use	Medina (IQR)	2(2,5)
Emotional Support	Medina (IQR)	4(3,5)
Behavioral Disengagement	Medina (IQR)	3(2,4)
Positive Reframing	Medina (IQR)	4(3,5)
Self-Blame	Medina (IQR)	4(2,5)
Planning	Medina (IQR)	4(4,6)
Humor	Medina (IQR)	2(2,2)
Acceptance	Medina (IQR)	4(4,6)
Venting	Medina (IQR)	4(3,5)
Religion	Medina (IQR)	7(5,8)
Instrumental support	Medina (IQR)	4(3,5)

When grouped by coping style, the median score for emotion-focused coping was 17 (IQR: 15–19), followed by avoidant/maladaptive coping with a median of 16 (IQR: 14–19), and problem-focused coping with a median of 11 (IQR: 10–13).

9.4 Factor affecting PTSD

9.4.1 Factors associated with PTSD

Sociodemographic factors

Age, family size, and monthly income were weakly to moderately associated with PTSD severity. Widowed and divorced participants had higher PTSD scores than other marital groups. PTSD scores differed by education level. Unemployed participants had higher scores than employed participants. Internally displaced persons had higher scores than permanent residents.

Trauma related factors

Cultural recognized symptoms distress showed very strong positive correlation. Cumulative trauma exposure also demonstrated a strong positive correlation and from the traumatic events, torture exposure showed a significant association (Table 9).

Variables	Trauma	Cultural Distress	GHQ	Avoidance	OSSS-3	HESPER	WASSS
Trauma	1	0.817	0.671	0.473	-0.307	0.166	0.686
Cultural symptoms	0.817	1	0.771	0.205	-0.384	0.224	0.654
GHQ	0.671	0.771	1	0.185	-0.506	0.309	0.657
Avoidance	0.473	0.205	0.185	1	0.044	0.067	0.25
OSSS-3	-0.307	-0.384	-0.506	0.044	1	-0.132	-0.333
HESPER	0.166	0.224	0.309	0.067	-0.132	1	0.159
WASSS	0.686	0.654	0.657	0.25	-0.333	0.159	1

Figure 8. Heatmap with correlation coefficients and color intensity

Psychological and coping Factors

All psychological and coping factors showed significant associations with PTSD symptom severity. General psychological distress was strongly positively correlated and severe symptoms and functional impairment also demonstrated a strong positive correlation.

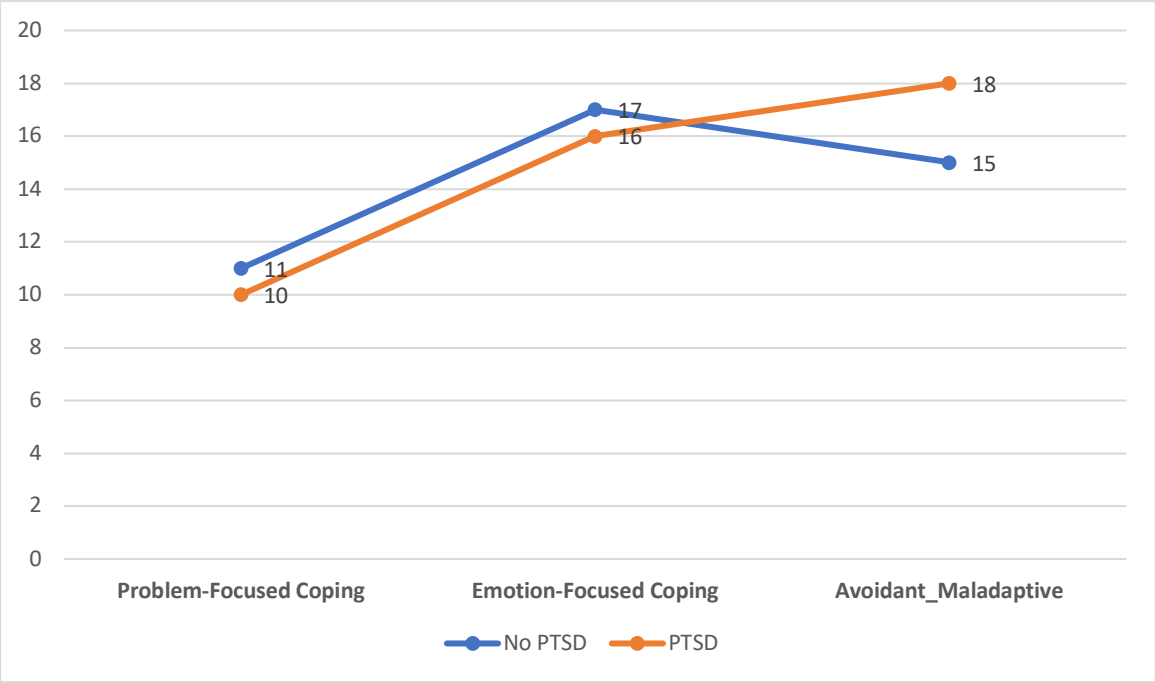


Figure 9. Median score coping strategies by PTSD Status

Regarding coping styles, problem-focused was weakly negatively correlated and emotion-focused was similarly weakly negatively correlated ($\rho = -0.149$, $p = 0.001$). Avoidant coping style showed a strong positive correlation (Figure 9).

Table 9. Association between selected variables and PTSD symptom severity (non-parametric tests)

Variable	Test used	Statistic	p-value	Interpretation
Age	Spearman correlation	ρ = 0.198	<0.001	Weak positive association
Sex	Mann–Whitney U	Z = −1.011	0.312	Not significant
Marital status	Kruskal–Wallis	H = 20.687	<0.001	Significant difference
Educational level	Kruskal–Wallis	H = 38.288	<0.001	Significant difference
Employment status	Mann–Whitney U	Z = −3.512	<0.001	Unemployed higher PTSD
Living situation (IDP)	Kruskal–Wallis	H = 77.842	<0.001	IDPs highest PTSD
Religion	Kruskal–Wallis	H = 1.619	0.445	Not significant
Family size	Spearman correlation	ρ = 0.177	<0.001	Weak positive association
Monthly income	Spearman correlation	ρ = −0.373	<0.001	Moderate negative association
Residential status	Mann–Whitney U	Z = −6.303	<0.001	IDPs significantly higher PTSD
Trauma exposure	Spearman correlation	P =0.467	<0.001	Strong association
Torture exposure	Mann–Whitney U	Z = −5.823	<0.001	Strong association
Physical assault	Mann–Whitney U	Z = −4.295	<0.001	Significant
Exposure to war	Mann–Whitney U	Z = −2.202	0.028	Significant

Witnessed sexual violence	Mann–Whitney U	Z = −2.404	0.016	Significant
Head injury	Mann–Whitney U	Z = −3.212	0.001	Significant
General psychological distress	Spearman correlation	ρ = 0.627	<0.001	Strong association
Severity symptoms and functional impairment	Spearman correlation	ρ = 0.664	<0.001	Strong association
Culturally recognized symptoms of suffering	Spearman correlation	ρ = 0.804	<0.001	Very strong association
Problem-focused coping	Spearman correlation	ρ = −0.150	0.001	Protective
Emotion-focused coping	Spearman correlation	ρ = −0.149	0.001	Protective
Avoidant/maladaptive coping	Spearman correlation	ρ = 0.610	<0.001	Strong risk factor
Social support	Spearman correlation	ρ = −0.312	<0.001	Protective
Perceived needs	Spearman correlation	ρ = 0.178	<0.001	Weak association

9.4.2 Multiple analysis of factors associated with PTSD

After adjusting for all variables in the model, multiple factors remained significantly associated with PTSD severity score.

The multivariable linear regression model was statistically significant ($F(20, 494) = 71.61$, $p < 0.001$) and explained a substantial proportion of variance in PTSD symptom severity ($R^2 = 0.74$) (Table 10).

Table 10. Multiple linear regression predicting PTSD symptom severity (N = 515)

Variable	B	Beta	p-value	95% CI (Lower, Upper)
Age	-0.052	-0.041	0.143	-0.122, 0.018
Marital status	0.744	0.036	0.172	-0.324, 1.813
Educational level	0.110	0.012	0.689	-0.430, 0.650
Employment status	1.748	0.057	**0.053**	**-0.023, 3.519**
Residential status	1.034	0.032	0.429	-1.530, 3.597
Family size	0.511	0.075	**0.006**	**0.149, 0.872**
Perceived need	-0.448	-0.091	**0.001**	**-0.722, -0.173**
Social support	0.150	0.025	0.403	-0.202, 0.502
Psychological distress	0.213	0.118	**0.005**	**0.064, 0.362**
Problem focused coping style	0.746	0.125	**<0.001**	0.359, 1.133
Emotion focused Coping style	-0.391	-0.078	**0.014**	**-0.704, -0.079**
Avoidant coping style	0.746	0.191	**<0.001**	**0.499, 0.994**
Cumulative trauma score	0.182	0.074	**0.039**	**0.009, 0.356**
Cultural symptoms of suffering	0.469	0.586	**<0.001**	**0.398, 0.539**

Cultural recognized symptoms suffering showed the strongest positive association (B = 0.469, SE = 0.036, β = 0.586, p < 0.001). Cumulative traumatic events were significantly associated (B = 0.182, SE = 0.088, β = 0.074, p = 0.039). No significant associations were observed for residential status, age, employment status, marital status, educational level, or social support in the multivariate model (Figure 10).

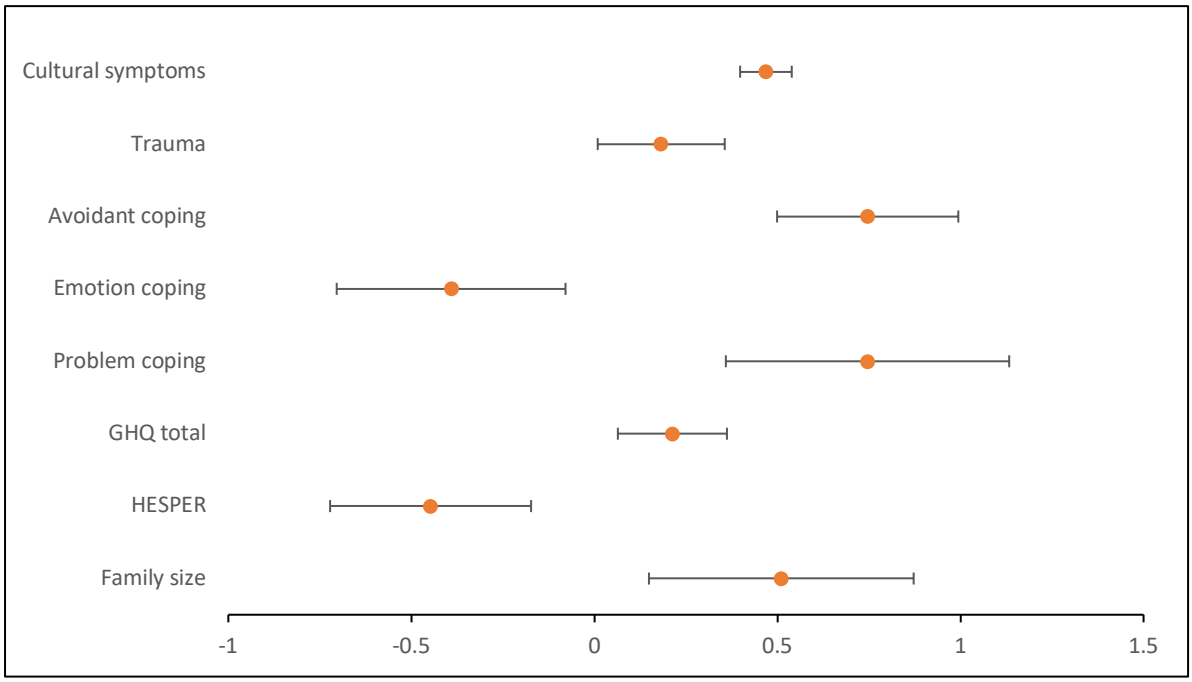


Figure 10. Forest plot of determinant of PTSD severity

10. Discussion

This study aimed to explore the effect of the northern Ethiopian conflict, November 2020 to November 2022, on mental health and psychosocial well-being of residents and IDPs in Axum town.

The study examined patterns of trauma exposure, the prevalence of PTSD and psychological distress, culturally recognized symptoms of suffering, coping strategies, social support, perceived needs, and functional impairment.

The findings have shown a significant burden of trauma with 99.8% of participants reported at least one traumatic event. PTSD prevalence of 41.9%, and 74.6% of participants experienced significant psychological distress.

Culturally recognized symptoms found as the strongest correlate of PTSD. Regarding the coping styles, religion was the most frequently used strategy, avoidant coping was strongly associated with worse outcomes, and problem-focused coping unexpectedly showed a positive association with PTSD severity. Social support was significantly low, with 77.5% of participants reporting poor support. Material needs especially food, shelter, and clean water were unmet, and one in three participants reported functional impairment due to emotional distress.

10.1 Trauma Exposure

Nearly all (99.8%) experienced at least one traumatic event, and 30% experienced more than eight. In the World Mental Health Survey, which included 24 countries across six continents, 70% of adults reported lifetime exposure to at least one traumatic event, and only 30.5% had experienced four or more events (36).In this study, finding of 99.8% exposure with the majority experiencing 8 or more events represents a greater burden when it compared with other findings. However, similar near-universal exposure has been documented in other protracted conflicts such as in Syria, where one study found that 98% of internally displaced persons reported war-related trauma (102). In Afghanistan, more than decades of conflict have similarly resulted in nearly universal exposure among civilian populations (48). This similar finding suggests that armed conflict results community level catastrophe.

The pattern of trauma exposure is also notable. In addition to high levels of combat exposure (74.8%) and forced displacement (68.0%), higher proportions reported direct physical assault (34.6%) and torture (20.2%), indicating that civilians were targeted rather than incidentally affected as similar with other armed conflicts. These results are comparable to reports from the Rwandan genocide, where 28–35% of survivors experienced direct physical violence, and a studies from Gaza documenting high rates of direct trauma exposure among civilians (54,79).

The low reported prevalence of rape (3.5%) in this study when it compared to the 9.7% report in the previous Tigray study might reflect methodological rather than actual differences (57). In this study direct face to face interviewing was applied in community setting rather than in confidential setting and this might result lower disclosure rate especially for sexual violence. this can be due to stigma, the interviewer gender and safety concerns. in conflict affected area the true prevalence of sexual violence is consistently underreported in community survey globally when it compared to studies that specifically asses gender-based violence which has more privacy protections (38).

10.2 Mental Health Outcomes

10.2.1 Prevalence of PTSD

The prevalence of probable PTSD in this study (41.9%) is higher than global estimates reported among war-affected populations. Meta-analyses have reported pooled prevalence rates of 23.7% and 26.5% although higher rates are also observed in settings characterized by extreme violence (7,47).

The result observed in this study is comparable to other African conflict setting including Ethiopia. For instance, a pooled estimate of PTSD prevalence 55.6% among displaced population documented in one of systematic review and meta-analysis study in Africa. Another systematic review in Ethiopia reported 48.4% of PTSD prevalence in conflict affected community which is higher than this study (10,56). while the first study pooler prevalence is higher, the figure represents not a point prevalence rather a mean from studies with varying estimates. The other reason that the prevalence of PTSD observed in Axum is higher might be, the study was done three years after the conflict resolution and since there was no intervention, the burden plus the ongoing daily stressors may increase the prevalence higher.

The interpretation of probable PTSD prevalence rate might require a special attention especially the nature of trauma exposure and the timing of the assessment. The trauma exposure measured in this study was not purely measuring those who have the potential to cause PTSD. For instance, one of the items in the HTQ trauma exposure inquiry item is lack of shelter and lack of food, this might not directly measure those who have potential to cause PTSD that are listed in DSM 5 criteria A of symptoms. This may affect the overall prevalence of PTSD by counting the trauma exposure which have no direct relation with PTSD.

Additionally, the assessment done approximately three years after the conflict ceased meaning these findings represent not acute reactions but continuous symptoms. The persistence of high PTSD prevalence years after conflict is consistent with longitudinal studies in Rwanda where rates remained elevated a decade after the conflict ended (54). these might reflect the lack of adequate mental health service and continuity of ongoing daily stressors.

A study done using HTQ, which is similar with this study, among Syrian refugees in Iraq reported a prevalence of 43.0% of PTSD (49). Another study done in Gaza have reported PTSD prevalence ranging from 30% to 50% at different time of conflicts (79). These comparable findings suggest that the mental health impact of conflict may be consistent across similar settings of civilian exposure additional to using similar tools to assess the impact of trauma exposure.

PTSD is associated with comorbid mental illness and functional impairment with higher rates of physical illness (103). In a setting where mental health service was limited before the conflict and have been affected by the destruction of healthcare facilities with comorbid mental illness and higher rate of physical illness, the majority of affected individual with PTSD are more likely to be untreated which further exacerbate the stress and increase the prevalence (11).

.

10.2.2 Psychological distress

The high prevalence of psychological distress which is (74.6%) indicates that the mental health burden extends beyond PTSD. The GHQ-12 tool can capture depression, anxiety and also social dysfunction. The high percentage of individuals experiencing significant distress suggests that even among those who do not meet criteria for probable PTSD, many are struggling with anxiety and depression that impair their daily functioning.

This finding is also seen in other studies. a study done in Turkey among Syrian refugees, 67.5% reported psychological distress using GHQ 12 tool and similarly in Gaza studies have reported similarly higher level of general psychological distress. (21,104). The slightly higher percent of psychological distress in Axum may be due to combination of displacement, ongoing lack of basic needs and inadequacy of healthcare services.

Additionally, individuals with slightly higher functional impairment may not meet full criteria for PTSD due to the affected individuals distress manifests as depression, anxiety or social withdrawal.

10.2.3 Social support

The higher prevalence of poor social support in Axum (77.5%) might reflect the extent of the conflict on social networks and bonding beyond individual level.

Researches have shown that, in post conflict environment, social support contributes for recovery by enabling affected individual to process distress, receive validation and restore a sense of safety (70). Studies among conflict affected populations have shown that those who have higher social support have lower rates of PTSD and depression. the lower perceived social support in this study might evidence why the Axum population have higher rate of PTSD (66,71).

10.2.4 Coping Strategies

Religion was the most frequently used coping strategy. This finding aligns with the central role of religious faith in Axum culture and with the broader literature identifying religious coping as a common response to trauma in African settings (74). The finding

that problem-focused coping strategies were used at moderate levels is consistent with expectations.

10.2.5 Culturally-grounded symptoms

In this study symptoms such as feeling unable to help others (67.2%), hopelessness (66.0%), and persistent questioning of why the events occurred (55.9%) were prominent cultural expressions of suffering in Axum community.

The SPIESS section of the HTQ was designed to capture how trauma is experienced and expressed in culturally specific ways that may not be fully captured by DSM-based symptom checklists (86).

In many non-Western settings the most distressing consequences of trauma are often related to disruptions in social roles, relationships, and the broader moral order (105). The most frequently endorsed symptoms in Axum closely correspond to what have been described as culturally patterned expressions, or “cultural scripts,” of trauma in East African contexts (28).

Similar expression of distress has been documented in Rwanda and Uganda, where experiences such as *kubabaza* (persistent rumination) and *kwiheba* (hopelessness) are often more common than classical PTSD symptoms (54).

The high prevalence of feeling unable to help others explained as in many African societies, identity and personhood are closely tied to social roles, and active participation in communal life which is called the philosophy of *ubuntu* (74). When individual faced difficulty of meeting the expectations, the impact might extend beyond psychological distress to a disruption of belonging and identity. Similarly, studies from Liberian refugees shown that the inability to care for family is a source of distress (55). In the Axum context, where displacement was apparent, the breakdown of these roles may represent a pathway through which trauma express into distress.

The item in culturally recognized symptoms of distress assessing “spending time wondering why these events happened” reflects an ongoing searching for meaning and closely linked to moral injury. Moral injury defined as the psychological consequences of experiencing or being unable to prevent actions that violate the moral

beliefs (106). In Axum, where individuals were exposed to significant traumatic events and the destruction of religiously significant sites likely carry significant psychological weight. One third of participants reported an intense urge for revenge shows the role of anger in expression of distress and may results challenges for long-term social recovery.

10.2.6 Perceived needs

From the perceived need assessment, the most reported need from the affected population is material deprivation as their most serious problem. problem related with food; insecure housing are the usual determinants of psychological distress than past trauma exposure in many posts conflict setting especially those who have ongoing daily stressors (107). The higher prevalence of perceived needs in Axum might suggest, daily stressors are also contributors to the mental health outcome additional to the trauma exposure.

10.2.7 IDP vulnerability

Internally displaced persons had significantly higher PTSD scores than permanent In this study internally displaced persons had significantly higher PTSD scores than permanent residents which is similar to other conflict affected areas. Studies consistently show that IDPs experiencing higher rates of PTSD, depression, and anxiety compared to non-displaced populations (48,108). This could be due to ongoing displacement and live in camp setting compounded with lack of perceived needs and inconsistent availability of mental health service in IDPs.

Research has shown that transition to camp setting results significant psychological distress and challenges adapting to the new environments where displaced persons often lack the social networks that facilitated coping in their original place (109). Studies have also shown that IDPs moved to camp settings experience physical distance from services and having mismatch between their living backgrounds and the new environment that contributes to perpetuating the psychological distress (110).

IDPs often experience social exclusion, stigmatization, and discrimination when accessing local services or interacting with host community members, which reinforces their marginalization and affect social support (111). Studies in in Tigray

during the northern conflict have shown that IDPs face challenges with the local residents sometimes viewing them with suspicion due to competition over scarce resources (112).

10.3 Factors associated with PTSD

One of this study's strong finding is that the strong independent association between culturally grounded symptoms and PTSD severity which explain not only the severity of PTSD but shows core feature of distress. One possible explanation is that the SPIESS items capture social and also existential consequences of trauma that are not fully seen within DSM criteria. For instance, research among Cambodian refugees has shown that culturally specific expressions such as experiencing a "weak heart" are closely linked to functional impairment than standard PTSD symptoms (113).

The dose response relationship which is well established in trauma research is also evident in this study with cumulative trauma exposure remained independently associated with PTSD severity ($\beta = 0.074$, $p = 0.039$). A study of Vietnamese ex-political detainees demonstrated a linear relationship between the number of torture events and severity of PTSD symptoms (45). A recent research has shown that every additional traumatic event increases the risk of PTSD by 30% especially when the trauma type is interpersonal violence (13). In this study, median of 12 traumatic events per participant represents a level of cumulative traumatic exposure that would be expected to produce severe and chronic symptomatology.

Another factor associated with PTSD was coping styles which showed paradoxical associations. The unexpected positive association between problem-focused coping and PTSD severity may be due to individuals with more severe symptoms are likely to engage in problem-focused coping because their distress might motivate them to actively seek solutions. In another way, the direction of this association cannot be determined from cross-sectional data. It might also be explained that those individuals with more severe PTSD symptoms engage in problem-focused coping as a last attempt to alleviate their distress which makes the coping strategy a consequence rather than a cause of the severity.

Another reason for the positive association of problem focused coping with PTSD severity is that in an area where lack of food, inadequate shelter, safety concerns are

of chronic, problem-focused coping may not result resolution of such problem which leads to continuous distress. This interpretation can be explained by the “mismatch” hypothesis in which coping strategies are most effective when they match the controllability of the stressor (114). In the Axum context, due to many of the most concerning issues and stressors are beyond individual control, it makes problem-focused coping less effective than emotion-focused strategies.

The strong positive association between avoidant coping and PTSD severity ($\beta = 0.191$, $p < 0.001$) is consistent with the previous literatures which showed maladaptive coping strategies worsen mental health outcomes (98). The use of avoidant coping in this affected population may show the severity of distress.

The finding of using emotion-focused coping mechanism resulted a protective effect in the multiple linear regression model suggests that these strategies may be more adaptive than problem-focused coping in this context.

Though social support showed a significant bivariate association, it did not associate in the multivariable model. One possible reason could be the effects of social support are mediated through other variables, especially culturally recognized symptoms. For example, the items that measures sense of being unable to help others in the culturally recognized symptoms may be due to a result of having poor social support. Alternatively, in a an area where social support is universally poor, its protective effects may be overwhelmed by the burden of trauma exposure. Similar findings have been reported in other settings where social support failed to show a direct effect which suggests in a place where there is extreme trauma, the protective effect of social support may be affected (107).

The other reason could be, PTSD symptoms such as irritability, emotional numbing, and avoidance can affect relationships and due to this, survivors may withdraw from others due to shame. Longitudinal research has demonstrated bidirectional relationships between PTSD and social support, where initial symptoms reduce support availability, and diminishing support then exacerbates symptoms (71).

Most of demographic factors that showed association in bivariate analysis did not remain significant in the multiple regression model. The higher PTSD scores among IDPs became non-significant after controlling other variables which suggest that

displacement status solely is less important than the cumulative traumatic exposure that accompany displacement. One reason could be, the effects of these demographic factors on PTSD severity are mostly affected by trauma exposure, coping, and cultural symptom expression which showed strong association in this study. This finding is similar with studies that have shown the relationship between displacement and mental health effect is mediated by exposure to violence and post-displacement stressors than the displacement only (108).

Family size being remained positively associated with PTSD severity which reflect that individuals with larger families might have more family members to worry about, have experienced more bereavement events, or face challenges in meeting family needs. Research support this finding that having larger family size has been associated with greater risk of PTSD due to the increased burden of care and the likelihood of having a family member injured or killed (115). In the present study where 57.9% of participants witnessed the death of a family member or friend where having higher family members increase the likelihood of being affected by the trauma which further increase the probability of having higher PTSD severity than those who have less family members.

11. Strengths and limitations

11.1 Strength

Using multiple validated tools which allowed to have a holistic assessment of trauma and mental health outcome make this study strong. The use of SPIESS section of the HTQ to capture culturally recognized symptoms of suffering was a key strength evidenced by strongest correlate of PTSD severity.

All instruments translated to Tigrigna through forward-backward translation, expert review, and pilot testing which followed the WHO standard guideline. Additionally, internal consistency was good to excellent for most of the used scales.

Using multi stage systematic sampling and achieving a large sample exceeding the initial targeted number of participants and a high response rate is also another strength of the present study.

Data was collected by master's-level professionals trained in trauma-informed data collection. The multiple linear regression model explained a significant amount of variation (R^2=0.74) and showed no sign of multicollinearity.

Ethical protections were considered throughout the data collection period. Initially data collectors were trained in trauma-informed data collection approach and were prepared to offer breathing and relaxation exercises if study participants experience distress and referral pathways to Axum Comprehensive Specialized Hospital were facilitated.

11.2 Limitations

Using cross-sectional study design is one limitation that the direction of effects cannot be determined. Additionally, recall bias might affected reporting of past traumatic events.

Since the current study used HTQ provisional cut point for PTSD with a mean score of above 2.5 which was initially used in a clinic-based setting, validity in the community study was not determined in Tigrigna speaking population which questions the validity of the cut point.

Since the study was done three years after the cessation of the conflict, it might not capture acute reactions during the conflict and the results may reflect the effects of ongoing stressors rather than the direct impact of war trauma alone.

Face-to-face interviewing possibly led to underreporting of sensitive events like sexual violence. The exclusion of those having severe mental illness may have led to the omission of the most severe mental health conditions which has the potential to underestimating the actual burden of psychiatric morbidity. Similarly, the exclusion of under 18 who are often vulnerable to trauma especially in armed conflict underestimates the mental health and psychosocial outcome.

12. Conclusion

The present study findings showed that the mental health consequences of the northern Ethiopian conflict in Axum are significant. The nearly universal exposure to traumatic events and the high prevalence of PTSD and psychological distress shows not only to the severity of the conflict but also to the long lasting nature of its impact.

The main contribution of this research is that culturally recognized expressions of distress were more strongly associated with PTSD severity suggesting that trauma in this affected population is more experienced through disruptions in social roles and collective identity. Religious coping was mostly used mechanism practiced reflect the central role of religion in the Axum community. Problem-focused coping was associated with greater PTSD severity while avoidant coping emerged as a significant risk factor for trauma severity. In contrast, emotion-focused coping showed protective. Additionally, social support may be mediated by trauma exposure and culturally grounded experiences of distress.

IDPs experienced a higher mental health problem than permanent residents due to higher levels of trauma exposure and the cumulative stressors associated with displacement including loss of social networks. Basic needs were identified as major concerns in this population. These findings highlight the close interconnection between mental health, perceived needs, and social recovery.

In general, the findings showed mental health assessments should incorporate culturally relevant expressions of distress and interventions should extend beyond individual level and should use community-based approach.

13. Recommendations

For mental health practice

Due to the higher impact of trauma on mental health outcome and psychodocial functioning, mental health services in Axum should adopt community-based approaches rather than individual oriented. With more than two third of participants reporting poor social support and one third experiencing functional impairment due to distress one-to-one sessions cannot meet the scale of need. Community health

workers and religious leaders are who trained in trauma-informed care can deliver structured peer support.

Because avoidant coping was strongly associated with higher PTSD severity, these groups should be designed as safe spaces where participants can share experiences and learn alternative strategies.

For policy maker

Health policy should understand that mental health cannot be addressed in isolation from basic needs and priority should be given to ongoing daily stressors.

For humanitarian and operational actors

Aid organizations should prioritize internally displaced persons (IDPs) who had significantly higher PTSD scores than permanent residents. Interventions should address the culturally recognized symptoms that were most strongly associated with PTSD severity.

Specific recommendation includes creating small local projects that restore the communities sense of agency and establishing volunteer roles within the community so that individuals can once again feel useful.

For future research

Longitudinal studies are needed to better understand the mental health outcomes over time. Qualitative research should explore the meaning of culturally recognized symptoms to inform intervention design. Future research should also include children and adolescents, who were not part of the present study.

14. REFERENCES

1. Devi S. Tigray atrocities compounded by lack of health care. The Lancet. 2021 Apr;397(10282):1336. doi:10.1016/S0140-6736(21)00825-4

2. Tewabe DS, Azage M, Wubetu GY, Fenta SA, Worke MD, Asres AM, et al. Correction to: Gender-based violence in the context of armed conflict in the Amhara Region, Northern Ethiopia. Confl Health. 2025 Apr 28;19(1):27. doi:10.1186/s13031-025-00665-1

3. Ethiopia – Tigray Conflict Fact Sheet #11 Fiscal Year (FY) 2021 - Ethiopia | ReliefWeb [Internet]. 2021 [cited 2026 Mar 24]. Available from: https://reliefweb.int/report/ethiopia/ethiopia-tigray-conflict-fact-sheet-11-fiscal-year-fy-2021

4. Gebreyesus A, Gebremariam AG, Kidanu KG, Gidey S, Haftu H, Nigusse AT, et al. Post-traumatic stress disorder symptoms among internally displaced persons: unveiling the impact of the war of Tigray. Discov Ment Health. 2024 May 28;4(1):18. doi:10.1007/s44192-024-00069-2

5. Violence Patterns in Ethiopia's Periphery - March 2024 | ACLED [Internet]. 2025 [cited 2026 Mar 24]. Available from: https://acleddata.com/update/violence-patterns-ethiopias-periphery-march-2024

6. Charlson F, Van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet. 2019 Jul;394(10194):240–8. doi:10.1016/S0140-6736(19)30934-1

7. Hoppen TH, Priebe S, Vetter I, Morina N. Global burden of post-traumatic stress disorder and major depression in countries affected by war between 1989 and 2019: a systematic review and meta-analysis. BMJ Glob Health. 2021 Jul;6(7):e006303. doi:10.1136/bmjgh-2021-006303

8. Morina N, Stam K, Pollet TV, Priebe S. Prevalence of depression and posttraumatic stress disorder in adult civilian survivors of war who stay in war-afflicted regions. A systematic review and meta-analysis of epidemiological studies. Journal of Affective Disorders. 2018 Oct;239:328–38. doi:10.1016/j.jad.2018.07.027

9. Hoppen TH, Morina N. The prevalence of PTSD and major depression in the global population of adult war survivors: a meta-analytically informed estimate in absolute numbers. European Journal of Psychotraumatology. 2019 Dec 31;10(1):1578637. doi:10.1080/20008198.2019.1578637

10. Tinsae T, Shumet S, Tadesse G, Takelle GM, Rtbey G, Melkam M, et al. Post-traumatic stress disorder in the Ethiopian population dwelling in war-affected communities: a systematic review and meta-analysis. Front Psychiatry. 2024 May 9;15:1399013. doi:10.3389/fpsyt.2024.1399013

11. Gesesew H, Berhane K, Siraj ES, Siraj D, Gebregziabher M, Gebre YG, et al. The impact of war on the health system of the Tigray region in Ethiopia: an assessment. BMJ Glob Health. 2021 Nov;6(11):e007328. doi:10.1136/bmjgh-2021-007328

12. Do TTH, Correa-Velez I, Dunne MP. Trauma Exposure and Mental Health Problems Among Adults in Central Vietnam: A Randomized Cross-Sectional Survey. Front Psychiatry. 2019 Feb 22;10:31. doi:10.3389/fpsyt.2019.00031

13. Karam EG, Friedman MJ, Hill ED, Kessler RC, McLaughlin KA, Petukhova M, et al. CUMULATIVE TRAUMAS AND RISK THRESHOLDS: 12-MONTH PTSD IN THE WORLD MENTAL HEALTH (WMH) SURVEYS: Cumulative Trauma and PTSD. Depress Anxiety. 2014 Feb;31(2):130–42. doi:10.1002/da.22169

14. Koenen KC, Ratanatharathorn A, Ng L, McLaughlin KA, Bromet EJ, Stein DJ, et al. Posttraumatic stress disorder in the World Mental Health Surveys. Psychol Med. 2017 Oct;47(13):2260–74. doi:10.1017/S0033291717000708

15. Kube T, Elssner AC, Herzog P. The relationship between multiple traumatic events and the severity of posttraumatic stress disorder symptoms – evidence for a cognitive link. European Journal of Psychotraumatology. 2023 Dec 31;14(1):2165025. doi:10.1080/20008066.2023.2165025

16. Calhoun CD, Stone KJ, Cobb AR, Patterson MW, Danielson CK, Bendezú JJ. The Role of Social Support in Coping with Psychological Trauma: An Integrated Biopsychosocial Model for Posttraumatic Stress Recovery. Psychiatr Q. 2022 Dec;93(4):949–70. doi:10.1007/s11126-022-10003-w

17. Panagioti M, Gooding PA, Taylor PJ, Tarrier N. Perceived social support buffers the impact of PTSD symptoms on suicidal behavior: Implications into suicide resilience research. Comprehensive Psychiatry. 2014 Jan;55(1):104–12. doi:10.1016/j.comppsych.2013.06.004

18. Van Reisen M, Mawere M, editors. Tigray: The Hysteresis of War [Internet]. Langaa RPCIG; 2024 [cited 2026 Mar 24]. Available from: http://www.jstor.org/stable/10.2307/jj.22136029 doi:10.2307/jj.22136029

19. Amone-P'Olak K, Omech B. Coping with post-war mental health problems among survivors of violence in Northern Uganda: Findings from the WAYS study. J Health Psychol. 2020 Oct;25(12):1857–70. doi:10.1177/1359105318775185

20. Garfin DR, Poulin MJ, Blum S, Silver RC. Aftermath of Terror: A Nationwide Longitudinal Study of Posttraumatic Stress and Worry Across the Decade Following the September 11, 2001 Terrorist Attacks. Journal of Traumatic Stress. 2018 Feb;31(1):146–56. doi:10.1002/jts.22262

21. Abudayya A, Bruaset GTF, Nyhus HB, Aburukba R, Tofthagen R. Consequences of war-related traumatic stress among Palestinian young people in the Gaza Strip: A scoping review. Mental Health & Prevention. 2023 Dec;32:200305. doi:10.1016/j.mhp.2023.200305

22. Levi-Belz Y, Groweiss Y, Blank C, Neria Y. PTSD, depression, and anxiety after the October 7, 2023 attack in Israel: a nationwide prospective study. eClinicalMedicine. 2024 Feb;68:102418. doi:10.1016/j.eclinm.2023.102418

23. Rigutto C, Sapara AO, Agyapong VIO. Anxiety, Depression and Posttraumatic Stress Disorder after Terrorist Attacks: A General Review of the Literature. Behavioral Sciences. 2021 Oct 19;11(10):140. doi:10.3390/bs11100140

24. Purgato M, Tedeschi F, Turrini G, Acartürk C, Anttila M, Augustinavicious J, et al. Trajectories of psychosocial symptoms and wellbeing in asylum seekers and refugees exposed to traumatic events and resettled in Western Europe, Turkey, and Uganda. European Journal of Psychotraumatology. 2022 Dec 19;13(2):2128270. doi:10.1080/20008066.2022.2128270

25. Newnham EA, Pearson RM, Stein A, Betancourt TS. Youth mental health after civil war: The importance of daily stressors. Br J Psychiatry. 2015 Feb;206(2):116–21. doi:10.1192/bjp.bp.114.146324

26. Njenga FG, Nguithi AN, Kang'ethe RN. War and mental disorders in Africa. World Psychiatry. 2006 Feb;5(1):38–9. PubMed PMID: 16757994; PubMed Central PMCID: PMC1472262.

27. Musisi S, Kinyanda E. Long-Term Impact of War, Civil War, and Persecution in Civilian Populations—Conflict and Post-Traumatic Stress in African Communities. Front Psychiatry. 2020 Feb 25;11:20. doi:10.3389/fpsyt.2020.00020

28. Mutuyimana C, Maercker A. Elements of cultural scripts of trauma sequelae among trauma victims in East Africa. Front Psychol. 2023 Oct 20;14:1206503. doi:10.3389/fpsyg.2023.1206503

29. Gebrekidan A, Haftu H, Hailu BY, Zenebe D, Gebremedhin M, Abraha HE, et al. The effect of war and siege on children with diabetes admitted to ayder comprehensive specialized hospital in mekelle, tigray, ethiopia: a cross-sectional study. Sci Rep. 2024 Oct 23;14(1):25007. doi:10.1038/s41598-024-76516-5

30. Gebregergs G, Berhe G, Gebrehiwot K, Mulugeta A. Predicting Tuberculosis Incidence and Its Trend in Tigray, Ethiopia: A Reality-Counterfactual Modeling Approach. IDR. 2024 Jul;Volume 17:3241–51. doi:10.2147/IDR.S464787

31. Hailu A, Gidey K, Zenebe D, Berhe E, Kidu M, Berhane S, et al. The Impact of the Northern Ethiopian Tigray War on Hypertensive Patients' Follow Up: a Brief Quantitative Study [Internet]. In Review; 2022 [cited 2026 Mar 24]. Available from: https://www.researchsquare.com/article/rs-2003722/v1 doi:10.21203/rs.3.rs-2003722/v1

32. Griffin D. The National Child Traumatic Stress Network [Text] [Internet]. 2018 [cited 2026 Mar 24]. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Available from: https://www.nctsn.org/resources/samhsas-concept-of-trauma-and-guidance-for-a-trauma-informed-approach

33. Leader Maynard J. Ideology and armed conflict. Journal of Peace Research. 2019 Sep 1;56(5):635–49. doi:10.1177/0022343319826629

34. geneva-academy.ch/wp-content/uploads/2025/09/The-War-Report-2018.pdf [Internet]. [cited 2026 Mar 24]. Available from: https://geneva-academy.ch/wp-content/uploads/2025/09/The-War-Report-2018.pdf

35. Moreno-Chaparro J, Piñeros-Ortiz S, Rodríguez-Ramírez L, Urrego-Mendoza Z, Garzón-Orjuela N, Eslava-Schmalbach J. Mental health consequences of armed conflicts in adults: an overview. Actas Esp Psiquiatr. 2022 Mar;50(2):68–91. PubMed PMID: 35312994; PubMed Central PMCID: PMC10803861.

36. Benjet C, Bromet E, Karam EG, Kessler RC, McLaughlin KA, Ruscio AM, et al. The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium. Psychol Med. 2016 Jan;46(2):327–43. doi:10.1017/S0033291715001981

37. Bell V, Méndez F, Martínez C, Palma PP, Bosch M. Characteristics of the Colombian armed conflict and the mental health of civilians living in active conflict zones. Confl Health. 2012 Dec;6(1):10. doi:10.1186/1752-1505-6-10

38. Ba I, Bhopal RS. Physical, mental and social consequences in civilians who have experienced war-related sexual violence: a systematic review (1981–2014). Public Health. 2017 Jan;142:121–35. doi:10.1016/j.puhe.2016.07.019

39. Cook TL, Shannon PJ, Vinson GA, Letts JP, Dwee E. War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study. BMC Int Health Hum Rights. 2015 Dec;15(1):8. doi:10.1186/s12914-015-0046-y

40. Musisi S, Kinyanda E. Long-Term Impact of War, Civil War, and Persecution in Civilian Populations—Conflict and Post-Traumatic Stress in African Communities. Front Psychiatry. 2020 Feb 25;11:20. doi:10.3389/fpsyt.2020.00020

41. Park J, Jun JY, Lee YJ, Kim S, Lee SH, Yoo SY, et al. The association between alexithymia and posttraumatic stress symptoms following multiple exposures to traumatic events in North Korean refugees. Journal of Psychosomatic Research. 2015 Jan;78(1):77–81. doi:10.1016/j.jpsychores.2014.09.007

42. Gonzalez A, Monzon N, Solis D, Jaycox L, Langley AK. Trauma Exposure in Elementary School Children: Description of Screening Procedures, Level of Exposure, and Posttraumatic Stress Symptoms. School Mental Health. 2016 Mar;8(1):77–88. doi:10.1007/s12310-015-9167-7

43. Kube T, Elssner AC, Herzog P. The relationship between multiple traumatic events and the severity of posttraumatic stress disorder symptoms – evidence for a cognitive link. European Journal of Psychotraumatology. 2023 Dec 31;14(1):2165025. doi:10.1080/20008066.2023.2165025

44. Do TTH, Correa-Velez I, Dunne MP. Trauma Exposure and Mental Health Problems Among Adults in Central Vietnam: A Randomized Cross-Sectional Survey. Front Psychiatry. 2019 Feb 22;10:31. doi:10.3389/fpsyt.2019.00031

45. Mollica RF, Mcinnes K, Pham T, Smith Fawzi MC, Murphy E, Lin L. The Dose-Effect Relationships between Torture and Psychiatric Symptoms in Vietnamese Ex-Political Detainees and a Comparison Group: The Journal of Nervous & Mental Disease. 1998 Sep;186(9):543–53. doi:10.1097/00005053-199809000-00005

46. Restrepo MT, Padilla-Medina D. Armed conflict exposure and mental health: examining the role of imperceptible violence. Medicine, Conflict and Survival. 2023 Jul 3;39(3):199–221. doi:10.1080/13623699.2023.2222360

47. Lim ICZY, Tam WWS, Chudzicka-Czupała A, McIntyre RS, Teopiz KM, Ho RC, et al. Prevalence of depression, anxiety and post-traumatic stress in war- and conflict-afflicted areas: A meta-analysis. Front Psychiatry. 2022 Sep 16;13:978703. doi:10.3389/fpsyt.2022.978703

48. Steel Z, Chey T, Silove D, Marnane C, Bryant RA, Van Ommeren M. Association of Torture and Other Potentially Traumatic Events With Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement: A Systematic Review and Meta-analysis. JAMA. 2009 Aug 5;302(5):537. doi:10.1001/jama.2009.1132

49. Mahmood HN, Ibrahim H, Goessmann K, Ismail AA, Neuner F. Post-traumatic stress disorder and depression among Syrian refugees residing in the Kurdistan region of Iraq. Confl Health. 2019 Dec;13(1):51. doi:10.1186/s13031-019-0238-5

50. Hazer L, Gredebäck G. The effects of war, displacement, and trauma on child development. Humanit Soc Sci Commun. 2023 Dec 5;10(1):909. doi:10.1057/s41599-023-02438-8

51. Rzońca P, Podgórski M, Łazarewicz M, Gałązkowski R, Rzońca E, Detsyk O, et al. The prevalence and determinants of PTSD, anxiety, and depression in Ukrainian civilian physicians and paramedics in wartime–An observational cross-sectional study six months after outbreak. Psychiatry Research. 2024 Apr;334:115836. doi:10.1016/j.psychres.2024.115836

52. Amsalem D, Haim-Nachum S, Lazarov A, Levi-Belz Y, Markowitz JC, Bergman M, et al. The effects of war-related experiences on mental health symptoms of individuals living in conflict zones: a longitudinal study. Sci Rep. 2025 Jan 6;15(1):889. doi:10.1038/s41598-024-84410-3

53. Khalil KA, Mohammed GTF, Ahmed ABM, Alrawa SS, Elawad H, Almahal AA, et al. War-related trauma and posttraumatic stress disorder in refugees, displaced, and nondisplaced people during armed conflict in Sudan: a cross-sectional study. Confl Health. 2024 Nov 1;18(1):66. doi:10.1186/s13031-024-00627-z

54. Rieder H, Elbert T. Rwanda – lasting imprints of a genocide: trauma, mental health and psychosocial conditions in survivors, former prisoners and their children. Confl Health. 2013 Dec;7(1):6. doi:10.1186/1752-1505-7-6

55. Dwanyen L, Wieling E, Griffes SE. “People are still living with pains of the war”: An assessment of long-term adjustment and consequences of war-related traumatic stress among Liberian refugees. Current Research in Ecological and Social Psychology. 2024;6:100191. doi:10.1016/j.cresp.2024.100191

56. Andualem F, Melkam M, Takelle GM, Nakie G, Tinsae T, Fentahun S, et al. Prevalence of posttraumatic stress disorder and associated factors among displaced people in Africa: a systematic review and meta-analysis. Front Psychiatry. 2024 Mar 5;15:1336665. doi:10.3389/fpsyt.2024.1336665

57. Fisseha G, Gebrehiwot TG, Gebremichael MW, Wahdey S, Meles GG, Gezae KE, et al. War-related sexual and gender-based violence in Tigray, Northern Ethiopia: a community-based study. BMJ Glob Health. 2023 Jul;8(7):e010270. doi:10.1136/bmjgh-2022-010270

58. Wilson K, Fornasier S, White KM. Psychological Predictors of Young Adults' Use of Social Networking Sites. Cyberpsychology, Behavior, and Social Networking. 2010 Apr;13(2):173–7. doi:10.1089/cyber.2009.0094

59. Grenawalt TA, Lu J, Hamner K, Gill C, Umucu E. Social isolation and well-being in veterans with mental illness. Journal of Mental Health. 2023 Mar 4;32(2):407–11. doi:10.1080/09638237.2021.2022625

60. Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy [Internet]. Washington, D.C.: National Academies Press; 2003 [cited 2026 Mar 24]. Available from: https://www.nationalacademies.org/publications/10717 doi:10.17226/10717

61. Social Isolation of War Veterans with Post-Traumatic Stress Disorder Based on Emotional Inhibition: The Mediating Role of Rejection Sensitivity. JMVH [Internet]. [cited 2026 Mar 24]. Available from: https://jmvh.org/article/social-isolation-of-war-veterans-with-post-traumatic-stress-disorder-based-on-emotional-inhibition-the-mediating-role-of-rejection-sensitivity/

62. Bolton D, Hill J, O'Ryan D, Udwin O, Boyle S, Yule W. Long-term effects of psychological trauma on psychosocial functioning. Child Psychology Psychiatry. 2004 Jul;45(5):1007–14. doi:10.1111/j.1469-7610.2004.t01-1-00292.x

63. Moreno-Chaparro J, Piñeros-Ortiz S, Rodríguez-Ramírez L, Urrego-Mendoza Z, Garzón-Orjuela N, Eslava-Schmalbach J. Mental health consequences of armed conflicts in adults: an overview. Actas Esp Psiquiatr. 2022 Mar;50(2):68–91. PubMed PMID: 35312994; PubMed Central PMCID: PMC10803861.

64. Doma H, Tran T, Rioseco P, Fisher J. Understanding the relationship between social support and mental health of humanitarian migrants resettled in Australia. BMC Public Health. 2022 Sep 13;22(1):1739. doi:10.1186/s12889-022-14082-z

65. Gorst-Unsworth C, Goldenberg E. Psychological sequelae of torture and organised violence suffered by refugees from Iraq: Trauma-related factors compared with social factors in exile. Br J Psychiatry. 1998 Jan;172(1):90–4. doi:10.1192/bjp.172.1.90

66. Gariépy G, Honkaniemi H, Quesnel-Vallée A. Social support and protection from depression: systematic review of current findings in Western countries. Br J Psychiatry. 2016 Oct;209(4):284–93. doi:10.1192/bjp.bp.115.169094

67. Sundvall M, Titelman D, DeMarinis V, Borisova L, Çetrez Ö. Safe but isolated – an interview study with Iraqi refugees in Sweden about social networks, social support, and mental health. Int J Soc Psychiatry. 2021 Jun;67(4):351–9. doi:10.1177/0020764020954257

68. Birman D, Tran N. Psychological distress and adjustment of Vietnamese refugees in the United States: Association with pre- and postmigration factors. American Journal of Orthopsychiatry. 2008 Jan;78(1):109–20. doi:10.1037/0002-9432.78.1.109

69. Agaibi CE, Wilson JP. Trauma, PTSD, and Resilience: A Review of the Literature. Trauma, Violence, & Abuse. 2005 Jul;6(3):195–216. doi:10.1177/1524838005277438

70. Ozer EJ, Best SR, Lipsey TL, Weiss DS. Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. Psychological Bulletin. 2003;129(1):52–73. doi:10.1037/0033-2909.129.1.52

71. Sippel LM, Liebman RE, Schäfer SK, Ennis N, Mattern AC, Rozek DC, et al. Sources of Social Support and Trauma Recovery: Evidence for Bidirectional Associations from a Recently Trauma-Exposed Community Sample. Behavioral Sciences. 2024 Mar 29;14(4):284. doi:10.3390/bs14040284

72. Cross CJ, Taylor RJ, Chatters LM. Family Social Support Networks of African American and Black Caribbean Adolescents. J Child Fam Stud. 2018 Sep;27(9):2757–71. doi:10.1007/s10826-018-1116-2

73. Papola D, Prina E, Ceccarelli C, Cadorin C, Gastaldon C, Ferreira MC, et al. Psychological and social interventions for the promotion of mental health in people living in low- and middle-income countries affected by humanitarian crises. Cochrane Common Mental Disorders Group, editor. Cochrane Database of Systematic Reviews. 2024 May 21;2024(5). doi:10.1002/14651858.CD014300.pub2

74. Chigangaidze RK, Matanga AA, Katsuro TR. Ubuntu Philosophy as a Humanistic–Existential Framework for the Fight Against the COVID-19 Pandemic. Journal of Humanistic Psychology. 2022 May;62(3):319–33. doi:10.1177/00221678211044554

75. Anbesaw T, Kassa MA, Yimam W, Kassaw AB, Belete M, Abera A, et al. Factors associated with depression among war-affected population in Northeast, Ethiopia. BMC Psychiatry. 2024 May 21;24(1):376. doi:10.1186/s12888-024-05812-1

76. Folkman S. Personal control and stress and coping processes: A theoretical analysis. Journal of Personality and Social Psychology. 1984;46(4):839–52. doi:10.1037/0022-3514.46.4.839

77. Chudzicka-Czupała A, Hapon N, Man RHC, Li DJ, Żywiołek-Szeja M, Karamushka L, et al. Associations between coping strategies and psychological distress among people living in Ukraine, Poland, and Taiwan during the initial stage of the 2022 War in Ukraine. European Journal of Psychotraumatology. 2023 Dec 31;14(1):2163129. doi:10.1080/20008066.2022.2163129

78. Almoshmosh N. The role of war trauma survivors in managing their own mental conditions, Syria civil war as an example. Avicenna J Med. 2016 Apr;06(02):54–9. doi:10.4103/2231-0770.179554

79. Khamis V. Coping with war trauma and psychological distress among school-age Palestinian children. American Journal of Orthopsychiatry. 2015 Jan;85(1):72–9. doi:10.1037/ort0000039

80. Iaali H, Eid K, El Darzi A, Joukhdar J, Khoury N, Jaffa MA. Population under Stress: The Coping Mechanisms of Lebanese Adults in Times of Intermingling Crises and Their Relationship with Stress. Huang D, editor. The Scientific World Journal. 2024 Mar 30;2024:1–16. doi:10.1155/2024/7281288

81. Gebrihet HG, Gebresilassie YH, Gebreselassie MA. Food Insecurity and Coping Strategies in War-Affected Urban Settings of Tigray, Ethiopia. Economies. 2025 Jan 1;13(1):7. doi:10.3390/economies13010007

82. Axum - Wikipedia [Internet]. [cited 2026 Mar 24]. Available from: https://en.wikipedia.org/wiki/Axum

83. Annexe-4-CET1129-Evaluation-report-of-CET1105-V4-final.pdf [Internet]. [cited 2026 Mar 24]. Available from: https://interaide.org/wp-content/uploads/2025/10/Annexe-4-CET1129-Evaluation-report-of-CET1105-V4-final.pdf

84. Mollica RF, Caspi-Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. The Harvard Trauma Questionnaire: Validating a Cross-Cultural Instrument for Measuring Torture, Trauma, and Posttraumatic Stress Disorder in Indochinese Refugees. The Journal of Nervous and Mental Disease. 1992 Feb;180(2):111–6. doi:10.1097/00005053-199202000-00008

85. Berthold SM, Mollica RF, Silove D, Tay AK, Lavelle J, Lindert J. The HTQ-5: revision of the Harvard Trauma Questionnaire for measuring torture, trauma and DSM-5 PTSD symptoms in refugee populations. European Journal of Public Health. 2019 Jun 1;29(3):468–74. doi:10.1093/eurpub/cky256

86. Berthold SM, Mollica RF, Silove D, Tay AK, Lavelle J, Lindert J. Skills, Physical, Intellectual, Emotional, Social, and Spiritual/Existential: Culture-Specific Functioning Scale [Internet]. 2020 [cited 2026 Mar 21]. Available from: https://doi.apa.org/doi/10.1037/t78381-000 doi:10.1037/t78381-000

87. Berhe SM, Azale T, Fanta T, Demeke W, Minyihun A. Prevalence and Predictors of Depression Among Eritrean Refugees in Ethiopia: A Cross-Sectional Survey. PRBM. 2021 Dec;Volume 14:1971–80. doi:10.2147/PRBM.S337255

88. Goldberg DP, Gater R, Sartorius N, Ustun TB, Piccinelli M, Gureje O, et al. The validity of two versions of the GHQ in the WHO study of mental illness in general health care. Psychol Med. 1997 Jan;27(1):191–7. doi:10.1017/S0033291796004242

89. Graetz B. Multidimensional properties of the General Health Questionnaire. Soc Psychiatry Psychiatr Epidemiol. 1991;26(3):132–8. doi:10.1007/BF00782952

90. Gelaye B, Tadesse MG, Lohsoonthorn V, Lertmeharit S, Pensuksan WC, Sanchez SE, et al. Psychometric properties and factor structure of the General Health Questionnaire as a

screening tool for anxiety and depressive symptoms in a multi-national study of young adults. Journal of Affective Disorders. 2015 Nov;187:197–202. doi:10.1016/j.jad.2015.08.045

91. Ali GC, Ryan G, De Silva MJ. Validated Screening Tools for Common Mental Disorders in Low and Middle Income Countries: A Systematic Review. Burns JK, editor. PLoS ONE. 2016 Jun 16;11(6):e0156939. doi:10.1371/journal.pone.0156939

92. Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings. Geneva: World Health Organization [u.a.]; 2012. 80 p. (Nonserial Publications).

93. Llosa AE, Van Ommeren M, Kolappa K, Ghantous Z, Souza R, Bastin P, et al. A two-phase approach for the identification of refugees with priority need for mental health care in Lebanon: a validation study. BMC Psychiatry. 2017 Dec;17(1):28. doi:10.1186/s12888-016-1154-5

94. WHO Team. The humanitarian emergency settings perceived needs scale (HESPER).

95. Semrau M, Evans-Lacko S, Alem A, Ayuso-Mateos JL, Chisholm D, Gureje O, et al. Strengthening mental health systems in low- and middle-income countries: the Emerald programme. BMC Med. 2015 Dec;13(1):79. doi:10.1186/s12916-015-0309-4

96. Kocalevent RD, Berg L, Beutel ME, Hinz A, Zenger M, Härter M, et al. Social support in the general population: standardization of the Oslo social support scale (OSSS-3). BMC Psychol. 2018 Dec;6(1):31. doi:10.1186/s40359-018-0249-9

97. Dalgard OS, Dowrick C, Lehtinen V, Vazquez-Barquero JL, Casey P, Wilkinson G, et al. Negative life events, social support and gender difference in depression: A multinational community survey with data from the ODIN study. Soc Psychiat Epidemiol. 2006 Jun;41(6):444–51. doi:10.1007/s00127-006-0051-5

98. Carver CS. You want to measure coping but your protocol' too long: Consider the brief cope. Int J Behav Med. 1997 Mar;4(1):92–100. doi:10.1207/s15327558ijbm0401_6

99. García FE, Barraza-Peña CG, Wlodarczyk A, Alvear-Carrasco M, Reyes-Reyes A. Psychometric properties of the Brief-COPE for the evaluation of coping strategies in the Chilean population. Psicol Refl Crít. 2018 Dec;31(1):22. doi:10.1186/s41155-018-0102-3

100. Azale T, Fekadu A, Medhin G, Hanlon C. Coping strategies of women with postpartum depression symptoms in rural Ethiopia: a cross-sectional community study. BMC Psychiatry. 2018 Dec;18(1):41. doi:10.1186/s12888-018-1624-z

101. Desie Y, Habtamu K, Asnake M, Gina E, Mequanint T. Coping strategies among Ethiopian migrant returnees who were in quarantine in the time of COVID-19: a center-based cross-sectional study. BMC Psychol. 2021 Dec 8;9(1):192. doi:10.1186/s40359-021-00699-z

102. Mahmood HN. The Implications of War and Conflict on the Mental Health of Syrian and Iraqi Displaced People [Application/pdf]. 2023;1509191 bytes. doi:10.4119/UNIBI/2968872

103. Kessler RC. Posttraumatic stress disorder: the burden to the individual and to society. J Clin Psychiatry. 2000;61 Suppl 5:4–12; discussion 13-14. PubMed PMID: 10761674.

104. Acarturk C, McGrath M, Roberts B, Ilkkursun Z, Cuijpers P, Sijbrandij M, et al. Prevalence and predictors of common mental disorders among Syrian refugees in Istanbul, Turkey: a cross-sectional study. Soc Psychiatry Psychiatr Epidemiol. 2021 Mar;56(3):475–84. doi:10.1007/s00127-020-01941-6

105. Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder AG, Guzder J, et al. Common mental health problems in immigrants and refugees: general approach in primary care. Canadian Medical Association Journal. 2011 Sep 6;183(12):E959–67. doi:10.1503/cmaj.090292

106. Litz BT, Stein N, Delaney E, Lebowitz L, Nash WP, Silva C, et al. Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. Clinical Psychology Review. 2009 Dec;29(8):695–706. doi:10.1016/j.cpr.2009.07.003

107. Miller KE, Rasmussen A. War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. Social Science & Medicine. 2010 Jan;70(1):7–16. doi:10.1016/j.socscimed.2009.09.029

108. Porter M, Haslam N. Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis. JAMA. 2005 Aug 3;294(5):602. doi:10.1001/jama.294.5.602

109. Kunnuji M, Onitolo E, Grant C. Fellow's brief: Addressing the humanitarian needs of forced rural-to-city migrants in north-west Nigeria with a focus on mental health vulnerability [Internet]. Institute of Development Studies; 2024 Oct [cited 2026 Mar 25]. Report No. Available from: https://opendocs.ids.ac.uk/articles/report/Fellow_s_Brief_Addressing_the_Humanitarian_Needs_of_Forced_Rural-to-City_Migrants_in_North-West_Nigeria_with_a_Focus_on_Mental_Health_Vulnerability/27377454?file=50112675 doi:10.19088/SSHAP.2024.058

110. Regasa D, Godesso A, Lietaert I. LIVING ON THE MARGINS : The Socio-spatial Representation of Urban Internally Displaced Persons in Ethiopia. Int J Urban Regional Res. 2023 May;47(3):369–85. doi:10.1111/1468-2427.13176

111. Yeshaneh BW. Voiceless and forgotten: The plight of internally displaced persons hosted in Dabat IDpPs Center, Ethiopia. J Internal Displacement. 2025 Oct 30;15(2):18–32. doi:10.4314/jid.v15i2.2

112. Zewude B, Siraw G. Sustainable integration of internally displaced persons (IDPs) in Ethiopia: exploring intentions about post-conflict resettlement choices. Cogent Social Sciences. 2024 Dec 31;10(1):2350116. doi:10.1080/23311886.2024.2350116

113. Hinton DE, Reis R, De Jong J. The "Thinking a Lot" Idiom of Distress and PTSD: An Examination of Their Relationship among Traumatized Cambodian Refugees Using the "Thinking a Lot" Questionnaire. Med Anthropol Q. 2015 Sep;29(3):357–80. doi:10.1111/maq.12204

114. Folkman S, Moskowitz JT. Coping: Pitfalls and Promise. Annu Rev Psychol. 2004 Feb 1;55(1):745–74. doi:10.1146/annurev.psych.55.090902.141456

115. Tol WA, Song S, Jordans MJD. Annual Research Review: Resilience and mental health in children and adolescents living in areas of armed conflict – a systematic review of findings in low- and middle-income countries. Child Psychology Psychiatry. 2013 Apr;54(4):445–60. doi:10.1111/jcpp.12053

11. Appendix

ANNEX 1 : Participants' Information Sheets

You are being invited to participate in a research study conducted by Addis Ababa University, Department of Psychiatry. This study aims to assess the patterns of trauma exposure, mental health outcomes, psychosocial consequences, coping strategies, and social support among survivors of the northern conflict in Axum town.

If you agree to participate, you will be asked to complete surveys. It will take approximately one hour. Your participation is entirely voluntary.

Some questions may be sensitive and may cause emotional discomfort. You can skip any questions you do not wish to answer or withdraw from the study at any time without any penalty.

Your participation will help us understand the needs of war survivors and improve mental health services in your community.

Your responses will be kept confidential. We will not use your name or any other identifying information in any reports or publications. All data will be stored securely.

Your participation is completely voluntary. You may withdraw from the study at any time without any consequences.

This research project is reviewed and approved by the Ethical Committee of Addis Ababa University, School of Medicine, and Department of Psychiatry. If you want to have more information or if you have any complaint, you can contact the committee through the address below. You can also contact the members of the research team by the contact information provided below.

Principal Investigator: Haileleul Mekonnen Tilinty

Phone: (+251)913861655

Email: haileleul.mekonnen@aau.edu.et

Annex 2-Informed Consent Form

Participant's Statement:

I have read the information provided above (or it has been read to me). I have had the opportunity to ask questions and have received satisfactory answers. I understand that my participation is voluntary and that I can withdraw at any time without giving any reason and without any negative consequences. I understand that my responses will be kept confidential.

I consent to participate in this study.

Participant Signature _____ Date _____

ANNEX 3 : Demographic Information

Please answer each question by selecting the appropriate category

Variable	Categories
Age	
Gender	■ Male ■ Female
Marital Status	■ Single ■ Married ■ Widowed ■ Divorced
Education Level	■
Occupation	■ Private or Government Work ■ Unemployed ■ specify:
Residential Status	■ Long-term resident ■ Internally Displaced Person (IDP)
Duration of Residence in Axum	■

Living Conditions	■ Own house ■ Rental ■ Temporary shelter ■ IDP camp
Household Size	■
Religon	■ Orthodox, ■ Protestant ■ Muslim ■ Other
Income Level (Monthly)	■

Annex 4- HTQ Cambodian Version

Part 1: Trauma Events

Please indicate whether you have experienced any of the following events (check YES or NO).

		YES	NO
1.	Lack of shelter		
2.	Lack of food or water		
3.	Ill health without access to medical care		
4.	Confiscation or destruction of personal property		
5.	Combat situation (e.g. shelling and grenade attacks)		
6.	Forced evacuation under dangerous conditions		
7.	Beating to the body		
8.	Rape		
9.	Other types of sexual abuse or sexual humiliation		
10.	Knifing or axing		
11.	Torture, i.e., while in captivity you received deliberate and systematic infliction of physical or mental suffering		

	(If YES, see Appendix)		
12.	Serious physical injury from combat situation or landmine		

		YES	NO
13.	Imprisonment		
14.	Forced labor (like animal or slave)		
15.	Extortion or robbery		
16.	Brainwashing		
17.	Forced to hide		
18.	Kidnapped		
19.	Other forced separation from family members		
20.	Forced to find and bury bodies		
21.	Enforced isolation from others		
22.	Someone was forced to betray you and place you at risk of death or injury		

23.	Prevented from burying someone		
24.	Forced to desecrate or destroy the bodies or graves of deceased persons		
25.	Forced to physically harm family member, or friend		
26.	Forced to physically harm someone who is not family or friend		
27.	Forced to destroy someone else's property or possessions		
28.	Forced to betray family member, or friend placing them at risk of death or injury		
29.	Forced to betray someone who is not family or friend placing them at risk of death or injury		
30.	Murder, or death due to violence, of spouse		

		YES	NO
31.	Murder, or death due to violence, of child		
32.	Murder, or death due to violence, of other family member or friend		
33.	Disappearance or kidnapping of spouse		

34.	Disappearance or kidnapping of child		
35.	Disappearance or kidnapping of other family member or friend		
36.	Serious physical injury of family member or friend due to combat situation or landmine		
37.	Witness beatings to head or body		
38.	Witness torture		
39.	Witness killing/murder		
40.	Witness rape or sexual abuse		
41.	Another situation that was very frightening or in which you felt your life was in danger Specify:		

Part 3: Head Injury

If you answer yes to the following trauma events, please indicate if you lost consciousness and for how long.

	Experienced		Loss of consciousness?		If yes, for how long?	
	Yes	No	Yes	No	Hours	Minutes
1. Beatings to the head						
2. Suffocation or strangulation						
3. Near drowning						
4. Other types of injury to the head (e.g. shrapnel, burns, etc.)						
5. Starvation						
If Yes: Normal weight:			Starvation weight:			
If Yes: Were you near death due to starvation?			Yes: No:			

Part 4: Trauma Symptoms DSM-V

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
1.	Recurrent thoughts or memories of the most hurtful or terrifying events				
2.	Feeling as though the event is happening again				
3.	Recurrent nightmares				
4.	Feeling detached or withdrawn from people				
5.	Unable to feel emotions				
6.	Feeling jumpy, easily startled				
7.	Difficulty concentrating				
8.	Trouble sleeping				
9.	Feeling on guard				

10.	Feeling irritable or having outbursts of anger				
11.	Avoiding activities that remind you of the traumatic or hurtful event				

How much have the following symptoms bothered you in the past week.

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
12.	Inability to remember parts of the most hurtful or traumatic events				
13.	Less interest in daily activities				
14.	Feeling as if you don't have a future				
15.	Avoiding thoughts or feelings associated with the traumatic or hurtful events				
16.	Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events				
17.	Feeling that the world is a very dangerous place				

18.	Feeling that you are a bad person				
19.	Blaming yourself for the traumatic event				
20.	Strong feeling of fear, horror, anger, guilt or shame when thinking about the traumatic event				
21.	Difficulty feeling love or happiness				
22.	Taking risks that may harm yourself or others				
23.	Feeling like you have been damaged as a person by the traumatic event				
24.	Feeling as if something reminds you of the trauma but it feels like a dream, that it is not happening to you, and/or that it is not real				
25.	Feeling people or objects around you are not real or strange				

PART 5: Torture History

Now I would like to ask you about events that many people consider torture. I will ask you whether an event

occurred; please answer yes or no.

Event	Yes	No
1. Beating, kicking, striking with objects		
2. Threats, humiliation		
3. Being chained or tied to others		
4. Exposed to heat, sun, strong light		
5. Exposed to rain, body immersion, cold		
6. Placed in a sack, box, or very small space		
7. Drowning, submersion of head in water		
8. Suffocation		
9. Overexertion, hard labor		
10. Exposed to unhygienic conditions conducive to infections or other diseases		
11. Blindfolding		
12. Isolation, solitary confinement. If yes, how long?		
13. Mock execution		

14. Made to witness other being tortured		
15. Starvation		
16. Sleep deprivation		
17. Suspension from a rod by hands and feet		
18. Rape, mutilation of genitalia		
19. Burning		
20. Beating the soles of the feet with rods		

Event	Yes	No
21. Blows to the ears		
22. Forced standing		
23. Throwing urine or feces at victim or being made to throw it at other prisoners		
24. Medicine administration (non-therapeutic)		
25. Needles under toes or fingernails		

26. Writing confessions numerous times		
27. Shocked repeatedly by electric instrument		
28. Other (specify)		

PART 6: Cultural Symptoms of Trauma

SPIESS: Refugee-/Culture-Specific Functioning

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives.

Please read each one carefully and decide how much the symptoms bothered you in the past week.

	(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
SKILLS AND TALENTS				
1. Feeling that the skills you had before your trauma are no longer useful or valued				

2. Feeling that you have less skills to cope with life than you had before				
3. Having difficulty dealing with new situations				
4. Work brings back bad memories				
5. Your fellow workmates are disturbing to be around				
PHYSICAL IMPAIRMENTS				
6. Feeling exhausted				
7. Feeling pain in your body				
8. Feeling sick a lot				
9. Feeling too sick to work or do house chores				
10. Feeling your body has gone down hill				
INTELLECTUAL FUNCTIONING				
11. Poor memory				
12. Feeling overwhelmed by work				

13. Finding out or being told by other people that you have done something that you cannot remember				
14. Difficulty paying attention				
15. Feeling unable to make daily plans				

	(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
EMOTIONAL FUNCTIONING				
16. Feeling as if you are split into two people and one of you is watching what the other is doing				
17. Blaming yourself for things that have happened				
18. Feeling guilty for having survived				
19. Hopelessness				
20. Feeling ashamed of the hurtful or traumatic events that have happened to you				
SOCIAL RELATIONSHIPS				

21. Feeling that people do not understand what happened to you				
22. Feeling others are hostile to you				
23. Feeling that you have no one to rely upon				
24. Feeling humiliated by your experience				
25. Feeling no trust in others				
SPIRITUAL / EXISTENTIAL CONCERNS				
26. Feeling powerless to help others				
27. Spending time thinking why these events happened to you				
28. Feeling that you are the only one that suffered these events				
29. Feeling that someone you trusted betrayed you				
30. Feeling a need for revenge				

ANNEX 5: WHO-UNHCR ASSESSMENT SCHEDULE OF SERIOUS SYMPTOMS IN HUMANITARIAN SETTINGS (WASSS)

PART A : QUESTIONS TO AND ABOUT THE RESPONDENT. IT IS ASSUMED THAT ESSENTIAL INFORMATION ABOUT THE PERSON (FOR EXAMPLE, SEX, AGE AND SO ON) ARE ESTABLISHED EARLIER IN THE INTERVIEW

A1. The next questions are about how you have been feeling during the last two weeks. About how often during the last two weeks did you feel so afraid that nothing could calm you down — would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?

1.	All of the time
2.	Most of the time
3.	Some of the time
4.	A little of the time
5.	None of the time
8.	(IF VOL) Don't know
9.	(IF VOL) Refused

A2. About how often during the last two weeks did you feel so angry that you felt out of control — would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?

1.	All of the time
2.	Most of the time
3.	Some of the time
4.	A little of the time
5.	None of the time
8.	(IF VOL) Don’t know
9.	(IF VOL) Refused

A3. During the last two weeks, about how often did you feel so uninterested in things that you used to like, that you did not want to do anything at all? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

1.	All of the time
2.	Most of the time
3.	Some of the time
4.	A little of the time
5.	None of the time
8.	(IF VOL) Don’t know
9.	(IF VOL) Refused

A4. During the last two weeks, about how often did you feel so hopeless that you did not want to carry on living? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

1.	All of the time
2.	Most of the time
3.	Some of the time
4.	A little of the time
5.	None of the time
8.	(IF VOL) Don't know
9.	(IF VOL) Refused

A5. You may have experienced one or more events that have been intensely upsetting to you, such as the recent emergency/disaster/war.12 During the last two weeks, about how often did you feel so severely upset about the emergency/disaster/war or another event in your life, that you tried to avoid places, people, conversations or activities that reminded you of such event? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

1.	All of the time
2.	Most of the time
3.	Some of the time

4.	A little of the time
5.	None of the time
8.	(IF VOL) Don’t know
9.	(IF VOL) Refused

A6. The next question is about how these feelings of fear, anger, fatigue, disinterest, hopelessness or upset may have affected you during the last two weeks. During the last two weeks, about how often were you unable to carry out essential activities for daily living because of these feelings? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

1.	All of the time
2.	Most of the time
3.	Some of the time
4.	A little of the time
5.	None of the time
8.	(IF VOL) Don’t know
9.	(IF VOL) Refused

ANNEX 6: THE HUMANITARIAN EMERGENCY SETTINGS PERCEIVED NEEDS SCALE (HESPER)

Date:	Interviewer name:	Participant number:
Location (name of city, village or camp):	Gender:	Age:

Rating: 0 = no serious problem 1 = serious problem 9 = does not know / not applicable / declines to answer	Ratings

I am going to ask you about the serious problems that you may currently be experiencing. We are interested in finding out what you think − a serious problem is a problem that you consider serious. There are no right or wrong answers. I am going to ask you about your own serious problems first.

1. Drinking water Do you have a serious problem because you do not have enough water that is safe for drinking or cooking?	
2. Food Do you have a serious problem with food? For example, because you do not have enough food, or good enough food, or because you are not able to cook food.	

3. Place to live in Do you have a serious problem because you do not have a suitable place to live in?	
4. Toilets Do you have a serious problem because you do not have easy and safe access to a clean toilet?	
5. Keeping clean For men: Do you have a serious problem because in your situation it is difficult to keep clean? For example, because you do not have enough soap, water or a suitable place to wash. For women: Do you have a serious problem because in your situation it is difficult to keep clean? For example, because you do not have enough soap, sanitary materials, water or a suitable place to wash.	
6. Clothes, shoes, bedding or blankets Do you have a serious problem because you do not have enough, or good enough, clothes, shoes, bedding or blankets?	
7. Income or livelihood Do you have a serious problem because you do not have enough income, money or resources to live?	
8. Physical health Do you have a serious problem with your physical health? For example, because you have a physical illness, injury or disability.	

9. Health care For men: Do you have a serious problem because you are not able to get adequate health care for yourself? For example, treatment or medicines. For women: Do you have a serious problem because you are not able to get adequate health care for yourself? For example, treatment or medicines, or health care during pregnancy or childbirth.	
10. Distress Do you have a serious problem because you feel very distressed? For example, very upset, sad, worried, scared, or angry.	
11. Safety Do you have a serious problem because you or your family are not safe or protected where you live now? For example, because of conflict, violence or crime in your community, city or village.	
12. Education for your children Do you have a serious problem because your children are not in school, or are not getting a good enough education?	
13. Care for family members Do you have a serious problem because in your situation it is difficult to care for family members who live with you? For example, young children in your family, or family members who are elderly, physically or mentally ill, or disabled.	
14. Support from others	

Do you have a serious problem because you are not getting enough support from people in your community? For example, emotional support or practical help.	
15. Separation from family members Do you have a serious problem because you are separated from family members?	
16. Being displaced from home Do you have a serious problem because you have been displaced from your home country, city or village?	

17. Information For displaced people: Do you have a serious problem because you do not have enough information? For example, because you do not have enough information about the aid that is available; or because you do not have enough information about what is happening in your home country or home town. For non-displaced people: Do you have a serious problem because you do not have enough information? For example, because you do not have enough information about the aid that is available.	
18. The way aid is provided Do you have a serious problem because of inadequate aid? For example, because you do not have fair access to the aid that is available, or because aid agencies are working on their own without involvement from people in your community.	

19. Respect Do you have a serious problem because you do not feel respected or you feel humiliated? For example, because of the situation you are living in, or because of the way people treat you.	
20. Moving between places Do you have a serious problem because you are not able to move between places? For example, going to another village or town.	
21. Too much free time Do you have a serious problem because you have too much free time in the day?	

The last few questions refer to people in your community*, so please think about members of your community when answering these questions.

22. Law and justice in your community Is there a serious problem in your community because of an inadequate system for law and justice, or because people do not know enough about their legal rights?	
23. Safety or protection from violence for women in your community Is there a serious problem for women in your community because of physical or sexual violence towards them, either in the community or in their homes?	
24. Alcohol or drug use in your community	

Is there a serious problem in your community because people drink a lot of alcohol, or use harmful drugs?	
25. Mental illness in your community Is there a serious problem in your community because people have a mental illness?	
26. Care for people in your community who are on their own Is there a serious problem in your community because there is not enough care for people who are on their own? For example, care for unaccompanied children, widows or elderly people, or unaccompanied people who have a physical or mental illness, or disability.	

Priority ratings for serious problems:

Read out the titles of all questions you have rated as ‘1’, as well as any other serious problems listed above. Write down the person’s answers (write down the number and title of the questions). 1. Out of these problems, which one is the most serious problem?
2. Which one is the second most serious problem?
3. Which one is the third most serious problem?

Annex 7: The General Health Questionnaire (GHQ) 12

The next questions are about how you have been feeling over the last few weeks.

1 Have you recently been able to concentrate on whatever you're doing?

1. Better than usual

2. Same as usual

3. Less than usual

4. Much less than usual

2• Have you recently lost much sleep over worry?

1. Not at all

2. No more than usual

3. Rather more than usual

4. Much more than usual

3• Have you recently felt that you were playing a useful part in things?

1. More so than usual

2. Same as usual

3. Less so than usual

4. Much less than usual

4• Have you recently felt capable of making decisions about things?

1. More so than usual

2. Same as usual

3. Less so than usual

4. Much less capable

5• Have you recently felt constantly under strain?

1. Not at all

2. No more than usual

3. Rather more than usual

4. Much more than usual

6• Have you recently felt you couldn't overcome your difficulties?

1. Not at all

2. No more than usual

3. Rather more than usual

4. Much more than usual

7• Have you recently been able to enjoy your normal day-to-day activities?

1. More so than usual

2. Same as usual

3. Less so than usual

4. Much less than usual

8• Have you recently been able to face up to problems?

1. More so than usual

2. Same as usual

3. Less able than usual

4. Much less able

9• Have you recently been feeling unhappy or depressed?

1. Not at all

2. No more than usual

3. Rather more than usual

4. Much more than usual

10• Have you recently been losing confidence in yourself?

1. Not at all

2. No more than usual

3. Rather more than usual

4. Much more than usual

11• Have you recently been thinking of yourself as a worthless person?

1. Not at all

2. No more than usual

3. Rather more than usual

4. Much more than usual

12• Have you recently been feeling reasonably happy, all things considered?

1. More so than usual

2. About the same as usual

3. Less so than usual

4. Much less than usual

ANNEX 8: Oslo Social Support Scale (OSSS-3)

1.How many people are so close to you that you can count on them if you have great personal problems?
○ ‘none’ ○ ‘1–2’ ○ ‘3–5’ ○ ‘5+’
2.How much interest and concern do people show in what you do?
○ ‘none’ ○ ‘little’ ○ ‘uncertain’ ○ ‘some’ ○ a lot
3.How easy is it to get practical help from neighbors if you should need it?
○ very difficult’ ○ ‘difficult’

- ‘possible’
- ‘easy’
- ‘Very easy’

ANNEX 9: Brief COPE

This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events.

Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can. This information is confidential/belongs to you; you may share if you choose. There are no “right” or “wrong” answers! We’re looking for a general pattern, not a specific “score”

1_____2_____3_____4

Not at all Little bit medium amount Doing a lot

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

Using this scale, respond to the following:

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using addictive behaviors or substances to make myself feel better.
5. I've been getting emotional support from others.

6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I’ve been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I’ve been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading,

daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I’ve been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I’ve been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

ANNEX 10: Tigrigna version of all instruments

ልጋብ 1: ንተሳተፍቲ ናይ ሓበሬታ ቐጥዒ

ኣብዙይ ብዩኒቨርስቲ ኣዲስ ኣበባ፣ ሳይካትሪ ዲፓርትመንት ዝካየድ መፅናዕቲ ንምስታፍ ፍቃደኛ ስለዝኾንኩም ነመስግን። እዚ መፅናዕቲ ካብ ኩናት ኣክሱም ዝተረፉ ሰባት፤ ናብ ከቢድ በሰላ፣ ሳዕቤን ጥዕና ኣእምሮ፣ ስነ-ኣእምሮኣዊን ማሕበራዊን ሳዕቤናቱን ዝነበሮም ተቓላዕነት ንምድህሳስን ሜላታት ምፅዋርን ማሕበራዊ ደገፍን ንምፅናዕ ዝዓለመ እዩ። ኣካይዳ ኣብዚ መፅናዕቲ ክትሳተፉ እንተተስማዕሚዕኩም፣ ነዙይ ዳህሳስ ክትውድኡ፣ ኣብ ቃለ-መጠይቕት ክትሳተፉ፣ ከምኡ'ውን/ወይ ድማ ኣብ ጉጅለኣዊ ዘተ ክትሳተፉ ኢኹም። እዚ መሕተት ኣስታት ሓደ ሰዓት ክወስድ እዩ። ተሳትፎኹም ምሉእ ብምሉእ ወለንታዊ እዩ።

ከስዕቦ ዝኽእል ሓደጋታትን ፀገማትን:- ገሊኣም ሕቶታት ተኣፍፍቲ ክኾኑን ስምዒታዊ ጓሂ ከምፅኡ ይኽእሉ እዮም። ዝኾነ ክትምልስዎም ዘይትደልዩ ሕቶታት ክትዘሎም ወይ ብዘይ መቐፃዕቲ ኣብ ዝኹነ ይኹን እዋን እቲ መፅናዕቲ ክተቋርጹ ትኽእሉ ኢኹም።

ክህልዉ ዝኽእሉ ረብሓታት:- ተሳትፎኹም ነቶም ካብ ውግእ ዝተረፉ ሰባት ዘድልዮም ነገራት ንኽንርድኣምን ኣብ ማሕበረሰብኩም ንዝወሃብ ኣገልግሎት ጥዕና ኣእምሮ ንምምሕያሽን ክሕግዘና እዩ።

ምስጢራውነት:- መልስታትኩም ምስጢራዊ ክኸውን እዩ። ካብዚ መፅናዕቲ እዚ ካብ ዝተረኸበ ሓበሬታ ኣብ ዝወጽእ ዝኾነ ፀብፃብ ወይ ሕትመታት ስምኩም ወይ ካልእ መለለዩ ሓበሬታ ኣይንጥቀመሉን ኢና። ኩሉ ሓበሬታ ብውሑስ መንገዲ ክቕመጥ እዩ።

ወለንታዊ ተሳትፎ:- ኣብዚ መፅናዕቲ እዚ ዘለኩም ተሳትፎ ምሉእ ብምሉእ ብወለንታኹም እዩ። ካብቲ መፅናዕቲ ኣብ ዝኾነ እዋን ብዘይ ዝኾነ ሳዕቤን ክተቋርፁ ትኽእሉ ኢኹም።

እዚ መፅናዕቲ ብኮሚቴ ስነ-ምግባር ኣዲስ ኣበባ ዩኒቨርሲቲ ፣ ቤት ትምህርቲ ሕክምና፣ ክፍሊ ሕክምና ስነ-ኣእምሮን ተገምጊሙን ፀዲቑን እዩ። ተወሳኺ ሓበሬታ እንተደሊኹም ወይ ዝኾነ ጥርዓን እንተሃልይኩም በዚ ኣብ ታሕቲ ዘሎ ኣድራሻ ነታ ኮሚቴ ክትረኽብዋ ትኽእሉ ኢኹም። ብተወሳኺ በዚ ኣብ ታሕቲ ተዋሂቡ ዘሎ ኣድራሻ ንኣባላት ናይቲ መፅናዕታዊ ጉጅለ ክትረኽብዎም ትኽእሉ ኢኹም።

ዋና ተመራማሪ፡ ሃይለልኡል መኮነን ቲሊንቲ

ስልኪ ቑፅሪ፡ (+251)913861655

ኢ-መይል፡- mekonnenhaileleul@gmail.com

ኣድራሻ፡ ናይ ኣእምሮ ሕክምና ክፍሊ፣ ኣዲስ ኣበባ ዩኒቨርስቲ

ስልኪ- (+251)118962052

ቤት ፅሕፈት ኮሚቴ ስነ-ምግባር ኣዲስ ኣበባ ዩኒቨርስቲ

ስልኪ- (+251)115 538734

ልጋብ 2: ናይ ስምምዕነት ፍቓድ

ናይ ተሳታፋይ መግለፂ

ኣብ ላዕሊ ዝተዋህበ ሓበሬታ ኣንቢበዮ ኣለኹ (ወይ ድማ ተነቢቡለይ ኣሎ) ። ሕቶታት ክሓትት ዕድል ረኺበን ዘዕግብ መልሲ ረኺበን እየ። ተሳትፎይ ብወለንታይ ዝፍፀም ምኻኑን ዝኾነ ምኽንያት ከይሃብኩን ብዘይ ዝኾነ ኣሉታዊ ሳዕቤንን ኣብ ዝኾነ እዋን ክቋርፅ ከም ዝኽእል ተረዲኡኒ ኣሎ። መልስታተይ ምስጢራዊ ክኸውን ምኻኑ ተረዲኡኒ ኣሎ።

ኣብዚ መፅናዕቲ ክሳተፍ ተሰማሚዐ እየ።

ናይ ተሳታፊ

ፊርማ_____ዕለት_____

ልጋብ 3: ማሕበራውን ስነ-ህዝባውን ዝምልከቱ ሕቶታት

በይዛኹም ንነፍሲ ወከፍ ሕቶ ዝምልከተኩም ምድብ ብምምራፅ መልሱ

ሕቶታት	መልሲ
ዕድመ	
ፆታ	ተባዕታይ ኣንስታይ
ኩነታት ሓዳር	
ናይ ትምህርቲ ደረጃ	
ኩነታት ስራሕ	
ኩነታት መንበሪ ቦታ	ቀዋሚ ነባሪ ተመዛባሊ
ንውሓት ግዘ ኣብ ኣኽሱም ዝነበርኩምሉ	
ኩነታት መነባብሮ	ናይ ባዕለይ ገዛ ዘለኒ ክራይ ገዛ ግዜያዊ መዕቆቢ መዕቆቢ ተመዛበልቲ
መጠን ስድራቤት	
ሃይማኖት	
ወርሓዊ ኣታዊ	

ልጋብ 4 ፡ ናይ ሃርቫርድ ናይ ትራውማ መጠይቕ ናይ ካምቦድያ ዓይነት (HTQ cambodian version)

ሕዚ ድማ ብዛዕባ ሕሉፍ ኩነታት ጥዕናኹም ህሉው ምልክታትን ክሓተካ/ኪ እየ። እዚ ሓበሬታ እዚ ዝሓሸ ሕክምናዊ ክንክን ምእንታን ኽንህበኩም ንኽሕግዘና ዝውዕል እዩ።

1ይ ክፋል፡ ፍፃመታት ስቕያት

ካብዞም ዝስዕቡ ፍፃመታት ዝኾነ ኣጋጢሙኩም እንተነይሩ ኣመልክቱ (እወ ወይ ኣይፋል ኣብ ዝብል ምልክት ግበሩ)

		እወ	ኣይፋል
1.	ስእነት መፅለሊ		
2.	ስእነት ዝበላዕ ወይ ዝስተ		
3.	ሕማም ኣብ ሕክምናዊ ክንክን ክትረክብ ዘይትኽእለሉ		
4.	ውልቃዊ ንብረት ምምንዛዕ ወይ ምዕናው		
5.	ንናይ ውግእ ኩነታት ተቃላዕነት (ንኣብነት መጥቃዕቲ ቦምባታትን ደብዳብን)		
6.	ኣብ ትሕቲ ሓደገኛ ኩነታት ብግዴታ ካብ መንበሪ ምልቓቕ		
7.	ኣካላዊ መውቃዕቲ		
8.	ጾታዊ ዓመፅ (ምግሳስ)		
9.	ካልእ ዓይነት ፆታዊ ዓመፅ ወይ ሕስረት		

10.	መውቃቲ ብፋስ/ ብኻራ መውጋእቲ		
11.	ስቅያት ማለት እውን ኣብ ቐይዲ ከለኻ/ኺ ኮነ ተባሂሉን ኣገባብ ብዘለዎ ኣካላዊ ወይ ኣእምሮኣዊ ስቓይ እንተበጺሑካ/ኪ (እወ እንተኾይኑ ሓባሪ ረኣይ/ዪ)		
12.	ከቢድ ኣካላዊ መጉዳእቲ ካብ ኩነታት ውግእ ወይ ካብ ኣብ መሬት ዝቐበሩ ነዶግቲ		
13.	ማእሰርቲ		
14.	ብግዲ(ካብ ፍቓድ ወጻኢ) ሸቐሊ (ከም ከም እንስሳ ወይ ባርያ)		
15.	ምጭብርባር ወይ ስርቂ		
16.	ሕፅበተ-ኣእምሮ (ኢንዶክትሪኔት ምግባር)		
17.	ክትሕባእ ምግዳድ		
18.	ጭውያ		
19.	ካብ ኣባላት ስድራቤት ብግዴታ ምፍልላይ		
20.	ሬሳታት ከደልን ክቐብርን ተገዲደ		
21.	ካብ ካልኦት ብግዴታ ምንፃል		
22.	ዝኾነ ሰብ ጠሊሙ ኣብ ሓደጋ ሞት ወይ መጉዳእቲ ከእትወካ/ኪ ተገዲዱ		
23.	ሰብ ከይቀብር ተኸልኪለ		
24.	ናይ ዝሞቱ ሰባት ሬሳ ወይ መቓብር ንከራኽስ ወይ ንከፅኑ ተገዲደ		
25.	ኣብ ልዕሊ ዓርከይ ወይ ኣባል ስድራቤተይ ኣካላዊ ጉድኣት ከብፅሕ ተገዲደ		
26.	ካብ ዓርከይ ወይ ኣባል ስድራቤተይ ወጻኢ ዝኮነ ሰብ ኣካላዊ ጉድኣት ከብፅሕ ተገዲደ		
27.	ናይ ካልእ ሰብ ንብረት ከፅኑ ተገዲደ		
28.	ኣባል ስድራቤተይ ወይ ዓርከይ ክጠልም ተገዲደ ንሓደጋ ሞት ወይ መጉዳእቲ ኣሳጢሐ		
29.	ቤተሰብ ወይ ዓርከይ ዘይኮነ ሰብ ክጠልም ተገዲደ ንሓደጋ ሞት ወይ መጉዳእቲ ኣሳጢሐ		
30.	ብሰንኪ ጎንፂ ናይ በዓል/ቲ ገዛይ ቅትለት ወይ ሞት ኣጓኒፉኒ		
31.	ብሰንኪ ጎንፂ ናይ ውላድ ቅትለት ወይ ሞት ኣጓኒፉኒ		
32.	ብሰንኪ ጎንፂ ናይ ካልእ ኣባል ስድራቤት ወይ ዓርኪ ቅትለት ወይ ሞት ኣጓኒፉኒ		
33.	ናይ በዓል/ቲ ገዛይ ምጥፋእ ወይ መጭወይቲ		

34.	ናይ ውላደይ ምጥፋእ ወይ መጭወይቲ		
35.	ናይ ካልእ ኣባል ስድራቤት ወይ ዓርኪ ምጥፋእ ወይ መጭወይቲ		
36.	ብሰንኪ ናይ ውግእ ኩነታት ወይ ነተጉቲ ኣብ ኣባል ስድራቤት ወይ ዓርኪ ዘበፅሐ ከቢድ ኣካላዊ መጉዳእቲ		
37.	ኣብ ርእሲ ወይ ኣብ ካልእ ኣካል ዝበፅሐ መግረፍቲ ሪኦ		
38.	ናይ ካልኦት ስቅያት ሪኦ		
39.	ናይ ካልኦት ቐትለት ሪኦ		
40.	ዶታዊ ዓመፅ ኣብ ካልኦት ከበጽሕ ሪኦ		
41.	ካልእ ኣዝዩ ዘፍርሕ ወይ ህይወትካ/ኪ ኣብ ሓደጋ ዘእተወ ተጓንፎ ግለፅ:		

3ይ ክፋል፡ መጉዳእቲ ርእሲ

ነዞም ዝስዕቡ ናይ ሕማቕ ተሞኩሮ ፍፃመታት እወ ኢልኩም እንተመሊኩም፤ በይዛኹም ሕልናኹም እንተስሒትኩም ንክንደይ ግዜ ከምዝሰሓትኩምን ኣመልክቱ።

ፍፃመታት	ኣጋጢሙኒ		ሕልና ምስሓት		እወ እንተኾይኑ ንኽንደይ ግዜ?	
	እወ	ኣይፋል	እወ	ኣይፋል	ሰዓታት	ደቓይቕ
1. ናይ ርእሲ መውቃዕቲ						
2. ትንፋስ ምዕፋን						
3. ከም ምጥሓል ዝመስል ስምዒት						
4. ካልኦት ዓይነታት መጉዳእቲ ኣብ ርእሲ (ንኣብነት ቅሪት ናይ ከቢድ ብረት፣ ቓፀሎ ወዘተ)						
5. ጥምየት						
እወ እንተኾይኑ: ንቡር ክብደት:			ናይ ጥሜት እዋን ክብደት:			
እወ እንተኾይኑ: ብሰንኪ ጥምየት ንሞት ተቓሪብካ/ኺ ዲኻ/ኺ?			እወ:	ኣይፋል:		

4ይ ክፋል፡ ምልክታት ስቕያት (በስላ) DSM-V

እዞም ዝስዕቡ ምልክታት ሰባት ኣብ ህይወቶም ጎዳኢ ወይ ዘስካሕክሕ ፍፃመታት ምስ ኣጋጠሞም ሓደ ሓደ ግዜ ዘጋጥሙ እዮም። በይዛኹም ነፍሲ ወከፎም ብጥንቃቐ ኣንብቡዎም እሞ ኣብ ዝሓለፈ ሰሙን እዞም ምልክታት ክሳብ ክንደይ ከም ዘፀገምኩም ግለፁ።

		(1) ብፍፁም	(2) ብውሑዱ	(3) ቀቁሩብ	(4) ብዝተጋነነ መልከዑ
1.	ተደጋጋሚ ሓሳባት ወይ ዝኽሪ ናይቲ ኣዝዩ ዝነድእ ወይ ዘስካሕክሕ ፍፃመታት				
2.	እቲ ፍፃመ ዳግማይ ዝፍፀም ዘሎ ኮይኑ ይስምዓካ/ኪ				
3.	ተደጋጋሚ ዘደንግፅ ሕልሚ				
4.	ካብ ሰባት ዝተነፀልካ ወይ ዝተረሓሓቕካ ኮይኑ ምስማዕ				
5.	ስምዒታት ክስመዓካ ዘይምኽኣል				
6.	ብቐሊሉ ናይ ምስንባድ ስምዒት				
7.	ትኹረት ንምግባር ምፅጋም				
8.	ናይ ድቃስ ፀገም				
9.	ኩሉ ሻዕ ንቐሕ ኾይንካ ናይ ምሕላይ ስምዒት				
10.	ናይ ቁጥዐ ወይ ሕርቃን ስምዒት				
11.	ነቲ ዘሕዝን ወይ ዝነድእ ፍጻመ ዘዘኻኽሩኻ/ኺ ንጥፈታት ምውጋድ				
12.	ንዝኾነ ክፋል ናይቲ ኣዝዩ ዝነድእ ወይ ዘሕዝን ፍፃመታት ክትዝክር ዘይምኽኣል				
13.	ኣብ መዓልታዊ ንጥፈታት ውሑድ ተገዳስነት ምርኣይ				
14.	መፃኢ ሂወት ከም ዘይብልካ/ኪ ኮይኑ ይስምዓካ				
15.	ምስቲ ዘሕዝን ወይ ዝነድእ ፍፃመታት ዝተኣሳሰሩ ሓሳባት ወይ ስምዒታት ምውጋድ				
16.	ነቲ ኣዝዩ ዝነድእ ወይ ዘሕዝን ፍጻመታት ምስዘከርካ/ኪ ሃንደበታዊ ስምዒታዊ ወይ ኣካላዊ ግብረ መልሲ ምርኣይ				
17.	ዓለም ኣዝያ ሓደገኛ ቦታ ኾይና ይስምዓካ/ኪ				
18.	ሕማቕ ሰብ እየ ዝብል ስምዒት				
19.	በቲ ዘሕዝን ፍፃመ ንነብስኻ/ኺ ምውቃስ				
20.	እቲ ዘሕዝን ፍፃመ ክትሓስብ/ቢ ከለኻ/ኺ ሓያል ፍርሒ፡ ራዕዲ፡ ሕርቃን፡ ናይ በደል ወይ ሕፍረት ስምዒት ምስማዕ				
21.	ፍቕሪ ወይ ሓጎስ ክስመዓካ/ኪ ምፅጋም				

22.	ንኑብስኻ/ኺ ወይ ንኻልኦት ክንድእ ዝኽእል ነገር ምግባር				
23.	ከም ሰብ በቲ ዘሕዝን ፍፃመ ዝተንዳእኻ/ኺ ኮይኑ ይስመዓካ/ኪ				
24.	ዝኾነ ነገር ነቲ ዘሕዝን ፍፃመ ዘዘኻኽረካ ኮይኑ ይስምዓካ ግን ከዓ ሕልሚ ይመስል፣ ከምዘየጋጥመካ ከምኡ'ውን/ወይ ድማ ናይ ብሓቂ ከም ዘይኮነ				
25.	ንኣብ ጥቓኻ/ኺ ዝርከቡ ሰባት ወይ ነገራት ዝስምዓካ ስምዒት ናይ ብሓቂ ከምዘይኮኑ ወይ ጋሻ ስምዒት				

5ይ ክፋል፡ ታሪኽ ስቅያት

ኽዚ ድማ ብዛዕባ ብዙሓት ሰባት ከም ስቅያት ዝኾፅርዎም ፍፃመታት ክንሓተኩም ኢና። እቲ ፍፃመ ኣጋጢሙ ድዩ ኣየጋጠመን እወ ወይ ኣይፋል ብምባል መልሲ ሃቡ።

ፍፃመ	እወ	ኣይፋል
1. ማህረምቲ ወይ መውቃዕቲ ብኣቕሑ		
2. ምፍርራሕ ወይ ውርደት		
3. ብሰንሰለት ወይ ምስ ካልኦት ሰባት ተጠሚርካ ምእሳር		
4. ንሙቐት፡ ንፀሓይ፡ ንብርቱዕ ብርሃን ምቅላዕ		
5. ንዝናብ ፣ ምጥሓል ኣካል፣ ንቐሪ ምቅላዕ		
6. ኣብ ውሽጢ ኽረጢት፣ ሳንዱቕ ወይ ኣብ ኣዝዩ ንእሽተይ ቦታ ምቕማጥ(ምእታው)		
7. ምጥናይ፡ ትሕቲ ርእሲ ኣብ ማይ ምጥሓል		
8. ምዕፋን ትንፋስ		
9. ልዕሊ ዓቕን ፃዕሪ፡ ከቢድ ናይ ጉልበት ስራሕ		
10. ንረኽሲ ወይ ንኻልእ ሕማማት ዝምቹ ፅሬት ዘይብሉ ቦታ ምቅላዕ		
11. ዓይኒ ምሸፋን		
12. ተነፅሎ፡ ንበይንኻ ምዕፃው። እወ እንተኾይኑ ክሳብ መዓዝ? If yes		
13. ናይ ምዕሻው ፈተነ ቕትለት		
14. ካልኦት ክሳቐዩ ከለዉ ክትምስከር ምግባር		
15. ጥሜት		

16. ድቃስ ምስአን/ምኽላእ		
17. ኣብ ብረት ብ ኢድ ወይ እግሪ ምንጥልጣል		
18. ዕታዊ መድፈርቲ ፡ ምቑራፅ ኣካላት ዕታዊ ርክብ		
19. ምቅፃል		
20. መውቓዕቲ ኽብዲ እግሪ ብብረት		
21. መውቃዕቲ ኣእዛን		
22. ብግዴታ ደው ምባል (ንብዙሕ ጊዜ)		
23. ሽንቲ ወይ ሰገራ ናብ ተጠቃሚ ምድርባይ ወይ ናብ ካልኦት እሱራት ክትድርብይ ምግዳድ		
24. ንሕክምናዊ ምኽንያት ዘይኮነ መድሓኒት ክትወስድ ምግዳድ		
25. መርፍእ ኣብ ትሕቲ ኣፃብዕቲ እግሪ ወይ ፅፍሪ ኣፃብዕቲ		
26. ኑዛዜ ብዙሕ ግዜ ምፅሓፍ		
27. ብተደጋጋሚ ብኤሌክትሪክ መሳርሒ ምስቓይ		
28. ካልእ (ግለፅ)		

6ይ ክፋል፡ ብባህሊ ዝፍለጡ ምልክታት ስቅያት

ኣካላዊ፣ ኣእምሮኣዊ፣ ስምዒታዊ፣ ማሕበራውን መንፈሳውን/ህልውናዊ ክእለታት መለክዒ (ንተመዛበልቲ/ ባህሊ መሰረት ዝገበረ ኣሰራርሓ) (SPIESS: Refugee-/culture-Specific Functioning)

እዞም ዝስዕቡ ምልክታት ሰባት ኣብ ህይወቶም ጎዳኢ ወይ ዘስካሕክሕ ፍፃመታት ምስ ኣጋጠሞም ሓደ ሓደ ግዜ ዘጋጥሙ እዮም። በይዛኹም ነፍሲ ወከፎም ብጥንቃቐ ኣንብብዎም እሞ ኣብ ዝሓለፉ ሰሙን እዞም ምልክታት ክሳብ ክንደይ ከም ዘፀግሙኹም ግለፁ።

		(1) ብፍፁም	(2) ብውሑዱ	(3) ቀቁሩብ	(4) ብዝተጋነነ መልክዑ
ክእለትን ተውህቦን					
1.	እቲ ቅድሚ ሕማቐ ተጓንፎ ዝነበረካ/ኪ ክእለት ድሕሪ ሕዚ ጠቓሚ ወይ ዋጋ ከምዘይብሉ ኾይኑ ይስምዓካ/ኪ				
2.	ካብቲ ቅድሚ ሕዚ ዝነበረካ/ኪ ንህይወት እትፃወረሉ/ርሉ ክእለት ከም ዝወሓደ ይስምዓካ/ኪ				
3.	ምስ ሓደሸቲ ኩነታት ክትጠዓዓም ምፅጋም				
4.	ስራሕኻ/ኺ ሕማቐ ተዘክሮታት የምፅእ				
5.	መሳርሕትኻ/ኺ ኣብ ጎንኻ/ኺ ምህላዎም ይርብሸካ/ኪ				
ኣካላዊ ጉድኣት					

6.	ናይ ድኻም ስምዒት				
7.	ኣብ ኣካላትካ/ኪ ቃንዛ ምህላው				
8.	ብዙሕ ጊዜ ናይ ሕማም ስምዒት ምህላው				
9.	ስራሕ ወይ ናይ ዕዮ ገዛ ክትሰርሕ ክትብል ናይ ሕማም ስምዒት ምህላው				
10.	ናይ ኣካላትካ/ኪ ዓቕሚ ከም ዝወረደ ይስምዓካ/ኪ				
ኣእምሮኣዊ ዓቕምታት					
11.	ድኹም ናይ ምዝካር ኽእለት				
12.	ብስራሕ ዝተጨናነቕ ስምዒት				
13.	ብባዕልኻ/ኺ ወይ ካልኦት ሰባት ክትገብሮ ትዝ ዘይብለካ/ኪ ነገራት ምዝካር				
14.	ኣቓልቦ ንምሃብ ምፅጋም				
15.	መዓልታዊ መደባት ክትገብር ዘይትኽእል ዓይነት ስምዒት				

		(1) ብፍፁም	(2) ብውሑዱ	(3) ቀቂሩብ	(4) ብዝተጋነነ መልክዑ
ስምዒታዊ ተግባራት					
16.	ኣብ ክልተ ተመቒልካ እቲ ሓደ ኣካልካ ካባኻ እንታይ ይገብር ከምዘሎ ዝዕዘብ ኮይኑ ይስምዓካ				
17.	ብዘጋጠሙ ነገራት ንነብስኻ ምውቃስ				
18.	ብህይወት ብምትራፍካ ናይ ገበነኛ ስምዒት ምህላው				
19.	ተስፋ ምቑራፅ				
20.	ብዘጋጠሙኻ/ኺ ጉዳእቲ ወይ መስካሕካሕቲ ፍፃመታት ምሕፋር				
ማሕበራዊ ርክብ					
21.	ሰባት እንታይ ከም ዘጋጠመካ ከም ዘይተረድኡም ኮይኑ ይስምዓካ				
22.	ካልኦት ኣብ ልዕሌኻ ሕማቕ ዝገብሩ ኮይኖም ይስምዓካ				
23.	መፀግዒ ዝኾነካ ሰብ ከም ዘይብልካ ኮይኑ ይስምዓካ				
24.	ብተመኩሮኻ ዝተዋረድካ ኮይኑ ይስምዓካ				
25.	ኣብ ካልኦት እምነት ዘይምህላይ ስምዒት				

መንፈሳዊ / ህላውናዊ ስክፍታታት					
26.	ንኻልኦት ንምሕጋዝ ዓቕሚ ዘይብልካ ኮይኑ ይስምዓካ				
27.	እዚ ፍፃመታት ንምንታይ ከም ዘጋጠመካ ክትሓስብ ግዜ ምሕላፍ				
28.	በዚ ፍጻመታት እዚ ንስኻ ጥራይ ከም ዝተሳቐኻ ኮይኑ ይስምዓካ				
29.	ትኣምኖ ሰብ ከም ዝጠለመካ ኮይኑ ይስምዓካ				
30.	ሕነ ፍደይ ዝብል ስምዒት ይስምዓካ				

ልጋብ 5፡ መደብ ገምጋም ውድብ ጥዕና ዓለም ናይ ሕቡራት መንግስታት ላዕለዋይ ናይ ስደተኛታት ኮምሽን (ሕመላኾስ) ከበድቲ ምልክታት ኣብ ኹነታት ሰብኣዊ ቕልውላው

ክፋል ሀ: ሕቶታት ንመላሲን ብዛዕባ መልሲ ዝህብ ሰብን። ብዛዕባ እቲ ሰብ ዝምልከት ኣገዳሲ ሓበሬታ (ንኣብነት ዖታ፡ ዕድመን ካልእን) ኣቐዲሙ ኣብቲ ቃለ መሕትት ከም ዝተመስረተ ይግመት

1ሀ. እዘን ዝቐፅላ ሕቶታት ኣብዘን ዝሓለፋ ክልተ ሰሙናት ከመይ ይስምዐኩም ከም ዝነበረ ዝገልፃ እየን። ኣብዘን ዝሓለፋ ክልተ ሰሙናት ክንደይ ግዜ እዩ ዝኾነ ነገር ክሃድእ ዘይኽእል ዓይነት ፍርሒ ተሰሚዑካ/ኪ - ኩሉ ጊዜ፡ መብዛሕትኡ ጊዜ፡ ሓደሓደ ጊዜ ፡ ቁሩብ ጊዜ፡ ወይስ ብፍፁም ምበልካ/ኪ?

1. 2.	ኩሉ ጊዜ መብዛሕትኡ ጊዜ
3. ሐ 4. ሐ 5. ሐ	ሓደሓደ ጊዜ ቁሩብ ጊዜ ብፍፁም
8. ሐ 9. ሐ	(ብፍቓድ እንተኾይኑ)) ኣይፈልጥን (ብፍቓድ እንተኾይኑ) ክምልስ ኣይደልን

ሀ2. ኣብዘን ዝሓለፋ ክልተ ሰሙናት ክንደይ ጊዜ ሓያል ሕርቃን ተሰሚዑካ/ኪ ክሳብ ካብ ቁፅፅር ወጻኢ ዝኾንካ/ኪ ኮይኑ ዝስመዓካ/ኪ - ኩሉ ጊዜ፡ መብዛሕትኡ ጊዜ፡ ሓደሓደ ጊዜ ፡ ቁሩብ ጊዜ፡ ወይስ ብፍፁም ምበልካ?

1. ሐ 2. ሐ	ኩሉ ጊዜ መብዛሕትኡ ጊዜ
3. ሐ 4. ሐ 5. ሐ	ሓደሓደ ጊዜ ቁሩብ ጊዜ ብፍፁም
8. ሐ 9. ሐ	(ብፍቓድ እንተኾይኑ) ኣይፈልጥን (ብፍቓድ እንተኾይኑ) ክምልስ ኣይደልን

ሀ3. ኣብዘን ዝሓለፋ ክልተ ሰሙናት፡ ንክንደይ ጊዜ ዝኣክል ኣብ ትፈትዮም/ይዮም ነገራት ኣዝዩ ዘይተገዳስነት ተሰሚዑካ/ኪ፡ ምንም ነገር ክትገብር/ሪ ዘይትደሊ/ዩ ዓይነት ስምዒት? (ኣድላዩ እንተኾይኑ ሐ: ኩሉ ጊዜ፡ መብዛሕትኡ ጊዜ፡ ሓደሓደ ጊዜ ፡ ቁሩብ ጊዜ፡ ወይስ ብፍፁም ምበልካ/ኪ?)

1. ሐ 2. ሐ	ኩሉ ጊዜ መብዛሕትኡ ጊዜ

3. ሐ 4. ሐ 5. ሐ	ሓደሓደ ጊዜ ቁሩብ ጊዜ ብፍፁም
8. ሐ 9. ሐ	(ብፍቓድ እንተኾይኑ) ኣይፈልጥን (ብፍቓድ እንተኾይኑ) ክምልስ ኣይደልን

ሀ4. ኣብዘን ዝሓለፉ ክልተ ሰሙናት፡ ክንደይ ግዜ ተስፋ ናይ ሙቐራፅ ስምዒት ክሳብ ምንባር ዘፅለኣካ/ኪ ተሰሚዑካ/ኪ? (ኣድላዩ እንተኾይኑ ሐ: ኩሉ ጊዜ፡ መብዛሕትኡ ጊዜ፡ ሓደሓደ ጊዜ ፡ ቁሩብ ጊዜ፡ ወይስ ብፍፁም ምበልካ/ኪ?)

1. ሐ 2. ሐ	ኩሉ ጊዜ መብዛሕትኡ ጊዜ
3. ሐ 4. ሐ 5. ሐ	ሓደሓደ ጊዜ ቁሩብ ጊዜ ብፍፁም
8. ሐ 9. ሐ	(ብፍቓድ እንተኾይኑ) ኣይፈልጥን (ብፍቓድ እንተኾይኑ) ክምልስ ኣይደልን

ሀ5. ሓደ ወይ ልዕሊኡ ብጣዕሚ ዘሕርቕካ/ኪ ፍፃመታት ኣብ ቀረባ እዋን ዘጋጠመ ሓደጋ/መዓት/ኩናት ኣጋጢሙካ/ኪ ክኸውን ይኽእል እዩ። ኣብዘን ዝሓለፉ ክልተ ሰሙናት ክንደይ ጊዜ ብዛዕባ በቲ ኣብ ህይወትካ/ኪ ዘጋጠመ ሓደጋ/መዓት/ኩናት ወይ ካልእ ፍጻመ ኣዚኻ/ኺ ተረቢሽካ/ኪ ካብ ከምዚ ዓይነት ፍፃመ ዘዘኻኽሩኻ/ኺ ቦታታት፡ ሰባት፡ ወግዕታት ወይ ንጥፈታት ክትርሕቕ/ቒ ሞኪርካ/ኪ? (ኣድላዩ እንተኾይኑ ሐ: ኩሉ ጊዜ፡ መብዛሕትኡ ጊዜ፡ ሓደሓደ ጊዜ ፡ ቁሩብ ጊዜ፡ ወይስ ብፍፁም ምበልካ?)

1. ሐ 2. ሐ	ኩሉ ጊዜ መብዛሕትኡ ጊዜ
3. ሐ 4. ሐ 5. ሐ	ሓደሓደ ጊዜ ቁሩብ ጊዜ ብፍፁም
8. ሐ 9. ሐ	(ብፍቓድ እንተኾይኑ) ኣይፈልጥን (ብፍቓድ እንተኾይኑ) ክምልስ ኣይደልን

ሀ6. እቲ ዝቐፅል ሕቶ እዚ ስምዒታት ፍርሒ፡ ሕርቃን፡ ድኻም፡ ዘይምግዳስ፡ ተስፋ ምቑራፅ ወይ ንዴት ኣብዘን ዝሓለፉ ክልተ ሰሙናት ብኽመይ ፀልዩካ/ኪ ክኸውን ይኽእል ዝብል እዩ። ኣብዘን ዝሓለፉ ክልተ ሰሙናት፡ ብሰንኪ እዚ ስምዒታት እዚ፡ ክንደይ ግዜ ንመዓልታዊ ናብራ ኣገደስቲ ንጥፈታት ክትፍፅም ዘይከኣልካ/ኪ? (ኣድላዩ እንተኾይኑ ሐ: ኩሉ ጊዜ፡ መብዛሕትኡ ጊዜ፡ ሓደሓደ ጊዜ ፡ ቁሩብ ጊዜ፡ ወይስ ብፍፁም ምበልካ/ኪ?)

1. ሐ 2. ሐ	ኩሉ ጊዜ መብዛሕትኡ ጊዜ
3. ሐ 4. ሐ 5. ሐ	ሓደሓደ ጊዜ ቁሩብ ጊዜ ብፍፁም
8. ሐ 9. ሐ	(ብፍቓድ እንተኾይኑ) ኣይፈልጥን (ብፍቓድ እንተኾይኑ) ክምልስ ኣይደልን

ልጋብ 6፡ ናይ ሰብኣዊ ህፁፅ ኹነታት ምድላዋት ተሓሳቢ ዝገበረ ድሌታት መለክዒ (HESPER)

ዕለት:	ስም ሓታቲ:	ናይ ተሳታፋይ መለለዪ ቑፅሪ:
ቦታ (ናይ ከተማ ስም ፣ ገጠር ወይ መዕቐቢ):	ዖታ:	ዕድመ:

ደረጃ ኣወሃህባ: 0 = ከቢድ ፀገም የለን 1 = ከቢድ ፀገም ኣሎ 9 = ኣይፈልጥን / ኣይምልከተንን / መልሲ ምሃብ ኣብዩ/ያ	ደረጃ

ኣብዚ ኽዚ እዋን ኣጋጢሞምኻ/ኺ ከኾኑ ዝኽእሉ ከበድቲ ፀገማት ክሓተካ/ኪ እየ። እንታይ ከም ትሓስብ/ቢ ክፈልጥ ይደሊ ኣለኹ። ከቢድ ፀገም ዝበሃል ንስኻ/ኺ ከቢድ ኢልካ/ኺ ትቐፅሮ ፀገም እዩ። ቅኑዕን ጌጋን ዝበሃል መልሲ የለን። መጀመርታ ብዛዕባ ናይ ባዕልኻ/ኺ ኽቢድ ፀገማት ክሓተካ/ኪ እየ።

1. ዝስተ ማይ ዝስተ ወይ ንመብሰሊ ምግቢ ፅሩይ ዝኾነ እኹል ማይ ስለዘይብልካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	
2. ምግቢ ምስ ምግቢ ተኣሳሲሩ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት እኹል ምግቢ ስለዘይብልካ፣ ወይ ፅቡቕ መግቢ ስለዘይብልካ፣ ወይ ምግቢ ክትሰርሕ ስለዘይትኽእል።	
3. ክትነብረሉ ትኽእል ቦታ ክትነብረሉ ትኽእል ምቹው ቦታ ስለ ዘይብልካ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	
4. ሽቓቕ ፅሩይ ሽቓቕ ብቐሊሉን ብውሑስን መንገዲ ስለዘይትረክብ/ቢ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	
5. ፅሬት ምሕላው ንደቂ ተባዕትዮ፡- ፅሬትካ ንምሕላው ኣፀጋሚ ስለዝኾነካ ከቢድ ፀገም ኣለካ ድዩ? ንኣብነት እኹል ሳሙና፣ ማይ ወይ ክትሕፀበሉ ትኽእል ምቹው ቦታ ስለዘይብልካ። ንደቂ ኣንስትዮ፡- ፅሬትኪ ንምሕላው ኣፀጋሚ ስለዝኾነኪ ከቢድ ፀገም ኣለኪ ድዩ? ንኣብነት እኹል ሳሙና፣ ንንፅህና ዝኸውን ኣቕሓ፣ ማይ ወይ ክትሕፀበሉ ትኽእሊ ምቹው ቦታ ስለዘይብልካ.	
6. ክዳውንቲ፣ ጫማ፣ ዓራት ወይ ኮቦርታ እኹል ወይ ፅቡቕ ክዳን፣ ጫማ፣ ዓራት ወይ ኮቦርታ ስለዘይብልካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	
7. ኣታዊ ወይ ኩነታት መነባብሮ ንምንባር እኹል ኣታዊ፣ ገንዘብ ወይ ዓቕሚ ስለዘይብልካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	
8. ኣካላዊ ጥዕና ኣብ ኣካላዊ ጥዕናኻ/ኺ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት ኣካላዊ ሕማም፣ መጉዳእቲ ወይ ስንክልና እንተሃልዩካ/ኪ	
9. ኽንክን ጥዕና ንደቂ ተባዕትዮ: ንነብስኻ እኹል ኽንክን ጥዕና ክትረክብ ስለዘይትኽእል ከቢድ ፀገም ኣለካ ድዩ? ንኣብነት ሕክምና ወይ መድሓኒት ዘይምርካብ። ንደቂ ኣንስትዮ: ንነብስኺ እኹል ኽንክን ጥዕና ክትረክቢ ስለዘይትኽእሊ ከቢድ ፀገም ኣለኪ ድዩ? ንኣብነት ሕክምና ወይ መድሓኒት ዘይምርካብ ወይ ኽንክን ጥዕና ኣብ እዋን ጥንሲ ወይ ሕርሲ ዘይምርካብ ።	
10. ጭንቀት ኽቢድ ጭንቀት ስለ ዝስምዓካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት ኣዚኻ/ኺ ተረቢሸካ/ኪ፣ ሓዚንካ/ኪ፣ ተጨኒቕካ/ኪ፡ ፈሪሕኻ/ኺ ወይ ሓሪቕካ/ኪ።	
11. ድሕንነት	

ንስኻ/ኺ ወይ ስድራኻ/ኺ ኣብዚ ኽዚ ትነብረሉ/ርሉ ቦታ ውሑስ ዘይምኽን ወይ ሓለዋ ስለዘይብልካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት ኣብ ሕብረተሰብካ/ኪ፣ ከተማኻ/ኺ ወይ መንደርካ/ኪ ብዝተፈጥረ ጎንፂ፡ ዓመጽ ወይ ገበን።	
12. ትምህርቲ ንደቅኻ/ኺ ደቅኻ ትምህርቲ ስለዘይኣተዩ ወይ እኹልን ፅቡቕን ትምህርቲ ስለዘይረኽቡ ከቢድ ፀገም ኣለካ ድዩ?	
13. ንኣባላት ስድራቤት ምሕብሓብ ኣብዚ ኽዚ ሰዓት ምሳኻ/ኺ ንዝነብሩ ኣባላት ስድራ ክትከናኸን/ኒ ኣፀጋሚ ስለዝኾነካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት ኣብ ስድራ ቤትካ/ኪ ዘለዉ ህጻናት ወይ ኣረጋውያን፣ ኣካላዊ ወይ ኣእምሮኣዊ ሕማም ዘለዎም ወይ ጉዱኣት ኣካል ዝኾኑ ኣባላት ስድራቤትካ/ኪ።	
14. ካብ ካልኦት ዝመፅእ ሓገዝ ኣብ ማሕበረሰብካ ካብ ዘለዉ ሰባት እኹል ደገፍ ስለዘይትረክብ ከቢድ ፀገም ኣለካ ድዩ? ንኣብነት ስምዒታዊ ሓገዝ ወይ ተግባራዊ ሓገዝ.	
15. ካብ ኣባላት ስድራቤት ምፍልላይ ካብ ኣባላት ስድራኻ/ኺ ስለ ዝተፈላለኻ/ኺ ከቢድ ጸገም ኣለካ/ኪ ድዩ?	
16. ካብ ገዛኻ/ኺ ምምዝባል ካብ ዓድኻ/ኺ፣ ከተማኻ/ኺ ወይ መንደርኻ/ኺ ስለ ዝተመዛበልካ/ኺ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	
17. ሓበሬታ ንተመዛበልቲ: እኹል ሓበሬታ ስለዘይብልካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት ብዛዕባ እቲ ዘሎ ሓገዝ እኹል ሓበሬታ ስለዘይብልካ/ኪ፣ ወይ ድማ ኣብ ትውልዲ ዓድኻ (ገጠር/ኹተማ) እንታይ ይፍፀም ከምዘሎ እኹል ሓበሬታ ስለዘይብልካ/ኪ። ንዘይተመዛበሉ ሰባት: እኹል ሓበሬታ ስለዘይብልካ/ኪ ከቢድ ፀገም ኣለካ ድዩ? ንኣብነት ብዛዕባ እቲ ዘሎ ሓገዝ እኹል ሓበሬታ ስለዘይብልካ/ኪ።	
18. ሓገዝ ዝወሃበሉ ኣግባብ ብሰንኪ ዘይእኹል ሓገዝ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት፡ ነቲ ዘሎ ሓገዝ ፍትሓዊ ተበፃሕነት ስለዘየለ፣ ወይ ድማ ትካላት ረድኤት ካብ ማሕበረሰብካ ዘለዉ ሰባት ከየሳተፉ ባዕለን ይሰርሓ ስለዘለዋ?	
19. ኣኽብሮት ብሰባት ከም ዝተኸበርካ/ኪ ስለ ዘይስመዓካ/ኪ ወይ ውርደት ስለ ዝስመዓካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት፡ ብሰንኪ እቲ እትነብረሉ ዘለኻ ኩነታት፣ ወይ ብሰንኪ እቲ ሰባት ንዓኻ ዝሪኡሉ መንገዲ?	
20. ካብ ቦታ ናብ ቦታ ምንቅስቓስ ካብ ቦታ ናብ ቦታ ክትንቀሳቐስ/ሲ ስለዘይትኽእል/ሊ ከቢድ ፀገም ኣለካ/ኪ ድዩ? ንኣብነት ናብ ካልእ ዓዲ ወይ ከተማ ምኻድ?	
21. ብዙሕ ነፃ ዝኾነ ጊዜ ኣብ መዓልቲ ብዙሕ ነፃ ዝኾነ ጊዜ ስለ ዝበዝሐካ/ኪ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	

እዘን ናይ መወዳእታ ሕቶታት ንኣብ ማሕበረሰብካ/ኪ ዝርከቡ ሰባት እየን ዘመልክታ። ስለዚ ነዞም ሕቶታት ክትምልስ/ሲ ከለኻ/ኺ ብዛዕባ ኣባላት ማሕበረሰብካ ሕሰብ/ቢ።

22. ሕግን ፍትሕን ኣብ ሕብረተሰብካ/ኪ ኣብ ሕብረተሰብካ/ኪ ብሰንኪ ዘይእኹል ስርዓት ሕግን ፍትሕን፣ ወይስ ሰባት ብዛዕባ ሕጋዊ መሰላቶም እኹል ፍልጠት ስለዘይብሎም ከቢድ ፀገም ኣሎ ድዩ?	
23. ድሕንነት ወይ ምክልኻል ካብ ዓመጽ ንደቂ ኣንስትዮ ኣብ ማሕበረሰብካ/ኪ ኣብ ማሕበረሰብካ/ኪ ኣብ ልዕሊ ደቂ ኣንስትዮ ዘነፃፀረ ኣካላዊ ወይ ፆታዊ ዓመፅ ምኽንያት ኣብ ማሕበረሰብ ይኹን ኣብ ገዝአን፣ ከቢድ ፀገም ኣለካ/ኪ ድዩ?	
24. ኣልኮላዊ መስተ ወይ ሓሸሽ ኣጠቓቕማ ኣብ ማሕበረሰብካ/ኪ	

ሰባት ብዙሕ ኣልኮላዊ መስተ ስለ ዝሰትዩ ወይ ጎዳኢ ዕፀፋርስ ስለ ዝጥቀሙ ኣብ ማሕበረሰብካ/ኪ ከቢድ ፀገም ኣሎ ድዩ?	
25. ሕማም ኣእምሮ ኣብ ማሕበረሰብካ/ኪ ሰባት ናይ ኣእምሮ ሕማም ስለዘለዎም ኣብ ሕብረተሰብካ/ኪ ከቢድ ፀገም ኣሎ ድዩ?	
26. ኣብ ሕብረተሰብካ/ኪ ንበይኖም ንዝነብሩ ሰባት ሓልዮት። ኣብ ሕብረተሰብካ/ኪ ንበይኖም ንዝነብሩ ሰባት እኹል ኽንክን ስለዘይብሎም ከቢድ ፀገም ኣሎ ድዩ? ንኣብነት፡ ሓብሓቢ ዘይብሎም ህፃናት፣ መበለታት ወይ ኣረጋውያን፣ ወይ ሓብሓቢ ዘይብሎም ኣካላዊ ወይ ኣእምሮኣዊ ሕማም ወይ ስንክልና ዘለዎም ሰባት ምሕብሓብ	

ካልኦት ከበድቲ ፀገማት

ካልእ ክሳብ ሕዚ ዘይሓተትኩኻ/ኺ ከቢድ ፀገም ኣለካ/ኪ ድዩ? መልሲ ናይቲ ሰብ ፅሓፉ። 27.

ንኸቢድ ፀገማት ቀዳምነት ዝወሃቦ ደረጃታት:

ኣርእስቲ ናይ ኩሎም ‘1’ ኢልካ ዝሃብካዮም ሕቶታት፣ ከምኡ’ውን ካልእ ኣብ ላዕሊ ዝተዘርዘረ ከቢድ ፀገማት ኣንብብ/ቢ። መልሲ ናይቲ ሰብ ፀሓፍ (ቁፅርን ኣርእስትን ናይቶም ሕቶታት ፅሓፍ/ፊ) 28. ካብዞም ፀገማት እዚኣም ኣየናይ እዩ እቲ ዝኸበደ ፀገም?
29. እቲ ኻልኣይ ዝኸበደ ፀገም ኣየናይ እዩ?
30. እቲ ሳልሳይ ዝኸበደ ፀገም ኣየናይ እዩ?

ልጋብ 7፡ ሓፈሻዊ መሕተት ጥዕና (GHQ) 12

እዘን ዝቐፅላ ሕቶታት ኣብ ዝሓለፈ ሒደት ሰሙናት ከመይ ይስምዓካ/ኪ ከምዝነበረ ዝምልከታ እየን

1• ኣብዚ ቀረባ እዋን ኣብ ዝኾነ ትገብሮ/ርዮ ነገር ክተትኩር/ሪ ትኽእል/ሊ ኔርካ/ኪ ዲኻ/ኺ?

1. ካብቲ ልሙድ ዝሓሸ
2. ከምቲ ልሙድ
3. ካብቲ ልሙድ ንታሕቲ
4. ካብቲ ልሙድ ኣዝዩ ዝወሓደ

2• ኣብዚ ቀረባ እዋን ብሰንኪ ጭንቀት ብዙሕ ድቃስ ስኢንካ/ኪ ዲኻ/ኺ?

1. ብፍፁም
2. ካብቲ ልሙድ ዘይበዝሕ
3. ካብቲ ልሙድ ንላዕሊ
4. ካብቲ ልሙድ ኣዝዩ ዝበዝሕ

3• ኣብዚ ቀረባ እዋን ኣብ ነገራት ጠቓሚ ግደ ትፃወት ከም ዘለኻ/ኺ ተሰሚዑካ/ኪ ድዩ?

1. ካብቲ ልሙድ ንላዕሊ
2. ከምቲ ልሙድ
3. ካብቲ ልሙድ ዝወሓደ
4. ካብቲ ልሙድ ኣዝዩ ዝወሓደ

4• ኣብዚ ቀረባ እዋን ውሳነታት ክትህብ/ቢ ዓቕሚ ዘለካ/ኪ ኮይኑ ተሰሚዑካ/ኪ ድዩ?

1. ካብቲ ልሙድ ንላዕሊ
2. ከምቲ ልሙድ
3. ካብቲ ልሙድ ዝወሓደ
4. ኣዝዩ ዝወሓደ ዓቕሚ ዘለዎ

5• ኣብዚ ቀረባ እዋን ቐፃልነት ዘለዎ ውጥረት ተሰሚዑካ/ኪ ድዩ?

1. ብፍፁም
2. ካብቲ ልሙድ ዘይበዝሕ
3. ካብቲ ልሙድ ንላዕሊ
4. ካብቲ ልሙድ ኣዝዩ ዝበዝሕ

6• ኣብዚ ቀረባ እዋን ንፀገማትካ/ኪ ክትሰግሮ/ርዮ ዘይትኽእል/ሊ ኮይኑ ተሰሚዑካ/ኪ ድዩ?

1. ብፍጹም
2. ካብቲ ልሙድ ዘይበዝሕ
3. ካብቲ ልሙድ ንላዕሊ
4. ካብቲ ልሙድ ኣዝዩ ዝበዝሕ

7• ኣብዚ ቀረባ እዋን ንቡር መዓልታዊ ንጥፈታትካ/ኪ ክተስተማቕር/ሪ ክኢልካ/ኪ ዲኻ/ኺ?

1. ካብቲ ልሙድ ንላዕሊ
2. ከምቲ ልሙድ
3. ካብቲ ልሙድ ዝወሓደ
4. ካብቲ ልሙድ ኣዝዩ ዝወሓደ

8• ኣብዚ ቀረባ እዋን ፀገማትካ/ኪ ክትፈትሕ/ሒ ክኢልካ/ኪ ዲኻ/ኺ?

1. ካብቲ ልሙድ ንላዕሊ
2. ከምቲ ልሙድ
3. ካብቲ ልሙድ ዝወሓደ
4. ኣዝዩ ዝወሓደ

9• ኣብዚ ቀረባ እዋን ናይ ዘይምሕጓስ ወይ ጭንቀት ስምዒት ክስመዓካ/ኪ ፀኒሑ ድ?
1. ብፍጹም
2. ካብቲ ልሙድ ዘይበዝሕ
3. ካብቲ ልሙድ ንላዕሊ
4. ካብቲ ልሙድ ኣዝዩ ዝበዝሕ
10• ኣብዚ ቀረባ እዋን ዓርሰ ምትእምማን ትስእን/ኒ ኣለኻ/ኺ ዲኻ/ኺ?
1. ብፍጹም
2. ካብቲ ልሙድ ዘይበዝሕ
3. ካብቲ ልሙድ ንላዕሊ
4. ካብቲ ልሙድ ኣዝዩ ዝበዝሕ
11• ኣብዚ ቀረባ እዋን ንባዕልኻ/ኺ ከም ዋጋ ዘይብሉ ሰብ ትሓስብ/ቢ ኣለኻ/ኺ ዲኻ/ኺ?
1. ብፍጹም
2. ካብቲ ልሙድ ዘይበዝሕ
3. ካብቲ ልሙድ ንላዕሊ
4. ካብቲ ልሙድ ኣዝዩ ዝበዝሕ
12• ኣብዚ ቀረባ እዋን ኩሉ ነገራት ኣብ ግምት ብምእታው ምኽንያታዊ ሓጎስ ክስምዓካ/ኪ ጸኒሑ ድዩ?
1. ካብቲ ልሙድ ንላዕሊ
2. ኣሲታት ከምቲ ልሙድ
3. ካብቲ ልሙድ ዝወሓደ
4. ካብቲ ልሙድ ኣዝዩ ዝወሓደ

ልጋብ 8 ፡ ማሕበራዊ ደገፍ ዝግምግም መለከዒ (Oslo Social Support Scale (OSSS-3))

እዞም ዝስዕቡ ሰለስተ ሕቶታት ምስ ማሕበራዊ ርክብኩም/ክን ዘጋጠመኩም/ክን ዝምለከቱ እዮም።

ተ ቁ	ሕቶታት	መልሲ
501	ከቢድ ናይ ውልቀ ሽግር ኣብዘጋጥምካ/ኪ ግዜ እትተኣማመነሉ/ንሉ ንብጣዕሚ ቀረባ ዝኾኑ ክንደይ ሰባት ክትረክብ/ቢ ትኽእል/ሊ ?	1. ምንም 2.1 ወይ 2 3. 3-5 4. ካብ 5 ንላዕሊ
502	ኣብቲ እትሰርሖ/ሕዮ ነገር ሰባት ክንደየናይ ዝኣክል ተገዳስነትን ሓልዮትን ይገብሩ/የርእዩ?	1. ምንም 2.ብጣዕሚ ዉሑድ 3. ኣይፍለጥን 4. ዝተውሰነ 5. ብጣዕሚ ብዙሕ
503	ኣብ ዝደለኻዮ/ኽዮ ግዜ ካብ ጎረቤትካ/ኪ ወይከዓ ካብ ዓርከኻ/ኺ ሓገዝ ንምርካብ ክንደይ ዝኣክል ቀሊል እዩ ?	5. ብጣዕሚ ቀሊል 4. ቀሊልእዩ 3. ምርካብ ይካኣል እዩ 2. ኣፀጋሚ እዩ 1. ብጣዕሚ ኣፀጋሚ እዩ

ልጋብ 9፡ ንዝገጠሙኻ ተጻንፍታት ናይ ምጽዋር ዓቕሚ ሓዲር መለከዒ (Brief COPE)

ሰባት ኣብ ህይወቶም ከበድቲ ወይ ውጥረት ዝመልኦ ፍፃመታት ምስ ዘጋጥሞም ከመይ ከም ዝምልሱ ንምፍላጥ ደሊና ኣለና። እዚ መሕተቲ እዚ ውጥረት ዝመልኦ ፍጻመታት ኣብ ዘጋጥመካ እዋን ብሓፈሻ እንታይ ከም ትገብርን ዝስመዓካን ከተመልክት ይሓተካ።
ትገብሮ ዲኻ ኣይትገብሮን ጥራይ እምበይ ይሰርሕ ድዩ ኣይሰርሕን ብዝብል መልሲ ኣይትሃብ። ነፍሲ ወከፍ ሕቶ ኣብ ኣእምሮኻ ካብቶም ካልኦት በበይኑ ደረጃ ክትህቦ ፈትን። መልስታትካ ብዝተኻእለካ መጠን ንዓኻ ሓቂ ዝኾኑ ግበሮ. እዚ ሓበሬታ ምስጢራዊ/ናትካ እዩ፤ እንተደሊኻ ክተካፍሎ ትኽእል ኢኻ። “ቅኑዕ” ወይ “ጌጋ” ዝብል መልሲ የለን። ፍሉይ “ነጥቢ” ዘይኮነስ ሓፈሻዊ ኢና ንደሊ ዘለና

1_____2_____3_____4
ብፍፁም ንእሽቶ ማእከላይ መጠን ብዙሕ

1 = እዚ ብፍፁም ኣይገበርኩን።
2 = እዚ ቀቁሩብ ክገብሮ ፀኒሐ

3 = እዚ ብማእከላይ መጠን ክገብሮ ፀኒሐ
4 = እዚ ብዙሕ ጊዜ ክገብሮ ፀኒሐ
ነዚ መለከዒ እዚ ተጠቒምካ ነዞም ዝስዕቡ መልሲ ሃብ
1. ላእምሮይ ካብ ነገራት ምዝካር ንምውፃእ ናብ ስራሕ ወይ ካልእ ንጥፈታት ክድህብ ፀኒሐ።
2. ፃዕረይ ኣብቲ ዘለኹዎ ኩነታት ገለ ነገር ኣብ ምግባር ክድህብ ፀኒሐ።
3. ንነብሰይ "እዚ ናይ ብሓቂ ኣይኮነን" ክብል ፀኒሐ።
4. ንነብሰይ ፅቡቕ ንኽስምዓኒ ወልፊ ዝፈጥር ባህርያት ወይ ንጥረ ነገራት ክጥቀም ፀኒሐ።
5. ካብ ካልኦት ስምዒታዊ ደገፍ ክረክብ ፀኒሐ።
6. ነቲ ፀገም ክፃወሮ ምፍታን ኣቋሪፀዮ።
7. ነቲ ኩነታት ንምምሕያሽ ስጉምቲ ይወስድ ነይረ።
8. ከም ዘጋጠመ ንምእማን ይኣብየኒ ነይሩ
9. ካብ ደስ ዘይብሉ ስሚዕታት ንምምላጥ ዝኾኑ ነገራት ይብል ነይረ
10. ካብ ካልኦት ሰባት ሓገዝን ምኽርን ክረክብ ፀኒሐ።
11. ኣልኮላዊ መስተ ወይ ካልእ ሓሸሽ ንኽጻዎሮ ይሕግዘኒ ነይሩ።
12. ብኻልእ መንገዲ ክርእዮ፣ ዝያዳ ኣወንታዊ ንኽመስል ይፅዕር ነይረ።
13. ንነብሰይ ክነቅፋ ፀኒሐ።
14. እንታይ ክገብር ከም ዘለኒ ስትራተጂ ከውፅእ ክፍትን ፀኒሐ።
15. ካብ ሰብ ምፅንናዕን ምርዳእን ክረክብ ፀኒሐ።
16. ንኽፃወሮ ዝገብሮ ፈተነ ኣቋሪፀዮ።
17. ኣብቲ ዝኸውን ዘሎ ነገር ፅቡቕ ነገር ክደሊ ፀኒሐ።
18. ብዛዕባኡ ቐልድታት ክቐልድ ፀኒሐ።
19. ብዛዕባኡ ውሑድ ክሓስበሉ ዝኽእለኒ ነገር ክገብር ፀኒሐ። ከም ፊልም፣ ቲቪ፣ ምንባብ፣ ምድቃስ ወይ ዕዳጋ ምኻድ።
20. ከም ዘጋጠመ ክውንነቱ ክቐበሎ ፀኒሐ።
21. ኣሉታዊ ስምዒታተይ ክገልፅ ፀኒሐ።
22. ኣብ ሃይማኖተይ ወይ መንፈሳዊ እምነተይ ምፅንናዕ ክረክብ ይፅዕር ነይረ።
23. እንታይ ክገብር ከም ዘለኒ ካብ ካልኦት ሰባት ምኽሪ ወይ ሓገዝ ክረክብ ይፅዕር ነይረ።
24. ምስኡ ክመይ ከምዝነብር ክመሃር ፀኒሐ።
25. እንታይ ስጉምቲ ክወስድ ከም ዘለኒ ኣበርቲዐ ይሓስብ ፀኒሐ።
26. ብዘጋጠሙ ነገራት ንነብሰይ ክወቅስ ፀኒሐ።
27. ክፅሊ ወይ ክስተንትን ፀኒሐ።
28. በቲ ኩነታት ክቐልድ ፀኒሐ.

12. Assurance of principal investigator

Declaration of original work

I, the undersigned, declare that this thesis is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

If proven otherwise, I understand that appropriate actions will be taken based on the Senate Legislation of Addis Ababa University and the Guidelines provided by the Ministry of Education.

Name of Investigator: Haileleul Mekonnen Tilinty

Signature: _____

Date of submission: May 15, 2026

This thesis work has been submitted to DOP with my approval as a supervisor

- ✓ Name and Signature of the first Supervisor

  _____

- ✓ Name and Signature of the second supervisor

  _____