



ADDIS ABABA UNIVERSITY
COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES
SCHOOL OF PSYCHOLOGY

PSYCHOLOGICAL DISTRESS AND COPING MECHANISMS AMONG
INTERNALLY DISPLACED RETURNEES: THE CASE OF YASO
DISTRICT, BENISHANGUL GUMUZ REGIONAL STATE

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**Psychological Distress and Coping Mechanisms among Internally
Displaced Returnees in Yaso District, Benishangul Gumuz Regional
State**

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This Thesis is submitted to the School of Psychology in Partial Fulfillment of the Requirements for MA DEGREE IN COUNSELING PSYCHOLOGY.

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ABBREVIATIONS AND ACRONYMS

AAH:	Action against Hunger
APA	American Psychological Association
CMD	Common Mental Disorder
IDMC	Internal Displacement Monitoring Centre
IDPs	Internally Displaced Persons
DSM	Diagnostic and Statistical Manual for Mental Disorders
GRID	Global Report on International Displacement
K 10	Kessler's 10-Item Psychological Distress Scale
OCHA	Office for the Coordination of Humanitarian Affairs
SPSS	Statistical Package for the Social Sciences
US-NHIS	United States National Health Interview Survey
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WB	World Bank

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ABSTRACT

The purpose of this study was to assess the prevalence of psychological distress and coping mechanisms among internally displaced returnees in Yaso district, Benishangul Gumuz Regional State. Descriptive cross-sectional study design was employed. Data were collected using (Kessler-10, Post traumatic stress-Checklist 5(PCL-5) and Brief Coping-28) from 378 participants recruited with simple random sampling techniques. Statistical Package for Social Science (SPSS) version 20 was used to analyze the data. Descriptive statistics like mean and percentage were used to summarize the characteristics of participants and findings. To look the association between trauma and distress, Pearson correlation and linear regression was also employed. High prevalence of psychological distress (26.4%) was found among internally displaced returnees. In the adjusted regression model, trauma (0.45 (0.37, 0.53) $p < 0.001$ and marital status (1.76, (0.75, 2.78) $P = 0.001$) were found to be significantly and positively associated with psychological distress while sex -2.67(-4.23,-1.11), $P = .001$ and coping strategies -0.15 (-0.25, -0.04) $p = 0.005$ were negatively associated with psychological distress. Finally the study indicated high adaptive/effective coping mechanism subscales/variables like amalgamated and religion ($M = 5.59$, $SD = 1.453$) and instrumental support ($M = 4.53$, $SD = 1.36$) were the most repeatedly reported respectively. Whereas denial ($M = 4.82$, $SD = 1.64$) and behavioral disengagement ($M = 4.20$, $SD = 1.28$) were the most frequently reported under maladaptive coping mechanism. The major inference of this study reveals that though the returnees are relatively using adaptive coping mechanism; on contrary the prevalence of psychological distress of the returnees is high so rehabilitation works are demanding to minimize further mental health problems.

Key Words: *Psychological distress, coping mechanisms, internally displaced persons/returnees.*

CHAPTER ONE: INTRODUCTION

This chapter was beginning with the introductory containing the background of the study, the statement of the problem, objectives of the study, research questions of the study, the scope of the study, the significance of the study, limitation of the study, the methodology and the organization of the study.

1.1 Background of the study

The existence of psychological distress has been identified for thousands of years (Mabitsela, 2003). For instance, a 3,900 years old manuscript from Egypt shows the sufferer's pessimism, loss of faith, inability to carry out everyday tasks of life and serious consideration of suicide (Kovacs and Beck, 1978). Furthermore, Mabitsela (2003) described the history of Job from the Holy Bible and illustrated a classic case of psychological distress. Psychological distress has been seen from Job's actions and sayings that expressed in losing interest in things he used to like doing, became hopeless, became withdrawing, self-blaming, self-depreciating and had sleep disturbances

The above historical scenario is congruent with some of the present accounts of the phenomenon of psychological distress. Still there is no clear agreement among scholars based on the concept and symptoms of psychological distress. According to Torkington (1991), the major disagreement among researchers on psychological distress has been over the meaning of the concept, and about what actually is meant by the assertion that a person is psychologically distressed.

Williams (2014) indicated that psychological distress is a vague and subjective experience. Gust et al. (2017) defined psychological distress as undifferentiated combinations of symptoms ranging from depression and general anxiety to personality traits, functional disabilities and behavioural problems. Similarly, Mirowsky and Ross (2002) described psychological distress as a state of emotional suffering characterized by symptoms of depression (e.g., lose of interest, sadness, hopelessness), anxiety (e.g., restlessness, feeling tense), and somatic symptoms (e.g., insomnia, headaches, lack of energy) although they are likely to vary across culture. In line with the ideas described above, Wheaton (2007) viewed psychological distress as an emotional disturbance that may impact on the social functioning and day-to-day living of individuals. On

the other hand, distress is a diagnostic criterion for some psychiatric disorders (e.g., obsessive-compulsive disorder and post-traumatic stress disorder) (Phillips, 2009; Watson, 2009).

Dohrenwend (1982) argued that psychological distress is usually described as a non-specific mental health problem. Whereas Wheaton (2007) indicated that psychological distress should be qualified and it is clearly characterized by depression and anxiety symptoms. It is widely agreed that the individual and the collective experience of a disease is partly bounded by cultural norms. Although negative states of mind such as feeling sad, depressed or anxious tend to be universal, the expression of these states of mind may vary in intensity and in form across and within societies (Kirmayer, 1989; Kleinman, 1991; Westermeyer and Janca, 1997). This trans-cultural variation is especially noteworthy in somatic symptoms.

Consequently, people who are experiencing or passing through such kind of psychological distress due to unpleasant life circumstances such as forced uprooting from their residence will build a coping mechanism in order to master, tolerate, reduce, or minimize stressful events. According to Folkman and Moskowitz (2000), coping refers to the cognitions and behaviours that people use to regulate distressing situations.

The concept and definition of internal displacement has been debated by different researchers for decades but no eventual concurrence has reached (Mooney, 2005). However, Mooney has stated that right now most researchers and humanitarian service givers are using the definition that the Global Report on International Displacement (GRID) has proposed. GRID defines internally displaced persons (IDPs) as "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border" (GRID,2019, P, 6).

Internally displaced persons are among the world's most vulnerable people, facing poverty, lost educational opportunities, unemployment, marginalization and insecurity (IOM, 2017). Similarly, a study conducted by the World Bank Group (2016) indicated that mental health and psychosocial problems are extremely common in major crises like conflict-affected incidences. The study further pointed out that there is a need for mental health and psychosocial support services in such events. Siriwardhana (2015) showed that there is strong association of poor

mental health and internal displacement, particularly in low and middle income countries. Weiss (2011) found that internally displaced returnees suffer from psychological distress due to risks of reclaiming land or receiving compensation for losses, insecurity, lack of accessing services (education, health care, employment opportunities...), experiencing persistent flashbacks and lack of enjoying full rights of citizenship.

Internally displaced persons usually use different coping mechanisms to adapt the above stated situations. The concept of coping is a very broad and several divisions have been made within this broad sphere. The important distinctions are the differences between situational coping responses and dispositional coping styles (Monzani et al, 2015). According to Monzani and her colleagues coping response refers to the ways people react and cope with specific difficulties and stressful circumstances, whereas dispositional coping styles corresponds to a tendency to use specific coping reactions to a greater or lesser degree under stress. The study further explains the adoption of situational coping responses as influenced by several different aspects, such as socioeconomic status, the dispositional coping style, dispositional optimism, causal attributions and the controllability of stressors. Generally, people show high unpredictability regarding to responses to threats and stressors, and several distinctions have been made between different types of coping.

Costa, Somerfield, and McCrae (1996) explained the concept of coping as a special category of adaptation elicited in normal individuals by unusually strenuous circumstances. According to Lazarus and Folkman (1984), on the other hand, coping is a constantly changing cognitive and behavioral effort which is undertaken by an individual in order to deal with demands which are especially challenging and are probably exceeding individual capacities and/or resources.

Identifying strategies that either individuals or groups use to adapt a taxing situation is significant. Though different kinds of strategies are indicated in the literature, recent studies concluded that coping dimensions are unstable and depend on the type of stress and sample (Campos et al, 2004). Several studies classified specific coping strategies, such as religion, positive reframing, humor, and acceptance, as problem-focused, emotion- focused, or avoidant (García, 2015).

To sum up, psychological distress is a general term used to describe unpleasant feelings or disturbing emotions that can be manifested by sadness, anxiety, distraction, and symptoms of mental illness that impact mental, physical and social functioning. Internally displaced persons are those who are forced or obliged to leave their habitual residence and did not cross recognized international borders. As mentioned above, studies have indicated that these people experience psychological distress (persistent flashbacks, sleep disturbances, anxiety, resentment, nightmares) due to risk factors associated with internal displacement. Consequently, this may prone people to traumatic emotions; on the contrary people can develop their own coping mechanisms to adapt the situation.

However, limited studies are available in the local context in relation to the psychological distress and coping mechanisms of internally displaced returnees. For instance, Action against Hunger (AAH) (2019) conducted a study in Yaso district among internally displaced returnees, but it gave much emphasis on how IDPs are acquiring services of humanitarian, food security and livelihood. Still the study indicated its observation that returnees are facing psychological distress like anxiety, flashbacks, and depression. Therefore, further empirical research focusing on specific variables is needed to understand the psychological needs of returnees and their coping mechanisms. Thus, this study aimed to fill the empirical gap in relation to the psychological distress and coping mechanisms of internally displaced returnees in Yaso district, Benishangul-Gumuz Regional State.

1.2. Statement of the problem

Gust, et al (2016) indicated that psychological distress has not been well studied in developing countries in general and in African countries in particular. Similarly, Mabaso, et al (2017) who carried out a study on the prevalence of psychological distress in South Africa found that there is no nationally representative data on the prevalence and factors associated with psychological distress.

Traumatic life events due to war, disaster, torture and mass violence are known to lead to serious psychological consequences and mental disorders (Mesfin, 2007). Moreover, post conflict displaced persons can be exposed to such traumatic events as lack of food, water, shelter and medical care; imprisonment; combat and injury; abuse and isolation; torture and murder and

death. In addition, these people could have usually gone through severe traumatic life events that cause psychological distress and that are detrimental to their mental as well as physical health. On the whole, they usually have a relatively poor quality of life (Mesfin, 2007; Siriwardhana, 2015).

On the contrary, mental health of IDPs has received inadequate attention from health care planners and from society in general (Marquez, 2016). If mental health issues are not effectively addressed, the long-term mental health and psychosocial wellbeing of the displaced population may be affected. Since unlike physical wounds and losses, conditions such as depression, anxiety (including post-traumatic stress disorder), and traumatic brain injuries, that affect mood, thoughts, and behavior, are often invisible. However, they persevere unrecognized, unacknowledged, or ignored in humanitarian and development-assistance programs, undermining efforts to help rebuild and sustain the lives of displaced populations (Marquez, 2016).

Predominantly, as far as the researcher has tried to find out exhaustive studies are carried out on refugees (with regard to their health, quality of life and living conditions). Fewer such studies are available concerning internally displaced persons, particularly in low-income countries (de Jong et al, 2003). Furthermore, the existing studies mentioned above mostly assessed the mental health status of refugees. Particularly in Ethiopia, only few studies (Fatuma et al, 2015; Mesfin, 2007) are carried out on the mental health of conflict-induced internally displaced returnees.

Siriwardh (2015) criticized studies conducted on the psychosocial health of internally displaced people. Long-term mental health and resilience trajectories of those affected by prolonged displacement and experiencing return migration during post-conflict periods remain important, yet critically understudied. Scant studies have been conducted in Ethiopia on mental health of refugees and quality of life of IDPs (Fatuma et al, 2015; Mesfin, 2007). The researcher could not find adequate studies that conducted particularly on the mental health of internally displaced returnees and their coping mechanism in Ethiopia context. Thus, this study was to assess the psychological distress and coping mechanisms of conflict-induced internally displaced returnees in Yaso District, Benishangul Gumuz Regional State.

1.3. Research questions

- ✚ What is the prevalence of psychological distress among internally displaced returnees in Yaso District?
- ✚ Is there a statistically significant association between socio-demographic characteristics and experience of trauma with psychological distress among internally displaced returnees in Yaso District?
- ✚ What kinds of coping mechanisms do internally displaced returnees in Yaso district use to deal with their difficult situations?

1.4. Objectives of the study

1.4.1 General objective

The overall objective of this study was to assess the psychological distress and coping mechanisms of internally displaced returnees in Yaso District, Benishangul-Gumuz Regional State.

1.4.2. Specific objectives

- ✚ To determine the prevalence of psychological distresses among internally displaced returnees in Yaso District.
- ✚ To investigate the association between socio-demographic characteristics and experience of trauma with psychological distress among internally displaced returnees in Yaso District
- ✚ To find out the coping mechanisms internally displaced returnees use to deal with their psychological distress in Yaso District

1.5. Significance of the study

As Global Report on International Displacement (GRID) (2019) shows, since the last three years Ethiopia has the largest figure in internally displaced people (i. e 2.9 million). According to government reports, these displaced people are returned to their original places and receiving humanitarian services. On the other hand as discussed so far, psychological distress and other related mental health problems are common among people with such experience. However as far as the researcher concerned there is no sufficient research specifically in Ethiopia that done on the mental health status of internally displaced returnees (Fatuma et al, 2015).

Therefore, the findings of this study would help organizations engaged in peace building and reconciliation activities to understand the needs of the displaced returnees and provide counseling and trauma healing services to these people. Counseling and other practitioners working in the rehabilitation of IDPs would use the inputs of this research to develop tailored training materials to create awareness on the mental health needs of displaced returnees. Furthermore, the findings can be used by other researchers as a stepping stone to conduct further research on the issue.

1.6. Scope of the study

The study was designed to investigate the psychological distress, examine the association between trauma and psychological distress and the coping mechanisms of internally displaced returnees. Geographically, the research was delimited to displaced returnees residing in eight localities in Yaso district of Kamashi zone in Benishangul Gumuz Regional States. As in 2018/19 internally displaced persons issue was a burning event that catches every person's mind. So the researcher inspired to conduct his study on this particular incidence. Fortunately at that time the organization in which the researcher working for was in process to for an agreement with Oromia and Benishangule Gumuz regional states to implement the peace building intervention. This made possible for the researcher to collect necessary data. Thus, the study population was selected from eight localities of Yaso district.

1.7. Operational definition of important terms

Psychological distress: psychological distress refers to general symptoms of anxiety and depression that a person experienced in the last four weeks and measured with Kessler-10 (k-10) prior to interview

Trauma: in this study, trauma refers to the degree to which an individual has been bothered in the last one month tied to his/her current distressing event and measured by PTSD checklist (PCL-5)

Socio-demographic characteristics: refer to self-report of sex, age (categorized in to four in range of 15-60), marital status, educational status, ethnicity, religion, income level, and residence of the respondents of the research.

Coping Mechanisms: are the coping strategies that has been used by IDP returnees and measured by Brief Cope-28.

1.8. Limitation of the study

This study has been conducted on accessing prevalence of psychological distress, association of psychological distress and traumatic experience and coping mechanism of internally displaced returnees. However the study has the following limitations:

1. The study has administered quantitative data collection approach alone, this might be limited the voice of participants as well as strength of analysis and findings of the study.
2. The second limitation was determining the total population and sampling. The number of returnees reported by government and the actual number of returnees who are known by local government are quite different. The current study depends on the register of Disaster Prevention and Preparedness Bureau which indicates the active returnees who are gaining humanitarian aid. However, still there is a doubt on actual number of returnees for the stability of people is not ensured due to security issue. Some people are registered and regularly receive the aid but live in bordering region (Oromia Regional State). Therefore, the sampling was drawn from register that supposed to be the actual population of returnees.
3. Due to sensitive and fragile nature of targeted/study area it was not possible to know the population of each localities and stratify sample size accordingly. This can limit the generalizability of the current study findings.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

This chapter reviewed the available literature on psychological distress, the association between traumatic events and psychological distress and coping mechanisms among internally displaced people. The first part attempted to assess the global and local situation of internally displacement. The second part dealt with the definition and theories of psychological distress. Then, the third part reviewed studies on psychological distress, on the association between traumatic events and psychological distress particularly in conflict induced internally displaced returnees and coping mechanisms of internally displaced persons.

2.1. The Concept of Internal Displacement

The concept and definition of IDPs emerged in the early 1990s (UNHCR, 2005). Several writers have been debating on the causes of internally displaced persons, concept and definition for long time but still not yet developed the legal definition (Mooney, 2005). However, according to Mooney, in 1998 United Nations Guiding Principles on Internal Displacement came with important and standard tool that gained recognition widely to address internally displaced persons in common understanding worldwide. The definition expresses internally displaced persons (IDPs) as, "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border."(Mooney, 1998; p, 16)

The other significant concept that should be underlined is what distinguishes and differs internally displaced persons from refugees. According to the UN Refugee Agency, the UNHCR, in both group of people often there is leaving own home for different reasons. However, civilians are recognized as 'refugees' when they cross an international frontier to seek sanctuary in another country. The internally displaced people, for whatever reason, remain in their own states (UNHCR, 2008). Although the reason for flight might be similar (civil conflict, humanitarian disaster etc) IDPs have not, unlike refugees, crossed an international border for the sake of safety

but have remained in their home country. Consequently, IDPs become tremendously vulnerable as they maintain their rights as citizens and protection of their government even though the government could have been involved in what caused the displacement in the first place (UNICEF, 1998).

The IDP definition references the triggers for internal displacement such as an armed conflict, generalized violence, human rights violations, and natural or human-made disasters. This is, however, not an exhaustive list, as indicated by the words "in particular". The phrase "as a result of or in order to avoid the effect of" also recognizes that persons may be internally displaced after suffering the effects of coercion or in anticipation of such effects (UN Guiding Principles on Internal Displacement, 2009).

According to UN Principles on Internal Displacement (2009) description and guidance of internally displaced persons, the IDP concept includes only specific groups, such as indigenous communities or pastoralists displaced because their routes of migration have been blocked by conflict, landmines or insecurity, may be considered as IDPs. However, the homeless and poor urban communities are not automatically considered to be IDPs even though they often suffer marginalization, impoverishment and human rights violations in their areas of residence. In other words, the IDP definition does not cover persons who move for economic reasons.

Generally, there are two important elements in the IDP definition: the movement is involuntary and takes place within national borders or physically remain within their own countries. The IDPs are those who triggered to forcefully uprooted from residence by armed conflict, generalized violence, human rights violations, and natural or human-made disasters.

2.2. The global situation of post-conflict internally displaced persons (IDPs)

According to Global Report on Internal Displacement (GRID, 2019), internal displacement is increasing from time to time. For instance, according to UNHCR (2007), the number of internally displaced persons worldwide in 2007 was 23.7 million from 52 different countries. However, at the end of 2018 this figure has raised to 41.3 million. Among these internally displaced persons, three-quarter or 30.9 million are located in only ten countries (GRID, 2019). Among these countries six of them are located in Africa and Ethiopia is leading by 2.9 million. The report also states that sixty-one per cent of the new displacements recorded in 2018, or 17.2 million, were triggered by disasters, and 39 per cent, or 10.8 million, by conflict.

Sub-Saharan Africa accounts for only 14 per cent of the world's population, but almost half of new conflict displacement took place in the region. There were 5.5 million new displacements associated with conflict and violence in 2017 (World Bank, 2018) in this region. Displacement in the Horn of Africa is a highly complex phenomenon. Behind immediate triggers such as natural hazard events lie a confluence of social, economic, political and environmental drivers of vulnerability and exposure that creates high levels of both disaster and displacement risk (Internal Displacement Monitoring Center IDMC,2017).

Furthermore, report of the United Nations High Commissioner for Refugees (UNHCR, 2014) indicated that the scale of internal displacement has risen to unprecedented levels. The report revealed that almost 60 million people are forcibly displaced globally, consisting of over 19.5 million refugees, 38.2 million internally displaced persons and 1.8 million asylum seekers. Among these over 40 million people are currently displaced by conflict inside their own countries, a number that represents 62 per cent of the total number of displaced persons worldwide (UNHCR, 2014).

As reviewed from different reports and literatures, though the number of internally displaced people is increasing from time to time, there is less attention by the international community in supporting IDPs. Most of the funds from the international community focused on refugees than internally displaced people. Mostly, material and non-material supports of IDPs are left for their own countries (Dereje, 2019).

2.3. The situation of post-conflict internally displaced persons (IDPs) in Ethiopia

In the last couple of years, in most part of Ethiopia Regional States, people have been uprooted from their homes and livelihoods in the face of civil conflict, natural or economic disasters, or other threats. Particularly, in civil conflict violence, the country's crisis has been deepening steadily since 2016, and inter-communal violence escalated significantly and spread to new areas last year (GRID, 2019). In 2018, the country becomes in the top of global list of internally displaced people (Internal Displacement Monitoring Centre, (IDMC), 2019). Consequently, there were 2.9 million displaced people across the country in 2019 (GRID, 2019; Office for the Coordination of Humanitarian Affairs, 2018).

Conflict and long term displacement were recorded along three of the Oromia region's borders, with the Southern Nations, Nationalities and Peoples' (SNNP) region in the south-west, the Benishangul-Gumuz region in the north-west and the Somali region in the east (GRID, 2019; Garedew and Nigusie, 2019). According to a report by Office for the Coordination of Humanitarian Affairs (OCHA) (2018), there are around 656,579 people displaced within their respective regions, including 428,569 people displaced within their woreda of origin (352,066 in Oromia and 76,503 in Somali), and 49,541 people displaced outside their woreda of origin but within the same region (27,079 in Somali and 22,462 in Oromia). There are also a group of IDPs who, even if they crossed regional borders, remained close to their areas of origin along the border, including 99,820 Somali IDPs and 78,649 Oromo IDPs (OCHA, 2018).

Moreover, the country's urban centers were also affected, including Addis Ababa, Dire Dawa and Jijiga. This is also true in other regional towns: Hawassa, Bahirdar and Mekelle and Zonal towns like, Central and West Gondar, Gurage, Metekel, Awi, Nekemet, Wolayita Sodo (OCHA, 2018; OCHA, 2019)

The literature showed that most of the displacement has been occurring due to ethnic clash, resource and religion based violence. Still, there are places where violence is not yet settled (Derege, 2019). However, IOM (2019) discloses that the government has implemented IDP

return operations at full scale since early May 2019 following the 8 April 2019 announcement of the Federal Government's Strategic Plan to Address Internal Displacement. As a result, by the end of May 2019 most IDP sites/camps became dismantled, particularly in East/West Wollega and Geddo/West Gujizones. Additionally, the report states that partners were engaged with government specially advocating for the returns to happen voluntarily, in safety, sustainably and with dignity.

The government has been criticized, however, for encouraging premature returns to regions not yet safe and for not doing enough to protect civilians. This resulted in insecurity in areas of return. In other areas of the country where returns have taken place, most IDPs have returned to their damaged homes or to areas nearby (IDMC, 2019.)

2.4 The concept and symptoms of psychological distress

The concept of psychological distress is often applied to the undifferentiated combinations of symptoms ranging from depression and general anxiety symptoms to personality traits, functional disabilities and behavioral problems (Drapeau, et al 2012). In other words, psychological distress is described as a negative emotional reaction or condition that is an attachment to the events of threat, harm or loss (Payton, 2009). Psychological distress is a normal emotional reaction to a stressor which raises the issue of delineating "normality" in different populations and in different situations (Horwitz 2007). The stressors or events can be happened by natural and manmade phenomena. José (2005) affirms that events forced by the physical environment which are harmful and greatly exceeds the coping capacity of the affected community can create psychological distresses. On top of this, Wang (2010) describes that disaster can be either caused by pure natural forces-- volcanic eruption, earthquake, tsunami, etc; or human activities-- war, terrorism attack, airplane crashes, rape, etc.

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV (2000) associates the concept of distress with functional impairment as criteria for most depressive disorders, anxiety disorders, personality disorders, sleep disorders, somatoform disorders and some other disorders (APA, 2005). Similarly, according to DSM-V explanation psychological distress that happens following traumatic or stressful events and in some cases its symptoms can

be well understood with fear-based or anxiety. On the contrary, many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic (reducing motivation to experience pleasure) and dysphoric (state of unease or dissatisfaction) symptoms (APA, 2005).

In other words it can be expressed in terms of externalizing angry and aggressive symptoms, or dissociative symptoms. Because of these variable expressions of clinical distress following exposure to catastrophic or aversive events, the above disorders have been grouped under a separate category which is known as trauma- and stressor-related disorders (APA, 2005).

Chalfant *et al.* (1990) defined psychological distress as a continuous experience of unhappiness, nervousness, irritability and problematic interpersonal relationships. In line with the above concept, Burnette and Mui (1997) have explained psychological distress as mild psychopathology and deviation from some objectively healthy state of being and implied by maladaptive patterns of coping. These authors summarized some common symptoms that are experiencing in the community. These are restlessness, depression, anger, anxiety, loneliness, isolation and problematic interpersonal relationships.

Williams, L. *et al.* (2007) described some common symptoms of psychological distress that is supposed to be universally experienced. These are weight gain, anger management problems, obsessive thoughts or compulsions, physical symptoms not explained by a medical condition. Amnesty International (2016) summarized some of internally displaced people's psychological distress symptoms. These are nightmares, getting angry easily, feeling unable to concentrate and considering suicide—common symptoms associated with post-traumatic stress disorder (PTSD) and depression. Many also spoke of headaches, stomach pains, backaches and heart palpitations—common physical manifestations of psychological stress.

In relation to psychological distress, Halling and Nill (1995) have stated three basic questions that are frequently asked in the context of psychology and psychiatry when trying to make sense of behavior. These questions are: “What kinds of behaviour are judged to be abnormal?” It would be professionals or layperson, “what are the various patterns or forms of disturbed

behaviour?”, “how can one make sense of the apparently senseless or irrational behavior of disturbed persons?” Phatares (1988) confirms the significance of these questions to understand who is seen as psychologically distressed as well as how being distressed is interpreted and how treatment will be carried out.

2.5. Theoretical perspectives of psychological distress

No completely satisfactory explanation has been offered to the causes and definition of psychological distress. There are different competing viewpoints which clearly show the incomplete knowledge regarding the meaning and contributory factors of the issue. As a result, different theorists have attempted to discuss the concept of psychological distress and symptoms. Out of various theories four of them that are relevant for this particular study are reviewed.

2.5.1. Psychodynamic theory

Freud is one of the earliest theorists on psychological distress. According to the theory, the human personality has three components: id, ego and superego. The id is libidinal energy motivated by pleasure principle; the ego realistically meets the wishes of the id and operates on reality principles, the superego controls applying social rules (Oginyi et al, 2017). Thus, according to the theory an unconscious conflict arises when libidinal impulses of id clash with the superego constraints on behaviour. This unconscious conflict may cause anxiety and psychological distress in an individual which results to maladaptive behavior (Oginyi et al, 2017; Box, 1998).

Furthermore, the traditional psychoanalytic model looks at pathology (psychological distress) from an intrapsychic (within psyche) view. The model gives attention to the role of unconscious processes and defense mechanisms in the determination of both normal and abnormal behavior. Accordingly early childhood experiences are imperative in later personality adjustment (Mabitsela, 2003). In other words, they understand the expression of a symptom in the present as an extension of past conflicts (Box, 1998). Therefore, psychological distress in a person's life may be described as his attempt to cope with present difficulties using past childhood defense mechanisms, which may seem maladaptive and socially inappropriate for the present situation (Mabitsela, 2003).

2.5.2 Medical Model/theory

According to Novello (1999) and Kaplan and Sadock (1998) the medical model is a prevailing or dominant view of pathology in the world. Particularly, psychological distress is regarded as a disease in the same category as any other physical illness. This model uses similar model in defining psychological distress as that used by medical practitioners. In other words, psychological distress is some form of neurological defect responsible for the disordered thinking and behavior and requires medical treatment and care (Carson, Butcher and Mineka, 1996).

The central point in the medical model is the association of distress with somatic symptoms, though its understanding and expression differ from culture to culture (Visser and Cleaver, 1999). According to these researchers, somatic symptoms provide the most common expression of psychological distress worldwide but the type of somatic symptoms associated with distress may differ across cultures. For instance, among Chinese, emotions are related to specific organs: anger is associated with the liver, worry with the lungs and fear with the kidneys. Similarly, Haitians tend to view depression as a consequence of either a medical condition - usually anaemia or malnutrition - or worry. Thus, somatisation is related to mood disorder and it is expressed by feeling empty or heavy-headed, insomnia, fatigue or low energy, and poor appetite (Visser and Cleaver, 1999). Again, in Arab culture, depression and somatisation are closely intertwined and depressive symptoms are expressed in physical terms, especially involving the chest and abdomen (Al-Krenawi and Graham 2000). Therefore, psychological distress would be a medical concern mostly when it is accompanied by other symptoms like somatic symptoms.

2.5.3 Interpersonal Theory

Interpersonal theory attributes psychological difficulties to dysfunctional patterns of interaction (Carson *et al.*, 1996). The theory argues that as far as human beings are defined as social, they are a product of a relationship that has with each other. Thus, psychological distress is described as the maladaptive behavior observed in relationships, which is caused by unsatisfactory relationships of the past or present. Psychological distress is identified when examining the

distressed person's different patterns of interpersonal relationships (Burnette and Mui,1997).According to this perspective, distress is alleviated through interpersonal therapy, which focuses on alleviating problems existing within relationships and on helping people achieve more satisfactory relationships through learning of new interpersonal skills(Carson *et al.*, 1996).

2.5.4. Cognitive Theory

According to the cognitive model, negatively biased cognition is a core process in psychological distress (Barlow & Durand 1999). This process is reflected when distressed patients typically have a negative view of themselves, their environment and the future (Weinrach, 1988). They begin view themselves as worthless, inadequate, unlovable and deficient. According to the cognitive theorists, people's excessive affect and dysfunctional behavior is due to excessive or inappropriate ways of interpreting their experiences. The theory suggests that psychological distress can be determined by an individual's belief and thought pattern. According to the theory, individual's behaviour is influenced by his/her perceptual system, self-efficacy, assumptions and belief system (Weinrach, 1988). Therefore, it becomes imperative that psychological distress such as anxiety, depression and somatic symptoms developed by victims of violence is a consequence of their perception and beliefs about their conditions (Oginyi et al, 2017).

The fundamental nature of the model is that, emotional difficulties/distress begin with the way some one sees events, like exaggerating beyond the available evidence. This manner of seeing things tends to have a negative influence on feelings and behavior in a vicious cycle (Barlow & Durand, 1999).

2.6 Association between internal displacement and psychological distress

Researchers agree that forcibly displaced people experience psychological distress at different levels. For instance, a research conducted among IDPs in Ukraine reported that displacement tends to aggravate mental disorders, including schizophrenia (GRID, 2019). Furthermore, harsh situations that IDPs experience result in psychosis and debilitating depression. The report discloses anxiety increases from between one and two percent in the general population globally to between three and four per cent among people caught up in humanitarian emergencies and

crises. Consequently, seventy-four per cent of IDPs in Ukraine were in need of mental healthcare.

Similarly, a study carried out by Amnesty International in South Darfur found that 62.2% of IDPs showed signs of a psychiatric disorder, higher prevalence of PTSD, affective disorders and anxiety (Amnesty International, 2016). In IDP camps of Southern Darfur, three out of four children in displacement camps showed signs of PTSD, and 38% signs of depression. Likewise, 36% of internally displaced adolescents in DRC reported higher levels of PTSD and internalizing symptoms.

In addition, Amnesty International (2016) carried out a study among South Sudanese internally displaced persons and found that they experience a range of symptoms commonly associated with mental health disorders such as post-traumatic stress disorder (PTSD) and depression. These symptoms are expressed by having nightmares, getting angry easily, feeling unable to concentrate, and considering suicide. Furthermore, the study identified symptoms related to somatic problems such as headaches, stomach pains, backaches, and heart palpitations—common physical manifestations of psychological stress. The victims explained their emotion in such feelings as unable to work, study, carry out basic daily tasks, care for children, or maintain relationships with friends and family. They attributed these mental, physical, emotional, relational, and spiritual impacts to their experiences as victims of forced displacement.

The Report by IDMC (2018) goes with the finding of Amnesty International that internally displaced persons are suffering from common conditions triggered by conflict, including post-traumatic stress disorder (PTSD) and other anxiety disorders, depression, and psychosomatic problems such as insomnia, or back and stomach aches. Accordingly, symptoms associated with these mental health conditions and psychological distress that are found in South Sudan's internally displaced victims are more broadly include feelings of shame, self-blame, fragmented memories, a lack of concentration, intrusive memories, the avoidance of circumstances associated with the stressor, sleep disorders, nightmares, flashbacks, irritability, anger, anxiety, and mistrust of other people. People suffering from poor mental health, particularly depression,

may also consider, or carry out, suicide, and are more prone to poor physical health, risk-taking, and harmful behaviours such as substance abuse.

Marquez (2016) states that forcibly displaced people's mental health needs have often been neglected in response plans of humanitarian services that are delivering by local and international organizations. Marquez argues that due to neglecting mental health problem, forcibly displaced people will often be unable to benefit fully from other forms of support that are provided to them. According to Marquez's study, addressing the mental health of conflict-induced internally displaced is vital to improve people's daily functioning and to protect the most vulnerable from further trauma.

However, some studies suggest returnees experience greater stress than IDPs, particularly those trying to re-establish their lives after protracted displacement. They may continue to face difficulties in meeting their needs in terms of work, food, shelter and healthcare, and they may also suffer from discrimination (GRID, 2019).

2.7. The association between socio-demographic characteristics and psychological distress among IDPs

Many studies indicate the association of socio-demographic characteristics and psychological distress among internally displaced persons. For instance, the study conducted in Iraq conflict induced displaced camp showed that there is significant effect of gender, level of education, monthly income, and family type on mental health of internally displaced persons (Hussein et al, 2018;Min et al, 2005). With regard to family type, the study indicated that in nuclear family there was increase in depression, anxiety and other psychological problems (Hussein et al, 2018; Min et al, 2005).

The study further showed that psychological distress increased with age due to life experiences and burden of responsibility to care for their families. As a result of these, they suffer from the psychological distress of their weak ability to provide their families (Al-Hadrawy, 2008).

Similarly, the level of education for displaced persons was associated with psychological distress. The study showed that as the level of education increases proportionally the level of psychological distress has increased because educated people do worry more than non-educated (Noori and Janet, 2007; Hussein et al, 2018). Concerning occupation, significant relationship was found between psychological distress and occupation. IDPs are more distressed because they left their occupation that have before displacement and became dependent of someone. Monthly income significantly triggers psychological distress and associated with various psychological problems (Raza, 2006; John, 2006; Hussein et al, 2018).

Similarly a study conducted in Kashmir among children whose age ranges 03-16yrs showed that females experience trauma more than males (Vishnevsky, Cann, Calhoun, Tedeschi, and Demakis, 2010). A study in Sierra Leonean during civil war also found that females reported higher psychiatric symptomatology (Hess, 2009). According to Hess's explanation females are more exposed to harmful practices like rape, sexual violence and other abusive experiences than male particularly during violence.

However, most of the research on this particular issue is mostly carried out on refugees. The researcher has faced problems to get literature purely addressing internally displaced returnees.

2.8 The association between trauma and psychological distress among IDPs

Research indicates that there is a strong association between extent of exposure to traumatic events and symptoms of psychological distress such as fear, panic, PTSD and depression. Individuals who are exposed to more types of traumatic events, more frequently, and over a longer period of time report more severe psychological symptoms (Karunakara et al., 2004; Mollica, et al., 1999). It is also notable that particular types of traumatic events appear to confer especially high risk for mental disorders. For example, rates of psychological disorders have been consistently found to be elevated amongst torture survivors compared to non-tortured groups and even after controlling for exposure to other types of traumatic events and mental impairment (Basoglu et al., 1994). A study conducted on West Papuan, Kenya IDPs indicated that living in settlements under conditions of extreme poverty and deprivation identified a range

of trauma experiences and ongoing stressors, functional impairment ranging from mild to extreme (Mironga et al, 2015).

Studies conducted in Juba, South Sudan and Uganda demonstrated significant association between individuals' trauma experience with psychological distresses, PTSD and depression (Roberts et al, 2009; Roberts et al, 2008). The traumatic events commonly exhibited in the studies in the two countries were being forcefully separating from family, experiencing very ill health without access to medical care, being injured, murder of stranger or strangers, being abducted or kidnapped, tortured or beaten, lack of housing or shelter and other nine trauma exposure events were reported as triggers for different psychological distresses.

Mental disorders associated with conflict induced internal displacement are varied (Porter, 2015). Most studies focused on a limited number of disorders, such as PTSD, anxiety and depression (Mels, 2010). However, current epidemiological researches are focusing on the broader common mental disorder (CMD) spectrum related to forced displacement (de Jong, 2003). Almedom and colleagues conducted a study to assess the prevalence of psychological distress among five different countries' displaced persons, and CMD prevalence is seen to vary substantially: 27.2% in Colombia, 27.8% in Ethiopia, 40.3% in Palestine, 57.7% in Cambodia, 62.3% in Algeria (Almedom, et al 2005).

Several studies were conducted in Sri Lanka where more than 90% of the population was internally displaced (Chesmal, 2014). The studies revealed civil conflict of the country has had an enormous impact on the mental health of the country's population. The impact had created disruption of family and community structure and destruction of the social fabric, networks, cohesion, and social capital as 'collective trauma' (Somasundaram et al, 2013). Conflict had created fundamental changes in family and community dynamics, leading to increased psychosocial problems in a collective sense. Another more recent study explored psychosocial status among displaced populations in the Vanni area of Northern Sri Lanka. These populations were displaced at the end of the conflict in 2009, and had endured extreme hardship during the closing stages of the war. The findings show collective symptoms of decreased psychosocial health and the author recommends interventions that target memory healing and psychosocial

regeneration of families and communities in the post-conflict rebuilding and rehabilitation phase (Reilley, 2002; Jenkinse et al, 2012).

Moreover, the studies conducted in Sri Lanka identified a range of issues linked to traumatic events that affect mental health of IDPs. These are unresolved grief, self-harm, suicidal ideations, insecurity, poverty, teenage pregnancies, gender based and domestic violence, poor psychological functions, absenteeism from school as well as from social affairs, neglect of the elderly and many others (Covey, 2004).

Generally, IDPs, particularly those affected by conflict, are at a high risk of mental health problems. The commonly reported psychological reactions are post-traumatic stress disorders (PTSDs) in reaction to violence and depression as a reaction to loss (Saxonet *al.*, 2016). Other types of mental health problems which have been reported are panic attacks and anxiety disorders. The psychological distress occurring in the post-conflict environment also contributes to harmful health behaviours such as hazardous drinking and increased smoking. These behaviours are linked to an increased burden of non-communicable diseases such as hypertension, chronic obstructive pulmonary disease and cancers (Roberts et al, 2012; Saxon *et al.* 2016).

2.9 Coping mechanisms of internally displaced persons

Coping is a very broad concept and several distinctions have been made within this broad domain. Situational coping responses and dispositional coping styles are the main distinctions in the study of coping (Carver and Scheier, 1994). The situational coping style is corresponding to the ways people react and cope with specific difficulties and stressful circumstances. Whereas, dispositional coping style is defined as a tendency that use specific coping reactions to a greater or lesser degree under stress. Empirical evidence suggests that the adoption of situational coping responses is influenced by several different aspects, such as socioeconomic status (Carver and Scheier, 1994; McIlvane, 2007).

People generally exhibit high inconsistency in their responses to threats and stressors, and several distinctions have been made between different types of coping (McIlvane, 2007). On top of this, Folkman and Lazarus (1980) have distinguished between problem-focused coping (such as strategies aimed at solving and actively responding to stressful situations) and emotion-focused coping (like strategies to manage or reduce emotions and feelings that are embedded within stressful situations). Carver et al, (1989) further distinguished between approach coping (that means strategies aimed at dealing actively with the stressor or related emotions) and avoidance coping (that means strategies aimed at avoiding stressful situations). In other words, the distinction between approach and avoidance coping is independent from the distinction between problem-focused and emotion-focused coping (Solberg and Segerstrom, 2006). Consequently, people can cope with a stressor's emotional consequences by either approaching or avoiding and/or people may cope with stressors by actively and directly approaching or avoiding problems.

Coping can be conceptualized as the individual's response or deal effectively with stressful or traumatic events. Although one stressor after another can have long term negative effects on a person; it can also be argued that if the person can cope, or deal effectively with the series of stressors, he or she may emerge much more resilient and competent than an individual who has not had to deal with as much stress during his or her lifetime (Cartwright & Cooper, 1987). Effective coping can change a stressful event into a more manageable one. Similarly, Carver and Connor-Smith (2010) defined coping as efforts to prevent or diminish threat, harm, and loss or to reduce associated distress.

In the same way, according to Lazarus (1984) coping can be classified as being either problem focused or emotion-focused in nature. For instance, problem focused coping involves activities that focus on directly changing elements of the stressful situation or conflict. While emotion-focused coping involves activities that focus more on modifying one's internal reactions or activities that seek to regulate internal emotions and may include cognitive distraction, seeking emotional support, emotional expression and cognitive restructuring (Lazarus, 1984; Thabet and Vostanis, 2017). Most types of distress usually require a combination of the two type of coping, although generally, individuals tend to use problem-focused coping when they feel that they can

do something constructive to deal with the stress effectively. Emotion-focused coping is utilized when the person feels that the stress is unmanageable (Folkman and Lazarus 1985).

Different researchers used different terms in order to express coping styles to describe problem focused coping mechanism-“engagement” or “active” though terminologies such as “disengagement” or “avoidant/passive” coping styles have been used to describe emotional focus coping (Sandler, Tein, and West, 1994).A study conducted in Nigeria among IDPs showed that displaced respondents use different coping styles. Most of them (79.6%) used positive reinterpretation and growth style. This was closely followed by seeking social support which is utilized by 76.9% of the respondents. Acceptance and planning are utilized by 76.6% of the respondents each while focus/venting of emotion is utilized by 70.5% of the respondents. Also 70.2% of the respondents reported the use of active coping and mental disengagement each while 69.6% of the internally displaced persons reported behavioral disengagement as their coping style (Oginyi et al, 2007).

A similar study conducted in Nigeria IDP camp indicated that 63% reported overcoming displacement distress via prayer and religious rituals. While for 59% of women family ties was also another important strategy of coping with distress amongst displaced women. Other activities the respondents are engaged in to overcome the stress associated with displacement include group discussions amongst IDPs as well as recreational activities such as draught or cards games (Osasumwen et al, 2018).

On the contrary, denial and seeking social support are utilized by 66.3% and 64.4% of the respondents, respectively. Similarly, 60.8% of the respondents utilized restraint coping, 60.5% utilized turned to religion while another 59.9% make use of suppression of competing activities in coping with their traumatic experience. In general, displaced persons utilized both problem focused and emotional focused coping strategies in dealing with their traumatic experiences (Ajibade et al, 2017).

Generally, as literatures clearly identified psychological distress is a subjective and vague mental suffering state that expressed different symptoms. The most common symptoms are depression (e.g., lose of interest, sadness, hopelessness), anxiety (e.g., restlessness, feeling tense), and somatic symptoms e.g., insomnia, headaches, lack of energy (Gust et al. , 2017, Mirowsky and

Ross,2002, Kirmayer, 1989& Kleinman, 1991). Studies indicated internally displaced returnees are among those who are suffering from psychological distress due to risks of reclaiming land or receiving compensation for losses, loses of loved one, insecurity, lack of accessing services (education, health care, employment opportunities...), experiencing persistent flash backs and lack of enjoying full rights of citizenship (Weiss, 2011) on the contrary, people need to sustain life regardless of challenges and fight emotional sorrows by their own coping strategies adaptive/ maladaptive coping mechanism(Campos et al. 2004). Thus, these general concepts were the most instruments and guiding principles to design the method and carry out the study.

CHAPTER THREE

3. RESEARCH METHODS AND PROCEDURES

3.1. Study design

The study employed a cross-sectional survey design. The researcher collected quantitative data to address the research questions. Reliable and valid data collection instruments were administered in order to collect the data that would answer the research questions.

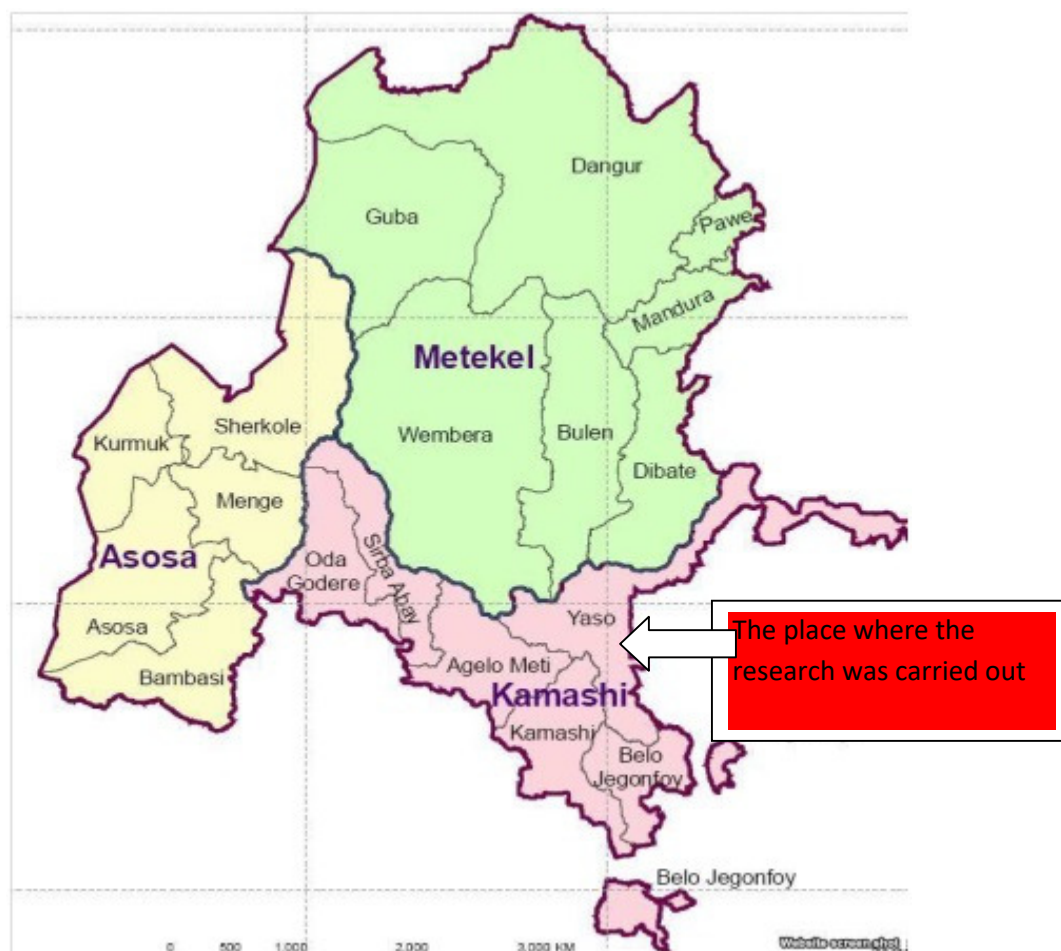
3.2. Description of the study area

Benishangul Gumuz Regional State (BGRS) is one of the Ten Federal States of Ethiopia located in the mid-western part of the country. Berta, Shinasha and Gumuz ethnic groups live in the region. Based on the information obtained from the 2007 Census conducted by the Central Statistical Agency of Ethiopia (CSA, 2007), the region consists of five indigenous ethnic groups: Berta, (26.7%), Gumuz (23.4%), Shinasha, (7.73%), Mao (0.6%) and Komo (0.2%).

Other ethnic groups also live in the region. These are Amhara (20.88%), Oromo (13.55%) and Agaw-Awi (4.22%). Accordingly, the main languages in the region include Berta (25.15%), Amharic (22.46%), Gumuz (20.59%), Oromo (17.69%), Shinasha (4.58%) and Awangi (4.01%). Regarding religion, 28.2% of the people follow Orthodox Christian, 51.3% are Muslim, 13.41% are Protestant, and 7.09% practiced traditional beliefs (CSA, 2007).

Kamashi Zone is one of the three zones in Benishangul Gumuz Regional State which is located 500km away from Addis Ababa and has a total population of 101,543, of whom 52,284 are men and 49,259 women (CSA, 2007). The four largest ethnic groups residing in the Kamashi Zone are Gumuz (60.56%), Oromo (24.61%), Amahara (11.11%), and Berta (2.83%); all the other ethnic groups made up 0.89% of the population. The main languages in the Zone include Gumuz (59.67%), Oromo (25.54%), Amharic (11.25%), and Berta (2.8%). The majority of the inhabitants are followers of Protestantism (56.24%), Ethiopian Orthodox Christianity (28.87%), Muslim (6.87%), traditional beliefs (6.06%) and Catholic (1.35%).

Kemashi Town is the capital of the zone and there are five districts in the Zone. Yaso district is one of the five districts. Please look at the below map for further understanding of the location of the district.



Concerning Yaso district the 2007 national census report indicated as all inhabitants were rural and a total population was 12,747(of whom 6,463 were men and 6,284 were women). The two largest ethnic groups in Yaso are Gumuz (86.2%), and Oromo (13.6%); all other ethnic groups made up 0.2% of the population. Gumuz is spoken as a first language by 86.5%, and Afan Oromo by 13.3%; the remaining 0.2% spoke all other languages. Regarding religion, the largest group of inhabitants follows traditional religion, with 48.3% of the population while 29.3% embraced Ethiopia Orthodox Christianity.

The conflict that has erupted in September 2018 in Kamashi zone and bordering Oromia resulted large-scale displacement , death and injury, loss of properties (such as houses, farmland), and damage to public infrastructure(such as health post, health center, schools, and training centers). Though most of the displaced people are Oromo, there are Amhara people too. Following the peace and reconciliation efforts among the three communities (Amhara, Oromo and Gumuz) which was mediated by elders, the process of returning IDPs to their place of origin started May 2019. Accordingly, among more than 52,000 were displaced and about 16,782 were returned, but the figures are a point of debate (IDMC, 2019 & AAH, 2019). However, information obtained from Disaster Prevention and Preparedness Bureau indicates that currently only 9232 returnees are registered and getting aid.

3.3 Population and sample

The source population for the study is internally displaced adult returnees currently residing in 8 localities of Yaso district. According to data obtained from the district office, there were 9,232 adults. They are currently residing in 8 localities. These are Ayani, Chikisha, Garba-Gudina, Gatira-Dami, Halo-Muka-Arba, KarsaDalati, Timijo-Meti, and Yaso.

The study participants were selected adults age ranged 18-60 years. The respondents' age were categorized in to four: 18-30, 31-40, 41-50 and 51-60 years. This was designed to select individuals who are able to respond to the questions in the questionnaires and to examine the association between traumatic experience and psychological distress by using confounding variables like age categories. The study population is those who were original residence in the Yaso district before displacing due to violence irrupted in 2018 in Kamashi Zone which resulted in mass displacement, death and property distraction. They are partially returned to their original residence in May 2019.

3.4. Sample size and sampling technique

The participants of the study were selected using proportionate stratified random sampling technique Yamane (1976). Yamane sample calculation is a way to determine the sample size for a study. It is the most ideal method to use when the only thing you know about the underlying population you are sampling from is its size (Zhang, 2017). Then the proportion for each locality

was determined after the total sampling size is estimated by using sample size calculation formula as indicated below.

$$n = N$$

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

Where n= corrected sample size,

N= population size (9232), and

e = margin of error (0.05)

Therefore n = 9232

$$1+9232 (0.05)^2$$

$$= 9232$$

$$24.08$$

$$= 382.$$

Based on the above calculation, the required sample size for the study was 382 people.

Table 1: Sample size from each locality

S/N	Name of the Kebele	Sample size for each Kebele	Remark
1	Ayani (9232)	48	Yaso district has 16 localities, but displacement has occurred in 8 localities. During data collection the returnees were not yet resided to their original localities, so the local government did not stratify the returnees based on their localities. The information obtained from Disaster Prevention and Preparedness Bureau showed that as returnees back to their original residences they just registered at district as returnee but living in bordering woreda, Haro-Limu (Oromia regional states). So getting population size of returnees on basis of their localities was not possible.
2	Chikisha	48	
3	Garba-Gudina	48	
4	Gatira-Dami	48	
5	Halo-Muka-Arba	48	
6	Karsa Dalati	48	
7	Timijo-Meti	47	
8	Yaso	47	
		382	

Returnees from each locality usually come to Yaso town, Disaster Prevention and Preparedness Bureau to get their monthly food aid. Each locality has its own designated date, though there is no exact data of returnees is there in each locality. Information found from the district shows that the pattern of the settlement was informal that mostly based on clans so from the beginning it was difficult to track out the exact population size of the localities. Consequently, as stated in the table above data collection technique was designed by using simple random sampling technique, from every locality every third person who is 18-60 age was picked as a respondent until the sample size for the locality is completed. Because of uneven distribution of the returnees different quota is allocated for the localities. Then systematic technique was chosen to obtain necessary data due to the situation of respondents explained so far. Furthermore, large size of returnees is still living in bordering region (Oromia) and few male returnees are living in Yaso by leaving back their children and wives together 10-15 people in one home. So the data collector team was decided to collect the data during aids distribution.

3.5. Data collection instruments

Questionnaire was used to collect data. The questionnaire had four parts. The first part consisted of questions which ask the socio-demographic characteristics of respondents. The second part assessed psychological distress, the third part traumatic events and the last part of the questionnaire assessed coping strategies. The socio-demographic variables assessed include sex, age, marital status, ethnicity, educational level, job status and monthly average income. Kessler Psychological Distress Scale (K10), posttraumatic stress disorder checklist (PCL-5), and Brief Cope-28 were used to measure psychological distress, traumatic experiences and coping strategies, respectively. The ten items of K-10 scale was administered to measure the level of psychological distress of the respondents. Whereas, PCL-5 which consisted of 20 items was administered to assess traumatic events and Brief Cope-28 was used to identify the coping strategies that the IDP returnees are using to cope up life after a year of displacement and losing families and properties.

According to Kessler and Mroczek (1994), K-10 scale measures non-specific psychological distress. The scale was developed by Ron Kessler and Dan Mroczek in 1992, as a short dimensional measure of non-specific psychological distress in the anxiety-depression spectrum,

for use in the United States National Health Interview Survey (US-NHIS) (Kessler and Mroczek, 1994). The scale consists of ten questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms that a person experienced in the last four weeks prior to interview. It contains low through to high threshold items. For each item there is a five-level response scale based on the amount of time the respondent reports experiencing the particular problem. These five response options are: none of the time, a little of the time, some of the time, most of the time and all of the time (Kessler and Mroczek, 1994).

Each item is scored from one 'none of the time' to five 'all of the time'. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress. Consequently the interpretation of scores and the cut-off scores of the instrument would be 10 - 19 likely to be well, from 20 - 24 likely to have a mild disorder from 25 - 29 likely to have a moderate disorder from 30 - 50 likely to have a severe disorder (Victorian Population Health Survey, 2001). It is easy to administer and takes around 8 minutes to complete.

It has been investigated and confirmed that K-10 scale has excellent internal consistency reliability, Cronbach's alpha of 0.93 in Ethiopia (Mousleya, et al, 2014.) The study was conducted in sample size of 349 to assess the mental distress of patients who were attending in Dembecha hospital, Gojjam. Also the Amharic translated version has previously been validated in Ethiopia for assessing depression by comparing results with psychiatric assessment. It has a sensitivity of 84.2% and specificity of 77.8% and used in relation to postnatal depression, depression in HIV, mental distress and podoconiosis and TB, and common mental disorders (Sofia et al, 2018).

Posttraumatic stress checklist s (PTSD Checklist (PCL) – 5, is a 20-item self-report measure that evaluates the degree to which an individual has been bothered in the past month by DSM–5 PTSD symptoms tied to his or her most currently distressing event (Weathers et al., 2013). Items are rated from 0 (not at all) to 4 (extremely) and are summed for a total severity score and took 15-20 minutes to fill out. The PCL-5 can be used to quantify and monitor symptoms over time,

to screen individuals for PTSD (Bovin et al., 2015). The instrument is a psychometrically sound measure of DSM-5 PTSD and valid and reliable that tremendous researches are internationally using (Blevins, 2015)

The researcher could not find valid instruments that can measure traumatic symptoms in Ethiopia. Instead, PCL-5 instrument was administered. PCL-5 scale is a valid instrument designed to investigate PTSD. Thus the instrument was administered to the association between traumatic events and psychological distress. Similarly there were studies conducted in Ethiopia by using the instrument for different (Elhai et al., 2018; Shimelis et al., 2015).

Regarding to Brief COPE -28, several internationally valid and reliable self-report measures of coping are currently available. However, the common drawback of these scales is their relatively extended length, ranging from 48 to 66 items (Monzani et al, 2015). As a result, researchers went forward to minimize the scale as manageable as possible and developed Brief COPE-28 scale.

Brief COPE -28 was developed by Charles S. Carver at the University of Miami which is one of the most commonly used coping measures and has been cited by more than 900 articles as of August 2011 (Carver, 1997; Fasil, 2018). The instrument is abridged version that consists of 14 theoretically derived models of coping responses from 28 items. These are: Self-distraction (from items, 1&19), Active coping (2&7), Denial (3&8), Substance use (3&21), Use of emotional support (5&15), Use of instrumental support (10&23), Behavioral disengagement (6&16), Venting (9&21), Positive reframing (12&17), Planning (14&25), Humor (8&18), Acceptance (20&24), Religion (22&27), and Self-blame (13&26) (Monzani, 2015). The scale was administered in about 20-25 minutes. Moreover, the Brief-COPE is a 28 item self-report questionnaire designed to measure effective and ineffective ways to cope with a stressful life event. The study conducted in Ambo and Rift Valley Universities found Cronbach's alpha reliability of 0.901.

Finally, Brief –COPE-28 and PCL-5 instruments (as translated K-10 instrument was obtained) were translated into local language, Amharic which is the working language of the region and the area too. Though larger people of the study area are speaking Afan Oromo, they cannot read and understand the Latin letter so all instruments were translated in to Amharic alone. Rigorous

forward and backward translation was done by two bilingual professionals. Procedurally, English version was first translated in to Amharic language then translated back to English. Two professionals were participated fully in both back and forward translation independently.

Finally a senior lecturer at Jimma University was asked to review on any item that found unclear or difficult to understand. The queries did not reveal any major changes that needed to be made to any of the items. The items of all the completed instruments were evaluated for wording and phrasing as well as for reliabilities to ensure that the resettled questionnaires were suitable for use in the main study. As a result, based on the comments and reviewing of the experts few changes were made in wording of four Amharic versions of traumatic symptoms inventory and three coping mechanism items.

3.6. Data collection procedures

Data collection was begun by approaching the local government personally and described the objective and procedure of the study. After permission was obtained from the local government, study participants were approached accordingly. All the necessary data from the sample were collected by using structured and self-report questionnaires. Assurances were also there for field observation in which challenges and general situations related to the topic was assessed. Then four (2 male and 2 female) data collectors were selected based on three issues: who have college degree, fluent speaker of both Amharic and Afan Oromo and who are familiar with the areas/localities. Data was collected in Amharic language alone. Before data being collected short-term that took more than three hours training was given to data collectors in order to familiarize them with the data collection tools and about the objectives and nature of the study. Then the data collectors were assigned to collect the data at 8 localities (though all of data were collected at the relief center where the returnees receive their monthly aid at Yaso district). The returnees have a monthly schedule to collect their food and non-items. So the data collectors were there to collect the data.

As most of the respondents are farmers and illiterates, the data collectors were assisted them in reading and filling out the questionnaires. Most of the respondents are Afan Oromo speakers

who can understand neither Gumuz (local language) nor Amharic language (the working language of the region). Also they cannot read Latin letter in which Afan Oromo language is using for writing. Therefore, all scales are prepared in Amharic language and the data collectors were helped most of participants in translation during data collection.

The current study conducted pilot study aimed to solve ambiguity (clarity, language and structure problems), and to check the reliability, particularly internal consistency of instruments. Accordingly, all questionnaires were administered to 30 returnees in same study area but different people from the study participants. The reliability estimates were performed to evaluate the homogeneity of sets of items from the same test (internal consistency) by utilizing cronbach's alpha test, which suggested being the most widely used methods for estimating internal consistency of instruments. The reliability analysis of measurement scale revealed that reliability coefficients of psychological distress measure (k10) was ($\alpha = .71$) and for brief cope, ($\alpha = .72$) and measures of trauma (ss ($\alpha = .86$)). The reliability analysis of measurement instruments indicates that the reliability statistics of all study variables were found to be within acceptable range of good reliability coefficients of internal consistency (cronbachs's alphas, above 0.63) of measurement items. Face validity of the tests were also checked from the pilot test and modification were made following the result.

3.7. Methods of data analysis

Three hundred and eighty-two (382) questionnaires were distributed to the study participants and out of 382 copies of questionnaire all were returned; however 4 questionnaires (3 female and 1 male) were discarded due to incompleteness. Therefore the remaining 378 copies were used for statistical analysis. And all data analyses were performed by using statistical software package for social science (SPSS) version 20. This study utilized both descriptive and inferential statistics.

3.7.1 Descriptive statistics

Descriptive statistics like mean, standard deviation frequency and percentage were computed to summarize the socio-demographic characteristics, level of psychological distress and coping strategies used by returnees.

3.7.2 Correlation and Regression Analysis

On top of the descriptive summary, Pearson correlation and linear regression model were run to see the bivariate and multivariable association between the independent (traumatic experiences) and dependent variables (psychological distress). Before conducting person correlation and linear regression model, the data set were tested for the basic assumption of linear regression analysis. Accordingly, the data were checked for normality, skewness and kurtosis using histograms. Where there were significant outliers found, such items dropped from the analysis and the data rechecked again for the normality and then both bivariate and multivariable linear regression model were run. Furthermore, linear regression model assumed that the relationship between each explanatory variables and outcome variables measured at interval /ratio level is linear and the variance of residuals is constant at each point of explanatory variables. Multicollinearity between the independent variables were also checked and no multicollinearity was found. After checking all these assumptions, first Pearson correlation and crude linear regression model (only the primary independent and outcome variable within the model) were computed. Then to test the independent link between the primary independent and dependent variable, multivariable linear comprising all other variables in a single regression model was conducted. All the association results were presented at 95% level of significance with their respective confidence intervals.

3.8. Ethical considerations

Ethical clearance was requested from Addis Ababa University, School of Psychology, but due to COVID-19 pandemic personal contact was restricted to maintain social distance. So the School was closed and obtaining ethical clearance was not possible at that time. This is really historic unfortunate event. Instead the researcher requested permission from local government in Yaso district and community elders (for they were acting as peacekeepers in the area to ensure stability) to collect data. As the permission was obtained, data collectors were trained on issues of ethics and confidentiality. Similarly, participants were requested to give oral consent to participate in the study and only those who give consent were included in the study. The privacy and confidentiality of the respondents was maintained.

CHAPTER FOUR

4. RESULTS OF THE STUDY

This section presents finding of the research, demographic background of participants (sex, age, marital status, educational level, religious background, ethnicity and income), the prevalence of psychological distress, traumatic experiences and symptoms prevalence, the association between traumatic experiences and psychological distress and coping mechanism of the respondents.

4.1. Socio-demographic characteristics of participants

Demographic variables	Category	Frequency	Percent
Sex	Male	213	56.3
	Female	165	43.6
Age	18-40	230	60.8
	41-60	148	39.3
Marital status	Married	229	60.6
	Single and others	149	39.4
Education status	Illiterate	164	43.4
	Literate	214	56.6
Ethnicity	Amahara	63	16.7
	Oromo	262	69.3
	Shinasha and others	53	13.9
Religion	Orthodox	111	29.4
	Protestant and others	267	70.6
Employment status	Employed	107	28.3
	Self employed	189	50
	Unemployed	82	21.7
Average monthly income	None	65	17.2
	1001 and above	313	82.8

Table 2 presents the socio-demographic characteristics of the respondents. A total of 378 internally displaced returnees participated in the study. From the total respondents, 213(56.3%) of them were male whereas 165(43.6%) were female. 107(28.3%) of the respondents age was between 18-30 years, 123(32.5%) 31-40 years, 81(21.2%) 41-50 years and 67(17.7%) 51-60 years. Regarding marital status, 229(60.6%) were married, 132 (34.9%) single, 3(1.1%) divorced and 14(5%) widowed. Most of the respondents were illiterate (43.4%); 21.4% completed primary school, 15.6% secondary completed and 19.6% had college diploma/degree.

Concerning ethnicity, 63(16.7%) of them were Amahara, 262(69.3%) Oromo, 27 (7.1%) a Shinasha and 26 (6.8%) other ethnic groups. Regarding religious affiliation, 111(29.4%) of them were Orthodox followers, 230(60.8%) belonged to Protestant and 4.0% were Catholic. Most of the respondents were self-employed (28.3%), 50% of them were employed and 21.7% unemployed in terms of employment status. 24.3% of the respondents earned 1501-2000birr average monthly income, 15.8% 2501-3000birr and 17.5% of them earned nothing.

4.2. The prevalence of psychological distress

The prevalence psychological distress was examined by using the cut-off scores of the instrument that would be 10 - 19 likely to be well, from 20 - 24 likely to have a mild disorder from 25 - 29 likely to have a moderate disorder from 30 – 50.

Table 3: The respondents' level of psychological distress

Level of psychological distress	Freq.	Percent
Low distress	160	42.3
Moderate distress	118	31.2
High distress	49	12.9
Very high/sever distress	51	13.5
Total	378	100

As it is indicated in Table 3 above, 42.3% of the respondents had low distress level, 31.2% moderate distress level, 12.9% high distress level and 13.5% very high/sever distress level. Kessler (2002) suggests cut off scores estimation of psychological distress level is 10 to 15 points “low distress”, 16 to 21 points “moderate”, 22 to 29 points “high” and 30 to 50 points “very high”. The prevalence for psychological distress cut point is “high” Kessler (2002). Therefore, the study indicated the overall prevalence of psychological distress of the respondents found to be 100 (26.4%).

4.3. Traumatic experiences and symptoms prevalence

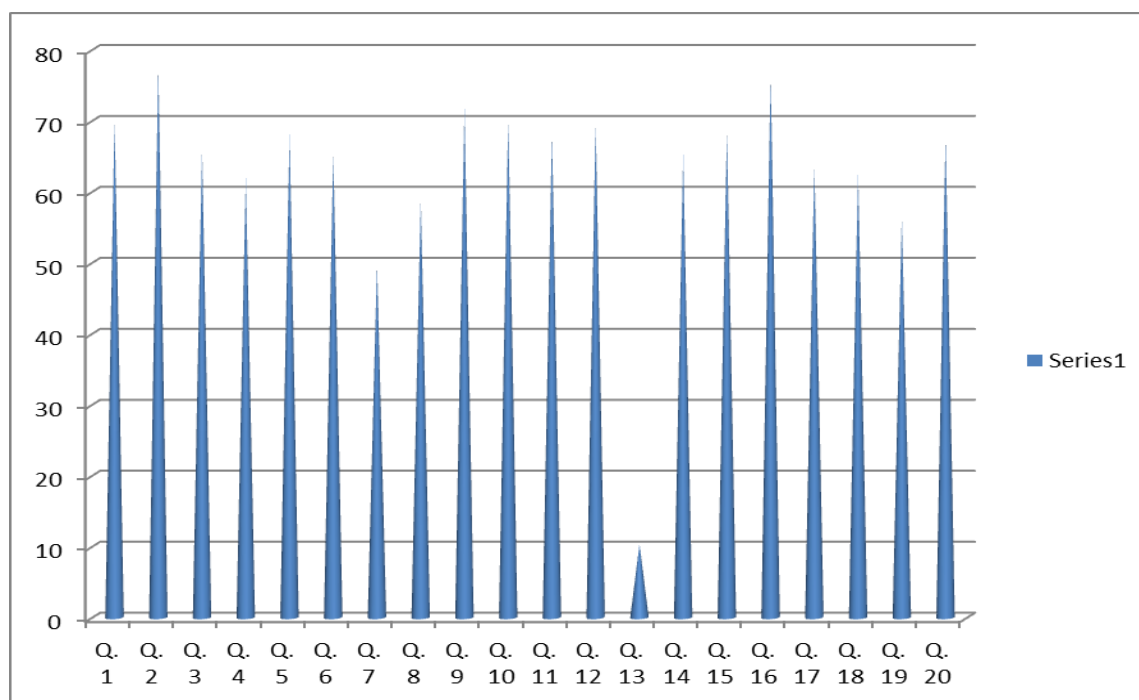


Chart 1: The distribution of traumatic symptoms and experiences in percentile

As indicated in chart 1 respondents reported high level of traumatic experiences and symptoms. Some traumatic experiences were relatively reported as common experience. For instance, repeated disturbing dreams of the stressful experience (Q. 2) 294 (77.7%), being “super alert” or watchful or on guard (Q. 16) 271(76.3%), feeling distant or cut off from other people (Q.9) 267(70.6%) and repeated, disturbing, and unwanted memories of the stressful experience (Q.10) 265(70.1%) were some of the common experiences that reported respectively from Moderately to Extremely scale.

While trouble remembering important parts of the stressful experience(Q.7) 188 (49.7%), having strong negative beliefs about self, other people, or the world(Q.8) 223(58%) and feeling very upset when something reminded the stressful experience(Q.18) 234 (62%) were relatively less experiencing or common report.

4.4. Association between trauma and psychological distress

The analysis was conducted by using crude and adjusted. As crude is the bivariate coefficient between independent and dependent variable while adjusted is the coefficient after other variables kept constant in the model. Both in the crude $\beta=0.42$ CI(0.35, 0.48) $P<0.001$ and after controlling for confounder variables like , sex, age, marital status, education, occupation, monthly income and coping mechanism, traumatic experiences found significantly associated in the full model adjusted model(with all explanatory variables and outcome variables) $\beta=0.45$ CI(0.37, 0.53) $p<0.001$ models with psychological distress. The association between trauma and psychological distress was significant both in the crude and adjusted model indicating that a unit change in the independent (trauma) variable leads to 0.45 times change in the dependent (psychological distress) variable in turn. Other variables, like marital status (divorced) $\beta=3.64$, (1.94, 5.33) $p<0.00$, older age group 51-60 years $\beta=6.55$ (4.01, 9.10) and elementary $\beta=6.61$ (4.20,9.01) $p<0.001$ and secondary level of education was found positively linked with psychological distress. Moreover, unemployment and self-employment were significantly and positively associated in crude model in $\beta= 6.82$ CI (4.87, 8.77) $p<0.001$ and $\beta= 5.82$ CI (3.28, 8.36) $p<0.001$ with distress respectively.

Whereas, in educational status college/university students were significantly and positively associated in the crude model $\beta=6.82$ CI (4.87, 8.77) $p<0.001$. Furthermore, variables indicate monthly income 2001-2500come and 3001 and above were significantly and negatively associated in crude model with $\beta=-11.01$ CI (-14.21, -7.78) $p<0.001$ and $\beta=-5.14$ CI (-8.18, -2.10) $p=0.001$ with distress respectively. Adaptive component of coping strategy $\beta=-0.20$ CI (-0.37,-0.03) $p=0.022$ was found negatively and significantly related with psychological distress.

Table 5: Association between trauma and psychological distress

Independent variables	Dependent variable Distress (k10 total score) (N=378)			
		β coefficient (95% Confidence Interval), P value		
Primary independent		Crude	Adjusted	
	Trauma (PCL -5 total score)	0.42 (0.35, 0.48) P<0.001 **	0.45 (0.37, 0.53) p<0.001 **	
Confounding variables (Variables that potentially can have a link with both psychological distress and trauma)	Sex	female	0.44 (-1.38, 2.25) P=0.637	-1.71(-3.18,-0.25) P=.022
	Age	15-30 years (reference)	1	1
		Age (31-40)	2.53 (0.26, 4.79), P=0.029	272.(0.74,4.71) P=0.007
		Age (41-50)	-2.09 (-4.34, 0.16) p=0.069	1.56 (-0.58, 3.70) p=0.153
		Age (51-60)	4.23 (1.53, 6.94) p=0.002	6.55(4.01, 9.10) p<0.001**
	Marriage	Married Reference	1	1
		Divorced,	2.58 (0.72, 4.44) p=0.007	3.64,(1.94,5.33) p<0.001**
		Single,	0.32 (-8.28, 8.91) p=0.942	-2.34 (-8.16, 3.48) p=0.429
		widowed	1.32 (-2.79, 5.43) p=0.529	-0.88 (-3.72, 1.97) p=0.544
	Education	illiterate,	1	1
		elementary	3.19 (1.22, 5.17) p=0.002	.661 (4.20,9.01) p<0.001**
		Secondary	-0.34 (-2.73, 2.04) p=0.778	3.39 (1.25, 5.53) p=0.002
		College/university	-9.64(-11.71,-7.56) p<0.001**	0.64 (-2.34, 3.63) p=0.670
	occupation	employed	1	1
		Unemployed,	6.82 (4.87, 8.77) p<0.001**	3.54 (0.94, 6.15) p=0.008
		private 3	5.82(3.28,8.36) p<0.001**	0.03 (-3.51, 3.56) p=0.989
	Income	1000-1500, reference.	1	1
		1501-2000	-1.76 (-4.54, 1.02) p=0.212	0.72 (-2.21, 3.66) p=0.628
		2001-2500	-0.12 (-2.56, 2.34) p=0.931	-1.60 (-4.74, 1.53) p=0.315
		2001-2500	-11.01(-14.21,-7.78) p<0.001**	-4.87 (-8.65, -1.10) p=0.012
		2501-3000	0.22 (-2.46, 2.92) p=0.868	1.15 (-2.30, 4.59) p=0.514
		3001 and above	-5.14 (-8.18, -2.10) p=0.001	-0.27 (-4.03, 3.48) p=0.885
	Coping (total score)	Adaptive coping	-0.23 (-0.44,-0.03) p=0.027*	-0.20(-0.37,-0.03) p=0.022*
Maladaptive coping		-0.17 (-0.38, 0.04) p=0.107	-0.03 (-0.21, 0.15) p=0.755	

**Significant at 0.01 * significant at 0.05

4.5. Types of coping strategies commonly used by respondents

Table 6: Types of Commonly used coping strategies

Coping strategy	Mean	Std. Dev.	Min	Max
Adaptive coping Style				
Active coping	4.359	1.118	2	8
Instrumental Support	4.529	1.364	2	8
Planning	4.266	1.397	2	8
Acceptance	4.068	1.393	2	8
Emotional Support	4.511	1.084	2	7
Humor	3.583	1.120	2	7
Positive Reframing	3.921	1.481	2	8
Religion	5.594	1.453	2	8
	\			
Maladaptive coping style				
Behavioral disengagement	4.198	1.280	2	7
Denial	4.820	1.638	2	8
Self-distraction	4.046	1.184	1	7
Self-blame	4.004	1.374	2	7
Substance use	3.871	1.152	2	6
Venting	3.734	1.162	2	7

As shown in Table 6 above, two items are aggregated and 14 types of coping subscales/strategies were derived out of 28 specific coping strategies. These 14 types of coping categories are grouped into maladaptive and adaptive coping strategy. The most frequently used adaptive coping mechanisms were found to be religion ($M=5.59$, $SD=1.453$) and instrumental support ($M=4.53$, $SD=1.36$). In addition, emotional support ($M=4.51$, $SD=1.08$), active coping ($M=4.36$, $SD=1.12$), planning ($M=4.27$, $SD=1.39$), positive reframing ($M=3.92$, $SD=1.5$), acceptance

($M=4.10$, $SD=1.39$) and humor ($M=3.58$, $SD=1.12$) were moderately used. On the other hand, the least commonly used adaptive coping styles were humor.

The most commonly used maladaptive coping mechanisms were denial ($M=4.82$, $SD=1.64$) and behavioral disengagement ($M=4.20$, $SD=1.28$). Self-distraction ($M=4.05$, $SD=1.18$), self-blame ($M=4.00$, $SD=1.37$), substance use ($M=3.87$, $SD=1.15$) and venting ($M=3.73$, $SD=1.26$) were also moderately used coping mechanisms.

CHAPTER FIVE

5. DISCUSSION

This study was designed to assess the prevalence of psychological distress, the association of traumatic experiences and psychological distress and coping mechanisms among internally displaced returnees in Yaso district, Benishangul Gumzu regional state. In this chapter the findings of the study are discussed and interpreted in line with the previous research and the socio-cultural context of the study area. The chapter is organized in to sections based on the research questions and the major findings of the study.

5.1. The prevalence of psychological distress among internally displaced returnees

Overall, 100 (26.4%) of the participants were found to experience psychological distress. Hence, the prevalence of psychological distress is found to be 57.6%. This is consistent with the study conducted in Nigeria among internally displaced people at 3 camps. The study found that 70% of the participants had general psychological distress and 53% PTSD (Oginyi, 2017). The study reported common distress symptoms which included somatization, obsession-compulsion, interpersonal sensitivity; depression, anxiety, phobic anxiety, hostility paranoid ideation, psycholicism and neuroticism. A study conducted in Africa found that the prevalence of mental health problems particularly post-traumatic stress disorder was 54%) and general psychological distress 56% for adult (Owoaje et al, 2016).

On the other hand, a study conducted in Sri Lanka among conflict affected displaced returnees found that 8.8% of the participants had psychological distress (Siriwardhana, 2015) which is much smaller than found in other studies. However, it would be difficult to compare the current study with the result found in Siri Lanka. The returnees in Siri Lanka have returned to their original residence after three decades while Yaso returnees have returned after only one year displacement. Secondly, the area is very fragile where security issues are not yet ensured. Thus, the respondents of this study may not forget the conflict incidences and their consequences rather they experience fresh emotional wound. On the contrary, the Sri Lanka returnees either adapt the situation or develop skills to cope up the situation.

Several studies showed that IDPs are highly exposed to psychological distress symptoms like violence, depression, anxiety, nightmare and daily stressors, when compared to returnees and non-displaced peers (Cao et al., 2012; Oginyiet et al., 2017). Other studies indicated that returnees experience psychological distress more than IDPs and non-displaced persons due to various reasons. Particularly, returnees may face difficulty to re-establish their lives after protracted displacement. They may continue to face difficulties in meeting their needs in terms of work, food, shelter and healthcare, and they may also suffer from discrimination (GRID, 2019).

A survey conducted in Kamashi zone (where Yaso district is located) revealed that returnees are experiencing mental health problems due to lack of resources like economic, food and other social services. Poor living conditions, uncertainties about the future, feeling of insecurity, and experiencing persistent flashbacks, sleep disturbances, anxiety, resentment and nightmares are important challenges of the returnees. Returnees reported that they are still in grieving due to the loss of their husband, son, daughter and other family members (AAH, 2019). Hence, psychological distress among returnees is expected to be high. Similarly, WHO estimated that in situations of armed conflict and other emergencies like displacements, the proportion of the population suffering from mild or moderate mental disorders rises from 10% to 15-20% (Amnesty International, 2015).

5.2 The association between trauma and psychological distress

The study found statistically significant association between trauma and psychological distress both in the crude and adjusted models. The association between trauma and psychological distress was significant both in the crude and adjusted model indicating that a unit change in the independent (trauma) variable leads to 0.45 times change in the mean of the dependent (psychological distress) variable in turn. This is consistent with previous study conducted on Undocumented Mexican Immigrants and found significant association of traumatic experience and psychological distress, $\chi^2(12, N = 248) = 51.38, p < .001$ (Garcini, et al, 2017). In the adjusted model variables like sex -2.67(-4.23,-1.11), $P=.001$ and marital status 1.76, (0.75, 2.78) $P=0.001$ were positively and significantly associated with distress, while coping strategies -0.15

(-0.25, -0.04) $p=0.005$ was found significantly and negatively associated with psychological distress. Marital status, 3.64,(1.94, 5.33) $p<0.001$, age 6.55(4.01, 9.10) $p=0. p<0.001$, educational status 6.61 (4.20, 9.01) $p<0.001$ and income 5.82 (3.28, 8.36) $p<0.001$ were positively and significantly associated with distress with.

The previous research carried out in Baghdad IDPs indicated that significant relationship psychological distress with demographic variables like age group, education and occupation at p -value ≤ 0.05 . While, there is high significant relationship regarding psychological distress with level of education and monthly income at p -value ≤ 0.001 . Unlike result found in this in marriage, 3.64,(1.94,5.33) $p<0.001$ no significant relationship is seen (Hussein et al,2018).

5.3 Coping mechanisms among returnees of internal displacement

As indicated in table 7, coping strategy was classified in to adaptive and maladaptive mechanism. Accordingly, under adaptive/effective coping mechanism there are some subscales/variables were administered and found to be amalgamated and religion (M=5.59, SD=1.453) and instrumental support (M=4.53, SD=1.36) were the most repeatedly reported respectively. Whereas the most frequently subscale under maladaptive coping mechanism were denial (M=4.82, SD=1.64) and behavioral disengagement (M=4.20, SD=1.28). As the result has indicated adaptive coping style is high (M=34.83, SD=4.313), when compared to maladaptive style (M=24.67, SD=4.221).

The result, consistent with the study conducted in Nigeria IDP camp indicated 63% reported overcoming displacement distress via prayer and religious rituals. While of 59% of them reported family ties was also another important strategy of coping with distress amongst displaced women (Osasumwen et al, 2018).

However, the result is inconsistent with study conducted in Georgia IDPs' coping mechanism and reporting high behavioral disengagement, self-destruction and substance use respectively (Saxonet *al.*2016). Additionally, the finding of Amnesty International (2016) which was carried out among South Sudan forced displaced persons indicated that displaced persons used behavioral disengagement, substance use and denial as coping mechanisms than adaptive than. The study of Amnesty International report showed that coping mechanisms of the respondents

differed on the basis of age, gender and education status. Accordingly, females use social and spiritual coping styles more than males. On the contrary, males use substance and practice behavioral disengagement (Amnesty International, 2016).

CHAPTER SIX

6. SUMMARY, CONCLUSION AND RECOMMENDATION

6.1. Summary

Various literatures indicated that internally displaced returnees are highly exposed to psychological distress as well as PTSD. Therefore, this paper critically reviewed different previous relevant studies respective to the objective of the study and examined the objectives with selected scientific scales.

Descriptive design was implemented and standardized and highly validated instruments, Kessler-10, Post traumatic stress-Checklist 5(PCL-5) and Brief Coping-28 was administered to collect data. In this study a purposive sample of 382 participants drawn from various 8 localities. The quantifiable data was analyzed using Statistical Package for Social Science (SPSS) version 20, with statistical tools including descriptive statistics, regression and Pearson correlation.

The prevalence of psychological distress result was indicated that out of the total of 378 respondents, 100 (26.4%) returnees were experiencing psychologically distress ranging from high to sever level. In addition, the association between trauma and psychological distress was significant both in the crude and adjusted model indicating that a unit change in the independent (trauma) variable leads to 0.45 times change in the dependent (psychological distress) variable in turn. In the adjusted model variables like sex and marital status were positively and significantly associated with distress. However, the significant association between education, income and age with psychological distress in the crude has gone in the adjusted model. On the other hand adaptive domain of coping strategy negatively associated with distress.

With regard to the coping mechanism, the most frequently used adaptive coping mechanism by the conflict-induced displaced returnees were religion and instrumental support respectively. In addition, emotional support, active coping, planning, positive reframing, homer and acceptance were also repeatedly reported as adaptive coping mechanisms by the returnees in order to overcome their circumstances. Concurrently, the most frequently used maladaptive coping mechanisms by the returnees were denial and behavioral disengagement. Along with this, self-

distraction, self-blame, substance use and venting, were highly reported maladaptive coping mechanism by returnees respectively

6.2 Conclusions

On the basis of the findings of this study the following conclusions have been reached.

The result of this study showed the high prevalence of psychological distress (57.6%) among internally displaced returnees. The study also indicated the significant association between psychological distress and traumatic events. The coping mechanism of the respondents was also the focusing of the study. Thus, the study found religion and instrumental support were the most used as adaptive coping mechanisms while denial and behavioral disengagement were identified as maladaptive coping mechanisms of the returnees that using to overcome their situations.

Beyond the finding obtained in the study, the researcher observed that respondents were in distressful situations. There are a lot of people who lost their family in horrible way and physically seen while slaughtered like an animal or brunt like wood. During the data gathering, the researcher observed 5 women who displayed mental health problems. These women were roaming in the Yaso town/woreda. The researcher asked the local people and was informed that these women lost their all family members in the ethnic violence and they were the only survivors in their families. One of the women was calling unceasingly the names of her children who were murdered in the attack.

As stated in chapter three, the returnees are afraid to continue living in their former houses and villages. Those who “attacked/perpetrators” were still not brought to justice; they walk freely. Some of those who committed the crime are using the properties of the displaced people. Moreover, living in an area where their family members are murdered is putting them in a sever state of mental problems. And some locals are coming and threatening them. So those who have returned are living in groups to protect themselves. Therefore, the researcher assumes that the prevalence of the psychological distress of the respondents would be beyond the result obtained in the study.

6.3 Recommendations

In the following the researcher has forwarded major recommendations to the concerned bodies in order to properly address the mental health of conflict affected displaced returnees.

- Mental health is recognized as a key public health issue for conflict-affected returnees so that all concerned governmental, non-governmental organizations and civil society shall know and address the need of these people appropriately so that it would possible to minimize the prevalence of psychological distress and ensure rehabilitation issue.
- Health policy makers and psychology professional associations have to work on the essentiality of psychological aids to IDPs and returnees' mental health and well-being.
- Tailored trainings and follow up activities shall be considered to ventilate the affected emotion of the returnees.
- Community-based and faith-based organizations and other nongovernmental organizations and governmental agencies shall work on the mental affected returnees to minimize the maladaptive coping strategies like denial and behavioral disengagement that mostly reported in the research.
- Finally, further studies in lager sample size have to be done on forced internally displaced returnees mental health and coping mechanisms. Also studies should be done on possible psychosocial intervention.

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APPENDICES

Appendix A: Socio-demographic characteristics of participants

Demographic variables	Category	Frequency	Percent
Sex	Male	213	56.3
	Female	165	43.6
Age	18-30	107	28.3
	31-40	123	32.5
	41-50	81	21.2
	51-60	67	17.7
Marital status	Married	229	60.6
	Single	132	34.9
	Divorced	3	1.1
	Widowed	14	5.0
Education status	Illiterate	164	43.4
	Primary	81	21.4
	Secondary	59	15.6
	College/University	74	19.6
Ethnicity	Amahara	63	16.7
	Oromo	262	69.3
	Shinasha	27	7.1
	Others	26	6.8
Religion	Orthodox	111	29.4
	Protestant	230	60.8
	Islam	36	9.5
	Catholic	1	.26
Employment status	Employed	107	28.3
	Self employed	189	50
	Unemployed	82	21.7
Average monthly income	None	65	17.2
	1001-1500	60	15.8
	1501-2000birr	92	24.3
	2001-2500	47	12.4
	2501-3000birr	66	17.5
	3001-and above	48	12.7

Appendix B: The distribution of traumatic symptoms and experiences in percentile

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
Repeated, disturbing, and unwanted memories of the stressful experience?	51(13.5%)	62(16.4%)	145(38.3%)	92(24.3%)	28(7.4%)
Repeated, disturbing dreams of the stressful experience?	38(10%)	46(12.2%)	97(25.6%)	125(33.1%)	72(19%)
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	50(13.2%)	79(21%)	123(32.5%)	100(26.4%)	26(6.9%)
Feeling very upset when something reminded you of the stressful experience?	52(13.7%)	92(24.3%)	141(37.3%)	64(16.9%)	29(7.7%)
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	30(8%)	90(23.8%)	124(32.8%)	107(28.3%)	27(7.1%)
Avoiding memories, thoughts, or feelings related to the stressful experience?	44(11.6%)	83(22%)	101(26.7%)	122(32.3%)	28(7.4)%
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	42(11.1%)	89(23.5 %)	113(30 %)	103(27.2%)	31(8.2 %)
Trouble remembering important parts of the stressful experience?	54(14.3%)	136(36%)	80(21.2%)	104(27.5%)	4(1%)
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	50(13.2%)	105(28.%)	140(37%)	52(13.7%)	31(8.1%)
Blaming yourself or	55(14.5%)	79(21%)	97(25.9 %)	115(30.4%)	32(8.4%)

someone else for the stressful experience or what happened after it?					
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	52(13.7%)	88(23.2%)	93(24.6 %)	118(31.2%)	27(7.1%)
Loss of interest in activities that you used to enjoy?	23(6.1 %)	84(22.2 %)	115(30.4 %)	127(33.6 %)	29(7.7%)
Feeling distant or cut off from other people?	46(12.2%)	65(17.2 %)	138(36.%)	90(23.8 %)	39(10.3%)
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	45(11.9%)	75(19.8 %)	125(33.0 %)	102(27 %)	31(8.2 %)
Irritable behavior, angry outbursts, or acting aggressively?	44(11.6 %)	71(18.7 %)	89(23.5 %)	138(36.5 %)	36(9.5 %)
Taking too many risks or doing things that could cause you harm?	47(12.4 %)	85(22.4 %)	129(34.1%)	98(26.1 %)	19(5 %)
Being “super alert” or watchful or on guard?	51(13.4 %)	78(20.6%)	123(32.5%)	95(25.1 %)	31(8.2%)
Feeling jumpy or easily startled?	48(12.7 %)	66(17.5 %)	132(41.5 %)	106(28 %)	26(6.8 %)
Having difficulty concentrating?	51(13.5%)	87(23 %)	131(34.7%)	95(25.2 %)	14(3.7 %)
Trouble falling or staying asleep?	58(15.3 %)	64(17.0 %)	132(35%)	95(25.1%)	29(7.7 %)

APPENDIX C: ENGLISH VERSION QUESTIONNAIRE

GENERAL INFORMATION

This questionnaire is designed to determine the prevalence of psychological distresses, to investigate the association between socio-demographic characteristics and experience of trauma with psychological distress and coping mechanisms among internally displaced returnees in Yaso District. The instrument has four sections. Section one is about the demographic variables concerning participants. In the second section, Kessler 10 (K10) test will be used to determine the prevalence of psychological distress of the returnees. In the third section, PTSD Checklist (PCL) - 5 will be administered to investigate the prevalence of PTSD experience. Finally, Brief Cope-28 is employed to assess the most commonly used coping mechanisms. As a result, you are kindly requested to give your truthful responses to each item of the questionnaire. Hence, your answers will be kept confidentially and would be used only for research purpose. To maintain anonymity, you are not required to write your name. The instrument will take 50-60minutes to fill out accordingly.

Thank you Very Much for your cooperation!!

By: Mekonnen Gameda

Background Information

Instruction: below is a list of questions which checks participants' demographic characteristics, please read each one carefully and respond the right answer which represents you. Put () symbol for questions with box choice.

1. Sex M F
2. Age 15-30 31-40 41-50 51-60
3. Marital status married Divorced
 Single Widowed
4. Educational status
 Illiterate
 Elementary school
 Secondary school
 College/ university
5. Ethnicity
 Amhara
 Oromo
 Benishangul
 Shinasha
 Others

6. Religion

 Orthodox Protestant Muslim Catholic Other7. Employment situation Employed Unemployed

8. Average household monthly income in birr

 From 1000-1500 1501-2000 2001-2500 2501-3000 3000 and above

Psychological Distress Scale (Kessler 10)

These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been.

1. During the last 30 days, about how often did you feel tired out for no good reason?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
2. During the last 30 days, about how often did you feel nervous?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
4. During the last 30 days, about how often did you feel hopeless?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
5. During the last 30 days, about how often did you feel restless or fidgety?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
6. During the last 30 days, about how often did you feel so restless you could not sit still?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
7. During the last 30 days, about how often did you feel depressed?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
8. During the last 30 days, about how often did you feel that everything was an effort?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time
10. During the last 30 days, about how often did you feel worthless?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

Kessler 10 Scale

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Sr.no	In the past month, how much were you bothered by:	Not at all	A little	Moderately	Quite a bit	Extremely
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			bit			
1	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2	Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4	Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8	Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12	Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13	Feeling distant or cut off from other	0	1	2	3	4

	people?					
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being “superalert” or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

Brief cope28 scale

Instruction: This part is about your cope mechanisms with the stress in your life. Please read each item carefully and respond by writing a √ mark on the place provided.

Choose one of the following where

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

No	Questions	1	2	3	4
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 alcohol or other drugs 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				
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.				

APPENDIX B: AMHARIC VERSION QUESTIONNAIRE

የስነ ትምህርት እና ባህሪ ጥናት ክፍል

ካዲንስ ስራ ትምህርት ክፍል

ማስተርስ ዲግሪ

በአገር ውስጥ ተፈናቅሎ ለተመለሱ ሰዎች የተዘጋጀ መጠይቅ

አጠቃላይ መረጃ

ውድ የዚህ ጥናት ተሳታፊዎች የዚህ መጠይቅ ዋና አላማ ከያሶ ወረዳ ተፈናቅሎ ቆይተው በአሁኑ ጊዜ ወደ ቀድሞ ቀያቸው የተመለሱ ሰዎች የሚገጥማቸውን የስነ-ልቦና ውጥረት፣ የስሜት ጎዳት ደረጃን እና የመቋቋሚያ ዜዴያቸውን መፈተሽ ነው። ከዚህ ጥናት የሚገኘው መረጃ የችግሩ መጠን ምን ያክል እንደሆነ የሚያመለክት ይሆናል። ጥናቱም ችግሩ በቀጥታ ለሚመለከተው የመንግስትም ሆነ የመንግስታዊ ያልሆኑ ድርጅቶች ቀርቦ የመፍትሄ አቅጣጫ ለመቅረፅ ይረዳቸዋል። እንዲሁም ጥናቱ የሚደረግባቸው ማህበረሰቦች በቀጥታም ሆነ በተዘዋዋሪ የጥናቱ ተጠቃሚ ይሆናሉ ተብሎ ይገመታል። ጥያቄዎችን በትኩረት አምብቦት ክክለኛውን መልስ መስጠት የጥናቱን አላማ ከዳር ለማድረስ ይረዳል። ለጥያቄዎቹ የሚሰጡት መልስ በሚስጥር የሚያዙና ለጥናቱ አላማ ብቻ የሚውሉ ይሆናሉ። ጥያቄዎቹንም ለመመለስ ከ50-60 ደቂቃ ይወስዳል። በዚህ መጠይቅ ውስጥ የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ይሆናል። ስም መፃፍ አያስፈልግም።

ስለ ትብብርዎ በቅድሚያ አመሰግናለሁ!

መኮንን ገመዳ

የጥናቱ ባለቤት

ተቀሳላክፍል አንድ

የግል መረጃዎች

መመሪያ: - ከዚህ በታች የተዘረዘሩት ጥያቄዎች የዚህ መጠይቅ ተሳታፊዎችን የግል መረጃ የሚዳስሱ ናቸው። ስለሆነም ጥያቄዎቹን በጥንቃቄ ካነበባችሁ በኋላ እኔን ይወክላል በምትሉት ትይዩ መልስስጡ። እንዲሁም ሳጥን ላላቸው ጥያቄዎች ()ምልክት አስቀምጡ

1. ጾታ M F

2. እድሜ 8-30 31-40 41-50 51-60

3. የጋብቻ ሁኔታ አግብቻለሁፈትቻ

አላገባሁም የትዳር አጋሬን በሞት

4. የትምህርት ደረጃ

ምንም አልተማርኩም

አንደኛ ደረጃ

ሁለተኛ ደረጃ

ኮሌጅ/ዩንቨርሲቲ

5. ብሔር

አማራ

አድሞ

ቤንሻንጉል

ሺናሽ

ሌሎች

6. ሐይማኖት

አርቶዶክስ

ፕሮቴስታንት

ሙስሊም

ካቶሊክ

ሌላ

7. የስራ ሁኔታ ተቀጣሪ የግል ስራ ስራ አጥ

8. አማካኝ የወር ገቢ በብር

ከ 1000-1500 ከ 501-2000

ከ 2001-2500 ከ 2501-3000 3000-ከዚያ በላይ

ኬስ ለር 10

አሁን ደግሞ ባለፈው አንድ ወር ስለነበረዎት ስሜት እጠይቅዎታለሁ፡ ለእያንዳንዱ ጥያቄ አራት ተመሳሳይ ምርጫዎች ይቀርብልዎታል፤ አንዱን ብቻ ይምረጡ፡

1. በዚህ 1 ወር ውስጥ የመደበኛ (መጨመር) ስሜት ምን ያህል ጊዜ ይሰማዎት ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	2. እምብዛም አይሰማኝም	3. ለጥቂት ጊዜያት	4. አብዛኛውን ጊዜ	5. ሁልጊዜ
2. በዚህ 1 ወር ውስጥ በጣም ከመደበኛው (ከመከፋት) የተነሳ ምንም ነገር ሊያስደስትዎ ያልቻለበት ወቅት ምን ያህል ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	2. እምብዛም አይሰማኝም	3. ለጥቂት ጊዜያት	4. አብዛኛውን ጊዜ	5. ሁልጊዜ
3. በዚህ 1 ወር ውስጥ ሊረጋገጡ ቢችሉም እንኳን የመጨመር ስሜት ምን ያህል ጊዜ ይሰማዎት ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	2. እምብዛም አይሰማኝም	3. ለጥቂት ጊዜያት	4. አብዛኛውን ጊዜ	5. ሁልጊዜ
4. በዚህ 1 ወር ውስጥ እጅግ ከመጨመር የተነሳ ምንም ነገር ሊያረጋጋዎት ያልቻለበት ወቅት ምን ያህል ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	2. እምብዛም አይሰማኝም	3. ለጥቂት ጊዜያት	4. አብዛኛውን ጊዜ	5. ሁልጊዜ
5. በዚህ 1 ወር ውስጥ የመቁነጥ ጥንጥ ወይም እረፍት የማጣት ስሜት ምን ያህል ጊዜ ይሰማዎት ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	2. እምብዛም አይሰማኝም	3. ለጥቂት ጊዜያት	4. አብዛኛውን ጊዜ	5. ሁልጊዜ
6. በዚህ 1 ወር ውስጥ እጅግ ከመቁነጥ ጥንጥ የተነሳ አንድ በታመቀ መጥ ያልቻሉበት ወቅት ምን ያህል ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም
7. በዚህ 1 ወር ውስጥ ለምንም አልጠቅምም (ዋጋ የለኝም) የሚል ስሜት ምን ያህል ጊዜ ይሰማዎት ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም
8. በዚህ 1 ወር ውስጥ ምንም ያህል ሳይሰሩ ሲደክምዎት የነበረው ምን ያህል ጊዜ ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም
9. በዚህ 1 ወር ውስጥ ተስፋ የመቁረጥ ስሜት ምን ያህል ጊዜ ይሰማዎት ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም

አያውቅም	አያውቅም	አያውቅም	አያውቅም	ተሰምቶኝ አያውቅም
10. በዚህ 1 ወር ውስጥ ሁሉንም ነገር (ለምሳሌ መናገር፣ መነሳት፣ መሄድ፣ የመሳሰሉትን) የግድዎን ያደርጉ የነበረውምን ያህል ጊዜ ነበር?				
1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም	1. በፍጹም ተሰምቶኝ አያውቅም

ፕሲኬል-5 ቅጽ

መመሪያ፡ ከዚህ በታች ያሉ የእክል መዘርዘሮች ሰዎች አንዳንድ ጊዜ ውጥረት ሲገጥማቸው የሚሰጡባቸው ምላሾች ናቸው፡፡ እባኮዎትን እያንዳንዱን እክል በጥንቃቄ ካነበቡ በኋላ በለፈው ወር ውስጥ ያሳሰቡትን ችግር ልክ በሚያመለክት ቁጥር ላይ ያክብቡ፡፡

ተራ ቁጥር	በለፈው ወር ከዚህ በታች ባሉ እክሎች ምን ያህል ተረብሻል?	በጭራሽ	በትንሹ	መካከለኛ	በመጠኑ	በጣም
1	ስለ ጥቃቱ በተደጋጋሚ የመረበሽ እና ያልተፈለጉ ትውስታዎች መኖር?					
2	ስለ ጥቃቱ ተደጋጋሚ የሚረብሹ ህልሞች ማየት					
3	በድንገት ያ ጥቃት እንደገና እየደረሰብዎ ያለ ያህል ወይም እዛጥቃት ላይ እንደገና እስካሉ እስኪመስሉት ድረስ ተሰምቶት ወይም ታይቶት ያውቃል?					
4	ጥቃቱን የሚያስታውሱት ነገር ላይ ሲሆኑ በጣም የመናደድ ስሜት ይታይበታል?					
5	የሆነ ነገር ጥቃቱን ሲያስታውሱት በጣም ጠንከር ያለ አካላዊ ምላሽ (ለምሳሌ እንደ ልብ ምት መጨመር፣ መተንፈስ አለመቻል እና ማላብን) የመሳሰሉትን አሳይተው ያውቃሉ					
6	ስለ ጥቃቱ የሚያስታውሱትን ትውስታዎች፣ ስሜቶች እና እሳቤዎች ማስወገድ?					
7	ውጫዊ የሆኑ ጥቃቱን የሚያስታውሱትን ነገሮች (ለምሳሌ፡ ሰዎች፣ ቦታ፣ ንግግር፣ እንቅስቃሴዎች፣ ነገሮች እና ሁኔታዎች) ማስወገድ እና ከነዚህ ነገሮች መራቅ ይታይበታል					
8	የደረሰዎበትን ያታዩ ጥቃት ዋና/ጠቃሚ ትውስታዎችን ለማስታወስ መናገር/አለመቻል?					

9	በጣም ጠንካራ የሆነ መጥፎ አመለካከት ስለራስዎ፣ ስለሌሎች ወይም ስለምትኖሩበት አለም በአጠቃላይ (ለምሳሌ፡ እኔ በጣም መጥፎ ነኝ፣ የሆነ በጣም ትልቅ ችግር አለብኝ እኔ ማ፣ ማንም አይታመንም እና አለም በአጠቃላይ አደገኛ ነች) ብሎ ማሰብ?					
10	ራስዎን ወይም ሌሎችን ለደረሰዎበት ጥቃት ወይም ከዛ በኋላ ለተፈጠሩት ነገሮች ሁሉ መውቀስ?					
11	ጠንክር ያለ መጥፎ ስሜት ይሰማዎታል (ፍርሃት፣ ንዴት፣ የጥፋተኝነት ስሜት ወይም ሀፍረትን የመሰሰሉ)?					
12	ከዚህ በፊት ያዝናናዎት እና ያስደስታዎት የነበረዎት ነገር ላይ ፍላጎት ማጣት ይታይበታል?					
13	ከሌሎች የመራቅ ወይም ግንኙነትዎን የማቆም ስሜት ይታይበታል?					
14	ጥሩ ስሜት ያለ መሰማት ችግር (ለምሳሌ ደስተኛ መሆን አለመቻል)?					
15	በጣም የሚያበሳጭባህ ሪዎችን ማሰባት፣ ንዴትን መቆቆም አለመቻል ወይም በሀይለኝነት ንዴትዎን መግለፅ?					
16	በጣም አደገኛ ነገሮችን ማድረግ ወይም ሊጎዳዎት የሚችሉ ነገሮችን ማድረግ?					
17	ሁሌም በጣም ጥንቁቅ፣ በዙሪያዎ ያሉትን ነገሮች ሁሉ በደንብ መከታተል (ማየት)፣ መሉ ጥበቃ ላይ መሆን?					
18	ስጋት ወይም በቀላሉ መጨነቅ እና ድንገተኛ መሆን					
19	ሀሳብን መሰብሰብ አለመቻል?					
20	እንቅልፍ ሊወስድ አለመቻል ወይም መተኛት አለመቻል?					

የአዕምሮ ጤና መቃወስን መቋቋሚያ ስኬል (ኮፕ 28)

መመሪያ፡ - ባለፈው ሰዓት የተሰማሽ/ህንስ ማት መሰረት በማድረግ የሚከተሉትን ሀሳቦች ካነበብሽ/ካበኋላ የምትስማ/ሚባትን ቁጥር () ምልክት አስቀምጭ፡

1. እኔ ይህን ነገር ምንም አላደርግም
2. እኔ ይህን ነገር እስካሁን በትንሹ አደርገዋለሁ
3. እኔ ይህን ነገር እስካሁን በመጠኑ አደርገዋለሁ
4. እኔ ይህን ነገር እስከ አሁን ለብዙ ጊዜ አደርገዋለሁ

ተ. ቁ	ጥያቄዎች	1	2	3	4
1	ችግሩን ለመርሳት ሌላ ስራ ወይም ተግባር እስራለሁ?				
2	ስለሌሎች ችግር በአትኩሮት ለመስራት እጥራለሁ?				
3	የሆነውን ነገር እውነት እንዳልሆነ ለአዕምሮ የእነግረዋለሁ?				
4	ነፃነት እንዲሰማኝ አልኮል ወይም ሌላ መደሃኒት እጠቀማለሁ?				
5	ከሌሎች ሰዎች የሚበረታቻ ድጋፍ እፈልጋለሁ?				
6	ከችግሩ ጋር መጋፈጡን አቆማለሁ?				
7	ሁኔታውን የተሻለ ለማድረግ የሆነ ድርጊት እተገብራለሁ?				
8	ገሩ እንዳልሆነ ወይም ምንም እንዳልተፈፀመ አምናለሁ?				
9	የያዘኝ መጥፎ ስሜት እንዲለቀኝ የሆነ ነገር እናገራለሁ?				
10	ከሌሎች ሰዎች እርዳታ /ምክር /አገኛለሁ /እፈልጋለሁ?				
11	ከሁኔታው ለመለቀቅ አልኮል ወይም ሌላ መደሃኒት እጠቀማለሁ?				
12	ነገሩን አወንታዊ /ጠቃሚ ለማድረግ ከተለያዩ የአቅጣጫ አስባለሁ				
13	ራሴን እወቅሳለሁ?				
14	ምን ማድረግ እንዳለብኝ ስትራቴጅ /ዘዴ እንድፋለሁ?				
15	ሌሎች ሰዎች ሁኔታውን እንዲቀበሉኝና እንዲረዱኝ አደርጋለሁ?				
16	ሁኔታውን ለመቋቋም ርምጃ አልወስድም?				
17	በሆነው ነገር ውስጥ መልካም ነገር ይሆናል ብዬ እፈልጋለሁ?				
18	ስለሁኔታው እቀል ዳለሁ?				
19	ነገሩን ቀለል ለማድረግ ፊልም፣ ቴሌቪዥን እመለከታለሁ አነባለሁ፣ እተኛለሁ፣ ህልም አያለሁ?				
20	የሚሆነውን የሁኔታውን እውነት አምኜ እቀበለዋለሁ?				
21	ስለሁኔታው ያለኝን አሉታዊ ስሜት እገልጻለሁ?				
22	ራሴን በህይወጥ ወይም በሞት ፈሳሚ እምነቶች አፅናናለሁ?				

23	ምን ማድረግ እንዳለብኝ ከሌሎች ሰዎች ምክር ወይም እርዳታ እጠይቃለሁ/አገኛለሁ?				
24	ከሁኔታው ጋር ተለማምጃ እኖራለሁ?				
25	ምን አይነት እርምጃ መውሰድ እንዳለብኝ ከልቤ አስባለሁ?				
26	ለሆኑት ነገሮች ሁሉ ራሴን ተጠያቂ አደርጋለሁ?				
27	እጸልያለሁ ወይም ተመስጦ አደርጋለሁ?				
28	በሆነው ነገር እደሰትበታለሁ?				