

**POST LORD'S RESISTANCE ARMY (PLRA) WAR CONSEQUENCES AND PTSD  
SYMPTOMS AMONG PATIENTS IN GULU REGIONAL REFERRAL HOSPITAL  
IN NORTHERN UGANDA**

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**A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES IN PARTIAL  
FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF THE  
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UNIVERSITY**

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## ABSTRACT

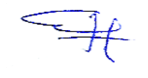
Globally, Post Traumatic Stress Disorder (PTSD) was projected as the prime reason for disability by the year 2020 and the most prevalent mental health issue among war survivors. This mixed methods study investigated the relationship between the Post LRA (PLRA) war consequences and the level of PTSD among patients in Gulu Regional Referral Hospital (GRRH), and the role of counseling psychology and social support in rehabilitation of the PTSD patients.

A total of 189 respondents participated in the key informant interviews, while 10 completed the questionnaires. The results showed that financial scarcity had the greatest consequence on flashbacks, followed by intrusive thoughts and nightmares. Remarriage and divorce had the greatest consequence on hyper vigilance followed by startle response, aggression and anger. Results further showed that Physical and psychological abuse were associated with social and occupational dysfunctions, while counseling psychology and social support had the greatest consequence on avoidance, followed by hyper arousal and re-experiencing, respectively. The study results suggest that provision of psychological counselling services and improving the social support system would ensure a faster recovery of PTSD patients.

The study recommends an integrated, holistic approach for the management of post LRA war consequences that entails medical, psychological, spiritual, material and social support services.

## DECLARATION

I hereby declare that this dissertation is my original work and has never been submitted before for the award of a Master of Arts in Counseling Psychology degree in any university.

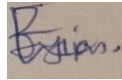
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## APPROVAL

I certify that this dissertation titled: “Post Lord’s Resistance Army (PLRA) war consequences and PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda” has been completed under my supervision and is ready for submission.

Supervisor: Betty Enyipu Akurut (PhD)

Signature:

A small, square image containing a handwritten signature in blue ink. The signature appears to be 'Betty Enyipu Akurut'.

Date: 19<sup>th</sup> March 2025

## DEDICATION

I dedicate this work to the Almighty God, my beloved mother Mrs. Alice Olweny, my husband, Mr. Tom Mboya Okecho and to Laker Testimony Deklyn my beautiful daughter.

## ACKNOWLEDGEMENT

I thank the Almighty God for always protecting my life and for His inspiration and sufficient Grace. My heartfelt appreciation goes to my supervisor Dr. Betty Enyipu Akurut for the tireless effort in guiding and monitoring this research to reach its final stage.

I thank the Belgian Technical Corporation (BTC) for sponsoring me for the Master of Arts in counseling psychology degree of Uganda Christian University (UCU).

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Finally, my appreciation goes to the Mental Health Unit staff of GRRH, the mental patients, their care givers, and the Library Department at Uganda Christian University. Their various contributions brought this research work to its conclusion.

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## ACRONYMS

**APA:** American Psychiatric Association

**DSM-IV-TR:** Diagnostics and Statistical Manual of Mental Disorders

**GRRH:** Gulu Regional Referral Hospital

**IDP Camps:** Internally Displaced People's Camps

**LRA:** Lord Resistance Army

**PLRA:** Post Lord Resistance Army

**PTSD:** Post Traumatic Stress Disorder

## CHAPTER ONE

### 1.0 Introduction

In most epidemiological surveys and studies on psychopathology of war survivors, Post Traumatic Stress Disorder (PTSD) symptoms are among the most prevalent mental health issues (Morina et al., 2018; Sijbrandij et al., 2017; Lindert et al., 2009; Fazel et al., 2005). This study was conducted to find out the connection between Post Lord Resistance Army (PLRA) war consequences, the PTSD Symptoms and the psychological counselling and social support services accorded to the PTSD patients to improve their mental and physical health.

### 1.1 Background

According to the American Psychiatric Association (APA) (2013) in their book “Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> Edition,” Post Traumatic Stress Disorder (PTSD) is a mental disorder that emerge from a direct or indirect experience of traumatic stressors. The key protocol for diagnosing PTSD are;

When one experienced traumatic event that involved actual or possible threat of death, serious injuries or violence. Followed by when one responded in horror and presented with the PTSD symptoms of re-experiencing, hyper arousal and avoidance. Lastly, when one suffered a significant clinical distress (functional impairment) that resulted into social dysfunction (inability to get along with others) and occupational dysfunctions (inability to do work) that have lasted for one month.

Globally, at least eight million people suffer Post Traumatic Stress Disorder (PTSD) annually, with stress-related disorders. PTSD was projected to be the second leading cause of disability by the year 2020 (WHO, 2014). Globally, PTSD accounts for 0.4% of a lifespan of disability, and was projected to rise by 0.6% (WHO, 2014). The global economic burden of stress-related mental illness is expected to rise in the coming decade (Biresaw & Gebeyehu, 2020). About 284 million people suffered from PTSD and anxiety disorders globally, out of which 63% are women (Anderson, 2009). According to Anderson (2009), and Walters (2014), most of the psychological trauma globally was war-induced. War induced psychological trauma in American soldiers was first observed during World War One (Murdoch & Sandler, 2001). PTSD has emerged as one of the signature wounds of the wars in the world for example, the war in Iraq, Afghanistan, and Syria among others (WHO, 2014).

According to Anderson (2009), and Walters (2014), handling PTSD has been burdensome especially for countries involved in war due to its adverse mental and physical health outcomes, yet it is often overlooked. From 1960, Sub Saharan Africa suffered civil war which led to low economic growth and development due to low infrastructural investments, marketing and loss of human capital. Similarly, Murdoch & Sandler (2001), noted that these wars had a catastrophic consequence on the health and wellbeing of nations in Africa and caused more mortality and disability than major diseases. Anderson (2009) observed that wars have destroyed communities and families and disrupted the development of the social and economic fabric of nations. The wars also resulted in long-term physical and psychological harm to

children and adults, as well as reduction in material and human capital (Murdoch & Sandler, 2001).

In a large epidemiological survey conducted by Biresaw & Gebeyehu (2020) between 1997 and 1999 among survivors of war or mass violence in developing countries, the prevalence rate of assessed PTSD was 37.4% in Algeria, 28.4% in Cambodia, 15.8% in Ethiopia, and 17.8% in Gaza. Conflict-linked trauma due to torture was a major cause of PTSD in all these countries except Cambodia. In Algeria and Gaza, very low quality of living conditions was vetted as source of PTSD. Alcohol abuse, family stress, demise or estrangements were closely linked with PTSD in Cambodia. In Kenya, the prevalence of PTSD was 10.6%. PTSD was associated with key traumatic events such as infirmity, battering, demise of close relations, marriage annulment, impoverishment and domestic violence (Jenkins et al., 2015; Pfeiffer & Elbert, 2011).

Pfeiffer & Elbert (2011), reported that Uganda has, since 1962, experienced civil war which has often plagued the country with multiple violent conflicts such as the Lord's Resistance Army (LRA) insurgency, and insurgencies that have been ongoing since 1987.

The community suffered a 20-year LRA war where, civilians experienced unselective massacres, battering and kidnapping for forceful servitude among others. Pfeiffer & Elbert (2011), estimated that approximately 2 million people in Northern Uganda were forcefully settled in internally displaced peoples' camp (IDP). It is projected that about 1,000 death cases were possible each week from infirmities and diseases for instance malaria and diarrhea. Other causes being molestation, and domestic violence

(Wakabi, 2006). A study conducted in Northern Uganda by (GRRH, 2013), to determine the consequences of the PLRA war on the abductees, revealed that at least 70% of the respondents experienced PTSD with 49% showing depression and anxiety. PTSD symptoms level was found to have a negative correlation with the time spent with the rebels. These experiences left lasting physical and mental scars among the people of Northern Uganda whose consequences have led to increased PTSD symptoms among the communities.

## **1.2 Theoretical background**

This research was modeled around the classical conditioning concept advanced by the Russian psychologist Ivan Pavlo between 1849 to 1936 (Ivan Pavlo's theory), cited in Ruiz and Sánchez (2020). Pavlov postulated that one's conduct is molded by their environment. He noted that association produces stimuli which influence a particular response either positively or negatively in living things.

The relevance of Pavlov's theory to this study is that it clearly underpins the relationship between the PLRA war consequences, PTSD symptoms and the role of counseling and social support; where the bell and the meat powder can be viewed as the post LRA war consequences, PTSD symptoms as the conditioned response which is salivating and the act of extinction as the role of counseling psychology and social support whose continuous administration would lead to extinction of PTSD symptoms hence recovery and vice-versa, just like the consequence of continuous ringing of the bell did.

Pavlov's principle of discrimination where the bell was continuously rung without the meat served that led to extinction is relevant to the study, indicating that when the patient's environment stabilizes with minimum similar war consequences, PTSD symptoms will gradually stop since the conditioned response had been extinguished.

The study adopted the classical conditioning theory because it offered significant practical proof to sanction the use of conditioned and unconditioned stimulus to influence the behavioral symptoms of a patient and the influence of counseling and social support services to help them recover faster. Ivan Pavlo's argument therefore supports all the three variables of the study.

### **1.3 Conceptual back ground**

The study used independent variables, dependent variables and intervening variables; PLRA war consequences was considered as independent, PTSD symptoms among patients as dependent, and the role of counselling psychology and social support provided to patients as intervening variables, respectively. PLRA war consequences as the independent variable included financial scarcity presented in patients living below a dollar a day, broken relationships leading to remarriages and divorce and domestic violence leading to physical and psychological abuse. These are the post LRA war consequences which when identified and handled well or minimized by the relevant stakeholders and actors will help to reduce the occurrence of PTSD symptoms among patients that report to the mental health Unit at GRRH. The dependent variable was PTSD symptoms among patients in GRRH which included re-experiencing which is presented in flashback, nightmares and intrusive thoughts. Hyper arousal which is

presented in hyper vigilant, aggression and anger and startle response and avoidance that is presented in avoidance of people, places and thoughts relating to traumatic events, social dysfunction and occupational dysfunction of the clients. These are symptoms and signs that helps a health practitioner to identify PTSD among patients. The intervening variables are the psychological counseling services and social support provided to the patients suffering from PTSD symptoms. The psychological counseling services and social support helped to improve the general health (cognitive and physical) of the patients hence reducing the occurrence of PTSD symptoms among patients. Because of this, this study on the association of PLRA war consequences with PTSD symptoms among patients in GRRH in Gulu District Northern Uganda was conducted.

#### **1.4 Contextual back ground**

The population of Northern Uganda in Acholi sub region experienced a lot of traumatic occurrences as postulated by Anderson (2009), which were characterized by looting, massive abductions, ruthless killings, rape, serious injuries, forceful body parts mutilation, disease outbreak (Ebola and HIV/AIDS), bomb blasts, and poor sanitation among others. Most of the people were forced to kill each other and rape their female relatives while others were forced to become child soldiers. Both the people that remained back in the IDP camps and those abducted and taken away lived in constant fear for their lives. Many people contracted HIV/AIDS, got unwanted pregnancies as many of them who returned with bastards after the war, lacked access to basic needs of life hence it made life very miserable during the 20 years of war

among the people of Acholi sub region. The Veterans' Health Administration (2014) ascertained that, the above experiences created intense fear, helplessness and horror, instigating clinically significant distress on the people. This was supported by Wakabi (2006), who argued that these occurrences overwhelmed the community with grief, guilt and shame among others, making life miserable, hopeless and meaningless for many. Henceforth, noticeable manifestation of symptoms like recurrent thoughts, hallucinations, nightmares, avoidance, hyper-vigilance, anger, extreme guilt and anxiety among others, were common among the individuals in the community.

Wakabi (2006), continued to ascertain that on return to their villages after the war, the community were faced with ghostly homes, mushrooming graves in the compound, inability to access basic needs, land mine injuries due to the numerous land mines left behind by rebels, rampant land conflicts as the majority of the vulnerable sections of the community were orphans (born during the war) and widows who are not well informed on the land demarcations. Consequently, they suffered in the hands of their neighbors and kinsmen, while some of the people were said to have experienced haunting vengeful spirits of those who were killed during the war. These activated the manifestation of PTSD symptoms among the people.

According to the GRRH annual report 2013, between 2007 and 2013, 1256 patients were diagnosed, treated and recovered from presenting PTSD symptoms and were discharged from the hospital. After two weeks, all of them had relapsed (GRRH, 2013). This implies that even if the LRA war visibly ended, huge wounds from the war that remained untreated in the lives of the people signifies that there is still war

invisibly going on in the minds of many people in the community. Because people lived long in the camp, their dignity was eroded and their biological functioning declined, consequent to their inability to fight stress. This therefore required a holistic strategy to improve their perceptions, environmental conditions and social support systems to help them recover properly

### **1.5 Statement of the Problem**

PTSD is a major mental health problem among the people of Northern Uganda affecting people of all categories. PTSD patients suffered occupational and social impairments plus other comorbidities such as mental and medical conditions that makes PTSD a serious health risks to the patients, their care givers and the health workers who equally suffer vicarious trauma Anxiety, Depression and substance abuse among others, (Yehuda, 2002; Strecker, 1944 & WHO, 2014). A report by the police, the district Local Council (LC) VI of Gulu and John Paul II Justice and Peace Center showed that there is increased crimes associated with self-harm, alcoholism, fights, suicidality attempts and other vices due to PTSD among patients in the community. Beside, many patients suffered sexual exploitations that exposed them to STIs/STDs and unwanted pregnancies and children. Managing the mental ill health condition dragged the affected households to catastrophic spending which disrupted savings and engagement in daily productivity for income generation, consequential to poverty. The government continuously suffered huge financial loss and human resources to address the patients' criminal acts and other health problems they, their caregivers and the health workers suffered. This increased the government's expenditure on

health and security and made PTSD not only a problem to the patients alone but also to the entire family members, the community and the government at large, and this motivated this study (Justice, 2014; GRRH, 2013; Police Record, 2012).

The effects of the post LRA war consequences have not been widely researched to date. Furthermore, little is known about the magnitude unto which the precipitating factors impact on the progression of PTSD among patients in the post LRA war period in the region. Evaluations of the existing interventions to arrest PTSD manifestations among patients frequently overlooked their effectiveness in totally mitigating the PTSD symptoms among patients and enforcing a concrete recovery. This study aimed to establish the post LRA war consequences to the PTSD symptoms level among patients, and to establish a holistic approach by strengthening those that are in place to totally mitigate the presentation of PTSD symptoms among PTSD patients in GRRH in Northern Uganda.

### **1.6 Purpose of the Study**

The study investigated the relationship between the Post Lord Resistance Army (PLRA) war consequences and PTSD Symptoms' level among patients in Gulu Regional Referral Hospital in Northern Uganda

### **1.7 Objective of the Study**

### **1.7.1 General Objective**

The study investigated the Post Lord's Resistance Army (PLRA) war consequences and PTSD symptoms among patients in Gulu regional referral hospital in Northern Uganda

### **1.7.2 Specific objectives**

The explicit objectives were:

1. To investigate the post LRA war consequences among patients in Gulu Regional Referral Hospital.
2. To assess the PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda
3. To determine the relationship between the consequences of the post LRA war and the level of PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda
4. To determine the role of counseling psychology and social support in rehabilitation of the PTSD patients in Gulu Regional Referral Hospital.

### **1.8 Research questions**

1. What is the post LRA war consequences among patients in Gulu Regional Referral Hospital in Northern Uganda?
2. What are the PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda?

3. What is the relationship between the consequences of the post LRA war and the level of PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda?
4. What are the roles of counseling psychology and social support in rehabilitation of the PTSD patients in Gulu Regional Referral Hospital in Northern Uganda?

### **1.9 Justification of the study**

The investigation on the PLRA war consequences and PTSD symptoms among mental health patients was vital because, failure to address the PTSD symptoms will lead to rampant increase in the numbers of the PTSD patients due to their living conditions, nature of relationships, every day occurrences that led to experiences of flashbacks and vicarious trauma from the care givers, medical persons, psychologists and social workers providing care and treatment for PTSD patients. In spite of these, there shall be increased development of other mental illnesses that are associated with PTSD such as, Anxiety, Depression, substance abuse, psychosis and Delirium tremens among others, (Yehuda, 2002; Strecker, 1944). These symptoms are presented by most of the patients at the mental unit at GRRH hence wanting a study to determine whether the PTSD symptoms have a relationship with the post LRA war consequences (Sommerville, 2018; American Psychiatric Association, 2013).

### **1.10 Significance of the Study**

Through this study technical information on the relationship between the PLRA war consequences and PTSD symptoms among patients was generated. This reflected that

wars and conflict are potential threats to the mental health of humans manifested through re-experiencing, hype-arousal and avoidance. This information can be used by government officials and non-governmental organization and mental health scholars for sensitizing the population on challenges and coping mechanism as well providing adequate resources, funds and better strategies for management of PTSD at GRRH to provide an enabling environment to improve the mental conditions of patients in the mental health unit.

The study provided a platform for PTSD patients to share their experiences that enabled the researcher to understand the gaps in accessing mental health services delivery and areas for improvement to aid better service delivery in the future. This research therefore documented information which could aid in informed decision making for relevant policies amendments by the stakeholders or the Ministry of Health on handling of PTSD symptoms among patients. Hence, improving patient lives.

The data generated through this study may be useful in promoting advocacy for more institutional support for war victims with signs of PTSD symptoms through assigning more health force to support them and more funds to provide medication to enhance their recovery.

## **1.11 Scope of the Study**

### **1.11.1 Content scope**

The research focused on post-lord resistance army (LRA) war consequences and PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda. The

major emphasis was put on the three variables which are the PLRA war consequences, PTSD symptoms level among patients and the role of counseling psychology and social support services as an intervening variable which helps in reducing the level of PTSD symptom among patients in GRRH.

### **1.11.2 Time scope**

The study covered the relationship between the PLRA war consequences with PTSD symptoms level among patients in GRRH in Northern Uganda and counseling psychology and social support services as an intervening variable which helped in reducing the level of PTSD symptoms among patients from the year 2011 to 2013. This was done to document sound reasons to explain the rise in PTSD symptoms among patients despite the relevant interventions in both at the health facility and communities by GRRH.

### **1.11.3 Geographical scope**

The study was conducted at Gulu regional referral hospital in Gulu District, the center for mental health treatment in Acholi and Lango Sub-Districts. It covers about 15 Districts of Northern Uganda. Gulu District covers 3,452.1km squared, and is located on the coordinate, 02°49'50.0"N 32°19'13.0"E on latitude 2.830556 longitude 32.320278. Gulu District is boarded by Lamwo District to the north, Pader and Omoro District to the east, Oyam District to the South and Nwoya District to the South West (Wikimedia Foundation, 2021). This research was therefore carried out at GRRH among patients at the mental health unit as they report for treatment from all the

seven districts in Acholi sub region that is Gulu, Amuru, Kitgum, Lamwo, Nwoya, Agago and Pader in Northern Uganda and the neighboring Lango Sub-region.

### **1.12 Operational Definition of terms**

**Abuse:** this may be emotional, spiritual, psychological or physical manipulation or misuse of power, office, things to inflict pain or gain at others expenses

**Aggression and anger:** it is a state of being violent and annoyed

**A sign:** is a health issue that can be observed or measured by a doctor.

**A symptom:** is the health issue that is only felt by the patient and raised as complaints and cannot be observed by a doctor

**Avoidance and numbing:** refers to a state where PTSD patients avoid anything, activity, personality or being related to their traumatic experiences. Numbing is when the patient becomes emotionally dead (Sripada et al., 2013).

**Broken relationships:** Are the dissolution of the cherished relationship.

**Divorce:** Refers to a socially recognized end of marriage agreement or contract between live partners.

**Domestic violence:** Refers to any form of abuse in a family.

**Financial scarcity:** It is a state of having low income or finding difficulty in money making.

Flashbacks: it is the state of recalling the past traumatic experiences where one can see or experience the traumatic events as if it is freshly happening again (APA, 2013).

Hyper-arousal: is the body's way of remaining prepared always. It is a state of experiencing a heightened anxiety that makes a patient increasingly sensitive and becomes excessively quick to respond to stimuli and events in the world around him/her (Marich 2014).

Hyper vigilance: it is a state of being very watchful and red alert due to fear of imagined danger or threats or insecurity, consequent to feeling insecure

Intrusive thoughts: these are thoughts about the traumatic experiences that keep coming up in some bodies mind uncontrollably.

Night mares; these are bad or terrifying dreams.

Occupational dysfunction: it is a situation when one avoids or totally loses interest in significant activities, they formerly enjoyed such as housework, office work and cultivations (The Veterans' Health Administration, 2014).

Physical abuse: refers to any form of physical pain or discomfort inflicted on a person by another more powerful than her/him.

Post LRA (PLRA) war: Refers to the period after the permanent cessation of the LRA war in the region

Post LRA war consequences: are the negative results of the LRA war in the community in the aftermath of the LRA war leading to presentation of the PTSD symptoms in the community.

Psychological abuse: is a behavior that aims to cause emotional or mental harm characterized by verbal threats, intimidation, isolation, victim blaming, humiliation and manipulation of children in order to demean or instill fear in an adult person (Charles et al., 2007).

PTSD symptoms: refer to signs of a disorder that emerges after one gets exposed to an extremely distressing situation that threatens their life or livelihood. Their children can be noticed through their disorganized or agitated behavior (APA, 2013).

Re-experiencing Symptoms: refer to reliving upsetting memories which include images, thoughts, and perceptions about the traumatic event (The National Center for Post Traumatic Stress Disorder, 2011)

Re-marriages: refers marrying again after any marriage breakup.

Social dysfunction: it is when one portrays avoidance of social activities like attending parties, religious functions and recreations.

Startled response: it is a state of having an automatic excessive quick respond to stimuli and events in the world around you.

Triggers: are the stimulus that arouses a sudden recollection or re-enactment of the specific distressing experience. It sets one on emotionally and activates memories of

ones' past traumatic events (The National Center for Post Traumatic Stress Disorder, 2011)

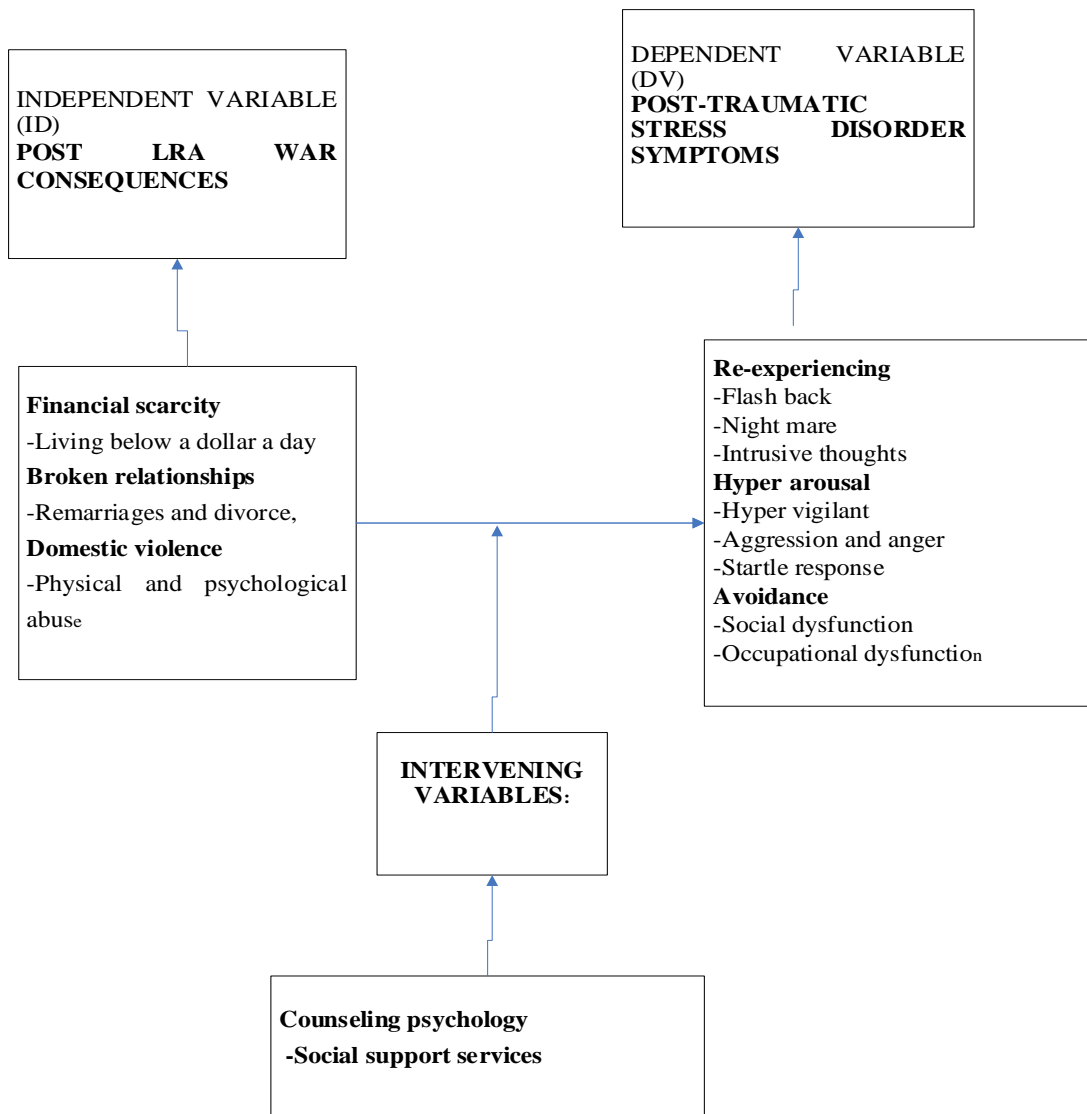
### **1.13 Conceptual Framework**

The conceptual framework is shown in figure 1. Three types of variables were considered to bring the study goal. The independent variable was the Post LRA war consequences, the dependent variable was PTSD symptoms among patients in GRRH and the intervening variable was the roles of counseling psychology and social support services provided to patients at GRRH in Gulu district in Northern Uganda.

PLRA war consequences as the independent variable included financial scarcity presented in patients living below a dollar a day, broken relationships leading to remarriages and divorce and domestic violence leading to physical and psychological abuse. These are the post LRA war consequences that precipitate the manifestation of the PTSD symptoms among patients and their holistic management mitigates the presentation of PTSD symptoms among patients in GRRH in Northern Uganda.

The dependent variable was PTSD symptoms among patients in GRRH which included re-experiencing which is presented in flashback, night mares and intrusive thoughts, hyper arousal which is presented in hyper vigilant, aggression and anger and startle response and avoidance that is presented in avoidance of people, places and thoughts relating to traumatic events, social dysfunction and occupation dysfunction. These are symptoms that helps a health practitioner to identify PTSD among patients at GRRH.

The roles of counseling psychology and social support as an intervening variable include psychological counseling and social support services provided to the patients suffering from PTSD symptoms. These helped to improve the mental, physical and spiritual health of the patients hence reducing the occurrence of PTSD symptoms among patients. Relative to this concept, this study was conducted to verify the relationship of PLRA war consequences and PTSD symptoms among patients in GRRH in Gulu district, Northern Uganda.



*Figure 1: Conceptual Framework of the Study*

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.0 Introduction

This chapter discussed the literature related to PLRA war consequences, PTSD symptoms level and the role of psychological counseling and social support services in mitigating the presentation of PTSD symptoms among patients.

#### 2.1. The Post LRA War Consequences

There are so many consequences of the post LRA war in the community, but the review is limited to a few consequences of the post LRA war that were commonly identified among the PTSD patients in GRRH, northern region such as financial scarcity, broken relationships, and domestic violence.

##### 2.1.1. Financial scarcity

According to Shah et al (2012), financial Scarcity is a condition of having insufficient financial resources to meet your demands. These demands constitute household expenses that have to be paid and the experience affects decision-making in all aspects of life and cause stress. Nia (2019), linked mental disorder to poverty that manifests in many ways; however, he said that the most underlying origin of PTSD symptoms remains the terrifying traumatic life event. Nia argued that inability to access basic needs and pay for life expenses lay a heavy burden on the shoulders and emotions of those living in poverty, making it difficult for them to enjoy life hence

relieving PTSD symptoms such as flash backs, nightmares, and increased arousal evidenced by an increased blood pressure or heart rate, anger outburst, insomnia and avoidance where they detach themselves from places, situation or people related to the event. Nia (2019), claimed that when people who lived in poverty are exposed to crime and violence, health challenges, homelessness, inability to get a long-time sustaining job and life-threatening events like accidents, floods, hunger and drought among others, they find life unbearable and consequently they relieve the trauma through re-experiencing.

### **2.1.2. Broken relationships**

According to Taylor (2019), broken relationships are very traumatic and emotionally are one of the greatest traumas that can lead to a lot of damage to one's emotional health and mental well -being. He argued that divorce and separation can lead to night terror, flashbacks and troubling intrusive thoughts. And that a frequent reminder of it leads to serious consequences on one's daily life and illnesses like depression, anxiety and complete loss of trust consequent to manifestation of PTSD symptoms. Experiences of broken relationships can lead one to living in constant fear, guilt, excessive worrying and night mare of the present and future since, the negative emotions that heightened keep resurfacing (Taylor, 2019). According to Taylor (2019), therapy has proven helpful for mental health patients who are going through divorce and those who have gone through it. A mental health patient can be helped but they need to be open for support and reach out for it.

### **2.1.3. Domestic violence**

According to the National Center for Post Traumatic Stress Disorder (2011), domestic violence affects people physically or mentally through both direct ways like wounds and injuries and indirect path ways like the psychological consequences of PTSD. For instance, being victims of domestic violence earned a person a name like “the battered one” which continuously reminded the victims about the past violence experienced that returned them to the hell they suffered leading to manifestation of re-experiencing, hyper arousal and avoidance symptoms. This was agreed by Charles et al., (2007), who ascertained that domestic violence violates the integrity of the victim and lower their self-esteem. Meanwhile, the pain inflicted in domestic violence through the act of name calling, criticism, degradation, manipulation, battering and belittling among others, destroy one’s self image and instill guilt among others, consequent to Post traumatic disorder symptom expressed in anger outburst, being easily startled, negative thoughts, insomnia, nightmares, flash backs and increased heartbeat.

### **2.2. Post- Traumatic Stress Disorder (PTSD) Symptoms**

According to the American Psychiatric Association (2013) in their book “Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> Edition,” PTSD symptoms are grouped into three main clusters of re-experiencing, hyper arousal and avoidance with many other symptoms under each of them. The researcher therefore used the three clusters of symptoms to represent all other symptoms of PTSD instead of discussing one symptom at a time as bellow;

### 2.2.1. Re-experiencing

According to the National Center for Post Traumatic Stress Disorder (2011), re-experiencing are symptoms that involve reliving upsetting memories which include images, thoughts, and perceptions about the traumatic event. This was agreeing with the Veterans' Affairs Mental Health Services Public report (2014), which postulated that these memories keep rebounding unexpectedly when triggered. This was supported by Kuipers et al (2014), who argued that in re-experiencing people can also experience vivid and terrifying nightmares in which they re-experience the trauma and often thrash around in their sleep or cry out and wake up feeling disorientated. These ordeals affected the PTSD patient with intense feelings of fear, and helplessness meanwhile others get emotionally upset, experience troubled breathing and horror that is related to their past traumatic events. In other case, the patients' suffered insomnia together with their family members who also wake up when the patient experienced nightmares and woke up (National Center for Post Traumatic Stress Disorder, 2011).

According to American Psychiatric Association (2013), re-experiencing similar traumatic incidences reminds a person of the past traumatic events they experienced. Consequently, they display symptoms expressed in their behavioral characteristics such as; re-experiencing, hyper arousal and avoidance which cause clinically substantial upset that influence individuals' performance. This was agreed by Ferry et al (2014), who ascertained that Northern Ireland for many years experienced exposure to traumatic stress in which many people developed PTSD symptoms. She argued that

despite the patients' efforts, they remain vulnerably helpless, nightmares were disturbing their sleep and they woke up to find themselves drenched in sweat.

### **2.2.2 Hyper-arousal**

According to Marich (2014), hyper-arousal is a state of experiencing a heightened anxiety that makes a patient increasingly sensitive and become excessively quick to respond to stimuli and events in the world around him/her.

According to the National Center for Post Traumatic Stress Disorder (2011), it is agreed that hyper-arousal causes the PTSD survivors to feel very anxious and fearful and this may show up in having trouble in falling or staying asleep. They argued that some patients experienced irritability or outbursts of anger which chases people away from them and can lead to joblessness and marital/relationship rifts when patients' acts are out of control. Meanwhile, some people have problems concentrating or focusing on tasks and continuously feel agitated and jumpy or get very startled by loud noises and take off for their lives over nothing insecure.

In support of the above argument, Chemtob et al (1997) argued that patients with PTSD feel that the best response to extreme threat is to act aggressively to protect themselves. He ascertained that the automatic response of irritability in the patients with PTSD create serious problems in the work place and in family life and can also affect the patients' feelings about themselves and their roles in society. This was in agreement with Gray et al (2010), who ascertained that irritability and angry outbursts are prevalent among the patients with PTSD and the manifestation are

normally associated with interpersonal violence, employment difficulties and so forth. Apart from that, Gray et al (2010), postulated that anger and irritability strain friendships and familial relationships thereby adversely impacting the quality of social support available.

According to Kuipers et al (2014), it is postulated that in hyper-arousal some patients with PTSD become hyper-vigilant, constantly looking out for danger or threats, and may be jumpier than usual. They ascertained that because of being hyper-vigilant, patients have upsetting feelings that make them act as if they are in danger again and again when they get stressed or reminded of their former trauma. More to this, Kuipers et al (2014), argued that, the hyper-arousal symptoms may lead to physical problems like constipation, diarrhea, rapid breathing, muscle tension or rapid heart rate that affect the general health and wellbeing of the patient.

Furthermore, the National Center for Post Traumatic Stress Disorder (2011), made observation that the deeper consequences of hyper-arousal on the family members of the patients are that they also begin to feel insecure when the patient shows feelings of insecurity. The preoccupation with keeping safe also prohibited the patient's participation in any activity of the day including his/her caregiver who is also withheld from doing work in order to provide care to the patient. This reduced family income and lowered the national productivity leading to poverty in the short run. The above symptoms made individuals hard to get along with and caused them to withdraw from the rest of the family making life miserable. Hyper-arousal symptoms

completely disrupted life every day, disintegrated social attachments, flattened emotions, were a source of isolations and loss of trust in mankind.

### **2.2.3. Avoidance**

According to Kuipers et al (2014), individuals may try to avoid situations that trigger memories of the traumatic event like sights, sounds or smells that are reminders of the traumatic event. Kuipers et al (2014), argued that, numbing symptoms are another way of avoidance in which the individual may find difficulties in being in touch with their feelings or express emotions toward other people. For instance, they emotionally freeze or isolate themselves. Furthermore, the Veterans' Health Service (2014) report, ascertained that, patients also lose interest in activities formerly enjoyed. This was in agreement with Sripada et al (2013) who ascertained that, PTSD patients avoid both internal and external reminders of the trauma including failure to recall important aspects of the trauma, loss of interest in significant activities they formerly enjoyed, and a sense of foreshortened future that normally led them to suicide. Kim et al (2022), argued that children patients portray biased impartiality or disaffection, array of distraught, and experience impaired working memory, and intrusion through shortfalls in mental flexibility.

Conclusively, Sripada et al (2013) showed that avoidance symptom is the most harmful symptoms to psychosocial functioning of the patient because it leads to social and occupational dysfunction in the patients. Similarly, avoidance prevents patients from learning new response patterns because they do not fully subject themselves to the emotional processing of their anxiety (Fleurkens et al., 2014).

## **2.3. Objective 3: The relationship between the consequences of the LRA war and the level of PTSD symptoms**

### **2.3.1. Relationship between Financial Scarcity and re-experiencing**

According to Kim et al (2024), living in financial scarcity means surviving daily in vulnerable conditions, and with financial instability that limits access to necessities such as food, shelter and water. There is a link between poverty and re-experiencing. One's socioeconomic status contributes to the majority of anxiety disorders. Financial scarcity acts as traumatic stressors where one's inability to pay for life expenses leads to intense emotional and mental challenges exhibited in re-experiencing witnessed through flashbacks and upsetting memories (Kim et al., 2024).

The world health organization agreed that poverty contributed to a high risk of factors for mental disorder globally (WHO, 2014). Furthermore, in a situational analysis, Kigozi & Ssebunya (2009), ascertained that, the mental health system in Uganda, conducted a Mental Health and Poverty Project of 2007, that concluded that, poverty was the most identified major risk factor for mental illness. Poverty was also attributed to be a strong causative and mediating factor for stress, frustrations and depression leading to re-experiencing which are the major mental health problems today. Relatively, the relationship between poverty and re-experiencing is a vicious cycle where poverty is a contributory factor for re-experiencing and at the same time, re-experiencing can also result in to poverty or financial scarcity; hence giving it an existence of a strong two-way relationship (Kigozi & Ssebunya, 2009).

### **2.3.2. Relationship between Broken Relationships and Hyper-Arousal**

According to Allisson & Susan (2019), the loss of a significant relationship can be one of life's most difficult challenges in that, following relationship dissolution, many people manifest symptoms similar to those experienced by people who have survived highly stressful situations. Separation increased one's risk of distressful psychological symptoms such as hyper-arousal and suicidal behavior. Allisson & Susan (2019), added that, the Social Readjustment Rating Scale (SRRS), which measures the relationship between life events, stress and susceptibility to illness, considered divorce and remarriage, to be one of the most severe life stressors. This therefore implied that the trauma caused by a divorce and remarriage cannot lead to a diagnosis of PTSD, though the victim can relieve PTSD symptoms like hyper-arousal. In review of the study, Allisson & Susan (2019), quoted a psychiatrist Dr. Susan Edelman who agreed that the breakup of a relationship and remarriage could lead to worsening symptoms of post-traumatic stress disorder characterized by hyper-arousal presented in anger, irritability and aggression, re-experiencing of symptoms, including intrusive thoughts or dreams about the dissolution and avoidance behaviors and decreased psychological well-being.

### **2.3.3. Relationship between Domestic Violence and Avoidance**

Gluck (2021), argued that there is a similarity between domestic violence and PTSD symptoms like avoidance among others. He proposed that domestic violence affected both physical and mental health directly due to injuries and indirectly through psychological consequences of trauma and stress causing PTSD symptom. This pointed

out that, those who undergo domestic violence, molesting, natural disasters, suffer similar PTSD symptoms of avoidance. He explained that, they expressed avoidance behaviors by isolating themselves from others or losing interest in activities formerly enjoyed and some people forgot, or conceal relevant parts of their traumatic experiences. Consequently, they found it difficult to live at peace with themselves or others.

Additionally, Gluck (2021), hypothesized that Children who only witnessed domestic violence suffered consequences that are devastating as those seen in physically battered children. Likewise, children who witnessed the abuse of their mothers at the hands of their fathers and vice versa experienced avoidance. Such children themselves also felt battered and suffered most profoundly as a result of their parent's behavior through emotional distress and exhibited a host of adverse behaviors and emotional problems such as poor parental relationship, critically delayed or distorted development resulting in to avoidance and re-experiencing.

## **2.4. The roles of psychological counselling and social support in mitigation of PTSD symptoms**

### **2.4.1. The role of psychological counseling**

Psychological counseling in this context are the psychological counseling approaches used to mitigate the PTSD symptoms.

According to Coventry et al (2020), PTSD is a tough thing to go through, but through early intervention and added help, it can be overcome. Psychological counseling is one of the best solutions for those who have developed PTSD symptoms as it gives them an avenue to express their feelings to be heard, hence reducing PTSD symptoms in the community. There is also psychological counseling where counselors help the clients spot their innate resources such as self-esteem, emotional intelligence, coping creativity, and help them invest these resources in managing and controlling their situations and opportunities, (Coventry et al., 2020).

The importance of the common approaches for psychotherapy in trauma counseling are;

**Psycho-education;** This is composed of educating the patient about what happened and how the experience affected them, what kept the experiences going, skills on how to manage symptoms of PTSD, and positive ways to handle trauma symptoms and consequences. This knowledge provides understanding and helps to fasten recovery processes in the patient (Melgosa, 2006).

**Narrative Exposure Therapy (NET);** according to the National Center for Post Traumatic Stress Disorder (2011), clients are cheered to narrate their trauma stories while being guided on how to handle their negative emotions in the process of narration until they no longer express the negative emotions as they narrate their trauma story. Continuous talking about these stressful events help clients and patients to feel less overwhelmed with their traumatic experiences hence recover.

**The Trauma Focused Cognitive Behavior Therapy (TFCBT);** According to Fredette et al (2016), it is believed that our behavior is determined by our perception and how we interpreted and understood our perception. TFCBT helps the client to identify and understand how their problems begun, what kept them going and how they could have avoided it. Here, a client is guided to identify the traumatic events experienced and to connect it to the thoughts and emotions they developed that was consequent to the behaviors they exhibited that made worse their PTSD symptoms. It was found that by examining and challenging thoughts about the trauma and by changing these thoughts, a client was able to change the way he/she feels and behaves to trauma experiences as well, hence recovery.

**Cognitive restructuring;** here, patients are guided to identify thoughts that make them feel afraid or upset and are guided on how to replace them with less distressing thoughts so as to avoid stress. It focuses on correcting painful and intrusive patterns of thoughts and behaviors by examining and challenging faulty thought processes in the client (National Center for Post Traumatic Stress Disorder, 2011).

**Exposure therapy;** according to Price et al (2013), in exposure therapy, patients are required to tell their traumatic story including their thoughts, feelings and behaviors. Then they are carefully and gradually exposed to the identified thoughts, emotions and the situations that affect their behavior, and are guided on how to deal with their perception and emotions in the exposure. This helped them to live peacefully.

**Family therapy;** according to the National Center for Post Traumatic Stress Disorder (2011), in family therapy, therapists provided information about the clients' condition

to the family so as to enable them learn skills to manage their loved ones' behavior and to understand them better for a fair treatment. Family therapy also guided the family on how they could communicate better to the PTSD patient and how to work through relationship problems caused by trauma symptoms presented in the patient. It also helps in addressing problems in the family that caused trauma in the patient hence recovery.

**Group therapy;** In group therapy, patients with similar traumatic experiences are grouped to share their trauma experiences as to how it impacted on their lives and how they coped with them. This encouraged others to know that they are not alone, learnt new coping skills and connect with others who truly understand what they have been through. She concluded that Group therapy offered a safe place to the patients for discussion of the traumatic events as well as the feelings and behaviors that emerged from the traumatic experience without fear of judgment from others who have not been through those experiences and this supported their recovery (Melgosa, 2006).

**Occupational therapy;** Here therapist helps patients and their caregivers identify and address recovery-based needs and strategies within the context of real-life demands such as candle, jewelries and soap makings, basket weaving, art and design, hooks knitting, caps knitting and tailoring services among others (Melgosa, 2006). Apart from working on the mind, Melgosa (2006) postulated that the therapy boosts the patients' self-esteem, helps them develop hope in themselves and their future and can keep the patients busy by increasing engagement in healthy, meaningful activities,

acquiring and sharing new skills with each other and earning a living through the sales of the products made.

#### **2.4.2. The role of social support**

According to Coventry et al (2020) Social support is a major protective factor against traumatic events for PTSD patients originating from romantic partners, family members, close friends, relatives or groups. Supportive behavior modifies the patients' environment and facilitate intrapersonal coping such as in helping the individual meet immediate physical safety and security needs, removing or reducing stressors not directly tied to the trauma and delivering of justice may positively impact intrapersonal efforts and further enhance recovery (Casey et al., 2022). Recent work has demonstrated that social identification with one's community, collective agency, and well-being stemming from expected support and shared goals in the wake of a common traumatic stressor can improve recovery (Coventry et al., 2020).

#### **2.5. Summary**

The literature review confirmed that relationship between the post LRA war consequences identified among the patients in the study and the PTSD symptoms exist. The research also supported counseling psychology and social support as a successful strategic intervention to mitigate the presentation of the PTSD symptoms among patients. In the existing work, however, the provision of social support and the counseling psychology as an intervention for PTSD did not fully arrest the progression

of PTSD symptoms among patients and other comorbidities due to the inadequate resources at GRRH and cultural degeneration in the region in the post LRA war period. The visible gap in the study was spiritual distress that was common among the PTSD patients at GRRH, that was strictly managed through spiritual counseling, healing and deliverance. This is also a contribution to this literature.

## CHAPTER THREE

### METHODOLOGY

#### 3.0. Introduction

This chapter provides a detailed description of the research methodology and material used in the study. It explains how the research was conducted and how data was generated and analyzed.

#### 3.1. Research methods

The research was executed using both qualitative and quantitative approach. Qualitative approach was applied to investigate the connection between the post LRA war consequences and PTSD symptoms and the relevancy of psychological counseling and social support Interventions to mitigate PTSD symptoms among patients in GRRH. Questionnaires were designed to collect data on post war consequences that comprised of financial scarcity;-Living below a dollar a day, Broken relationships;- Remarriages and divorce and Domestic violence;-Physical and psychological abuse and on PTSD symptoms such as re-experiencing that entailed flash back, night mare, Intrusive thoughts, hyper arousal that comprises of hyper vigilant, aggression and anger, startle response and lastly avoidance that engulfed Social dysfunction and occupational dysfunction; and the role of counseling psychology and social support services provided to mitigate PTSD symptoms among patients.

The data collected using questionnaires, were assorted and coded using excel sheet then transferred to SPSS version 22 for further analysis per study objective. The frequency counts, percentages, correlations and regressions using inferential data analysis was done. Analysis of data on demographic information was done using a descriptive statistic. Regression was used to test relationship between post LRA war consequences, posttraumatic stress symptoms level among patients and psychological counseling and social support services to mitigate PTSD symptoms among patients in GRRH. All through triangulation was used to legitimize personal views and interest that were mitigated by sticking on ethical standards of participation during data collection and analysis (Sarantakos, 2005).

### **3.2. Research Design**

The study used a cross-sectional design since it allows for a large amount of data to be collected within the required period of time. The mental health patients at GRRH were sampled and studied because they had the characteristics required for the study of PTSD patients at GRRH, in Northern Uganda. The design was chosen to generate relevant information and provide real time updates to reveal a snapshot of the mental health condition in GRRH in Northern Uganda within the specific time period (Oso & Onen, 2009).

### **3.3. Study Population**

The mental health patients annual report used in this study showed that, there were 405 patients recorded attending health service at GRRH mental health unit, who

presented with PTSD symptoms in the three-year period between 2011-2013 (GRRH, 2013). There were also 26 health workers assigned to work at the mental health unit at GRRH; Psychologist (3), Nursing assistants (9), Social workers (2), Psychiatric doctors (1), Psychiatric Clinical officers (6) Psychiatric Nurses (5) (Gulu District health office updated health worker list, 2012/2013). All the patients registered together with health team above formed the sampled population for this study.

### 3.4. Sample size determination

The research retrieved the sample population of health workers, and PTSD patients from GRRH and Gulu district local government (Gulu District health office updated health worker list, 2012/2013). The total sample size of health workers and PTSD patients was determined using the mathematical tables postulated by Krejcie & Morgan (1970) for generating health research sample. This is because this table helps to reduce errors by increasing percentage confidence level. Additionally, it enables participants to have equal chance to represent the population thus eliminating biasness. The sample size of the PTSD patient respondents was selected using the simple random sampling method using the formula postulated by Krejcie and Morgan (1970) below:

$$\text{Sample} = \frac{\text{Sample of component of accessible population} * \text{Total number of sample size}}{\text{Total number of accessible populations}}$$

According to the data collected, 405 PTSD patients were accessible and 26 health workers were accessible as well. The two accessible populations when added=431

total number of accessible populations. According to the Krejcie and Morgan (1970), for a total number of accessible populations of 431, the total number of sample size is 201. This therefore implies that, PTSD patient sample size = $405/431*201=189$  sample size of patients to be interviewed. More to that, for 26 accessible population of health workers, the sample size will be:

$26/431*201=12$  health workers to be included in the study or interviewed. This therefore when summed up gives an overall sample size population of 201. A summary of the population, sample and sampling techniques is provided in the table 1 below.

**Table 1: Sample size of the respondents**

<b>Respondents</b>	<b>Accessible population</b>	<b>Sample size</b>	<b>Sampling techniques</b>
PTSD patients	405	189	Simple random sampling
Health workers	26	12	Purposive sampling
<b>Total</b>	<b>431</b>	<b>201</b>	

### **3.4.1 Sampling procedures**

The study employed purposive sampling and simple random sampling to select the number of patient respondents and health workers for the study. This is because it allows for equal chances of participation and reduce minimum biasness among respondents. On the other hand, it enables researcher to put to use her personal knowledge and experience which are relevant to the study based on the assumption that the respondents have the information required in advance (Oso & Onen, 2009).

### **3.5. Data collection methods**

The research methods used to collect the data for the study included; interview method and questionnaire survey method, for collecting primary data during the study.

#### **3.5.1. Questionnaire survey method**

Survey questionnaires were used as a method of choice for collecting quantitative data. It was employed to collect specific information from respondents on Post Lord Resistance Army (PLRA) war consequences, PTSD symptoms level among patients and the role of psychological counselling and social support in mitigation of the PTSD symptoms among PTSD patients in GRRH in Northern Uganda. The respondents above 18 years were given questionnaires to fill and return for coding and analysis after completion. The questionnaire survey method was used because it was time saving, allowed for collection of information from a large population reducing the room for distortion of responses (Sarantakos, 2005).

The questionnaire contained questions that were composed to obtain responses from the respondents about the PLRA war consequences, the PTSD symptoms manifested among patients, the relationship between the PLRA war consequences and the PTSD symptoms, and the psychological counseling and social support services provided to mitigate the PTSD symptoms among patients in GRRH.

### **3.5.2. Interview method**

This is a method of data collection where information from the respondents is derived through having them involved in a face-to-face interview. This method helped the researcher to easily acquire from the PTSD patient respondents significant and comprehensive information on the PLRA war consequences and PTSD Symptoms level among patients in Gulu Regional Referral Hospital in Northern Uganda and psychological counseling and social support services to mitigate PTSD symptoms among patients in GRRH.

### **3.6. Data collection instruments**

In order to obtain comprehensive data from the PTSD patient respondents and the health workers from GRRH, the researcher used the questionnaires and interview guides. The motivation to use these tools were prompted by the sampling population characteristics, closeness, period and the availability of resources required. Described below are the tools used in the study;

The researcher used questionnaires for the key informants for collection of data that could easily be attained within a short time because the respondents could easily fill in the questionnaires. The researcher was motivated to use this method because the majority of the respondents were literate. For the PTSD patient respondents, an interview guide with list of questions for discussions on proposed topics required for the study was used. The instrument helped the researcher to attain in-depth qualitative data that were impossible to generate using a questionnaire.

### 3.7. Reliability and validity of instrument

#### 3.7.1. Validity

To determine the validity, the tool was given to three specialists; The principal Psychiatric clinical officer and Psychiatric doctor at Gulu regional referral hospital and a lecturer of Gulu University to evaluate and approve the items in the questionnaire and interview guide. The assessment of the significance of each item in the instrument in relation to the objectives of the study was done by rating each item on the scale of 1- 4, where; relevant equates to (4), quite relevant equates to (3), somewhat relevant equates to (2) and not relevant equates to (1). Bobi health center three in Gulu city was chosen for pre-test of the questionnaire's validity. This was followed by calculation of the content validity index (C.V.I) using the formula:

CVI = No of Item declared valid by the judges

Total No of items on the questionnaire

Judge 1:

CVI = 0.8

Judge 2:

CVI = 0.85

Judge 3:

CVI = 0.85

Therefore, content validity index average was:

CVI = 0.833

For the questionnaire, the overall content validity index (CVI) was 0.833 meaning that the items on the tools were asking relevant questions. An instrument which had an average index of 0.70 and above shall be accepted and considered as being valid (Amin, 2005). Some adjustments were made in regard to the advice of the three judges with whom the tools were vetted.

### **3.7.2. Reliability**

To test the reliability of the questionnaire, a pilot study was done at Bobi Health Centre III in Bobi Sub County that included 10 respondents with PTSD as a result of the LRA war. The test pre-test method was used to find out if the tools would produce consistent results. The tools were tested twice at an interval of two weeks using the same participants to check the validity and credibility in data collection. Cronbach's Alpha Reliability coefficients (Cronbach, 1951), were generated using the statistical package for social scientists (SPSS) computer program to estimate the reliability of the questionnaire. The summary of the results are in table 2 below.

**Table 2: Reliability statistics**

Items tested	Cronbach's Alpha	Number of items 1	Cronbach's Alpha	Number of items 2
Post LRA war consequences	0.780	4	0.780	4
Post Traumatic Stress symptoms	0.639	6	0.639	6
Counseling psychology and social support	0.620	2	0.584	3

### **3.8. Research procedure**

An introductory letter from Uganda Christian University (UCU) was submitted to the District authorities and permission was granted by the Chief Administrative Officer (CAO), District Health Officer (DHO) to carry out the research. The introductory letter from both the University and the District bearing the signatures and stamps from the university and Gulu District officials were presented to GRRH, health workers and respondents to enable the successful collection of data at the mental health Unit.

### **3.9. Measurement of variables**

All the response of the participants was rated using a Likert scale of 1- 5 dimensions on scale of Strongly Agree (SA), Agree (A), Undecided (U), Strongly Disagree (SD) and Disagree (D) respectively.

### 3.10. Data analysis

#### 3.10.1. Quantitative analysis

Data was analyzed using SPSS version 22. The collected raw data from the field were categorized and coded using Microsoft excel, then fed to the SPSS for further analysis. Correlation coefficients were generated to understand the relationship between the two variables and to generate conclusions. The strength of the relationship between the independent variables (consequences of the PLRA war) and dependable variables (PSTD symptoms) was analysed using Pearson's correlation coefficient (Obilor and Amadi, 2018). The Pearson coefficient correlation equation used was:

$$r = \frac{\sum[(x_i - \bar{x})(y_i - \bar{y})]}{\sqrt{[\sum(x_i - \bar{x})^2 \sum(y_i - \bar{y})^2]}}$$

Where,  $r$  is the Pearson correlation coefficient,

$x_i$  and  $y_i$  are the independent values for each  $x$  and  $y$  variables,

$\bar{x}$  and  $\bar{y}$  are the average for the  $x$  and  $y$  variables,

and  $\Sigma$  is the summation of the variables,

$\Sigma (x_i - \bar{x})(y_i - \bar{y})$  is the sum of the products of the deviations of each data point from its respective mean,

$\Sigma(x_i - \bar{x})^2$  is the sum of the squared deviations of the  $x$ -variable from its average

$\Sigma(y_i - \bar{y})^2$  is the sum of the squared deviations of the  $y$ -variable from its average.

### **3.10.2. Qualitative analysis**

Verbal communications during interviews with the respondents were analyzed and quoted to complement the quantitative data from the questionnaires.

### **3.11. Ethical consideration**

Ethical consideration was strictly followed during the study by attaining permission from the Chief administrative office and the principal administrator, GRRH to carry out the study in Gulu district. After permission was granted, informed consent was attained from the respondents to fill in the questionnaires and the health workers to be interviewed. Each questionnaire for the health workers and an interview guide for PTSD respondents began with a statement of purpose for the interview, a promise of confidentiality and an assurance that there was no right and wrong answer hence they should freely answer the question as they saw fit. The PTSD respondents were reassured together with the health worker respondents involved in the study, that the work was entirely for academic purposes, and that no names of the respondents will appear on any questionnaire. The PTSD patient respondents and the health worker respondents, who participated in this study were all briefed before the survey and invited to be part in the study and were informed that participation was optional. The research findings in the subsequent chapters were therefore unearthed in adherence to strong ethical procedures throughout the research.

### **3.12. Limitations of the Study**

The geographical scope of the study of PTSD symptoms among patients due to the post LRA war consequences was confined to patients that sought for medical treatment, psychological counseling and social support services at the mental health unit at GRRH. Other patients who could not access the hospital due to the long distances or who were probably attended to traditionally or had to seek support elsewhere in other health facilities were not captured.

This research offers a glimpse of what is happening in the lives of the people after their returned to their homes. A key limitation to this study is that the physical, psychological, political situation and socio-economic status of PTSD patients displayed may not portray the reality in those who are not attending the service at the mental health unit making the conceptualization of post LRA war consequences, PTSD symptom and psychological counselling and social support as a moderating variable difficult to conclude. However, if this study was done in the whole of the greater north, it would give it a wider perception and recognition.

The period of two years chosen as a basis for analyzing the post LRA War consequences and PTSD symptom among patients at the mental health unit at GRRH and psychological counselling and social support as a moderating variable may not display the sufficiency of the real state of the PTSD symptoms among all patients in Northern Uganda because the hostile consequence of the war for more than 2 decades crippled their physical, psychological ,social and economic lives leaving incomputable

and unimaginable scars in the physical, mental, social and economic lives of the people in the region.

In addition to that, the resettlement of the people of northern Uganda back to their home from the IDP camps has not taken more than 10 years. This therefore means there are still many consequences that they are not exposed to besides there are so many traumatic events that they could not have brought out during the therapy that remains triggering factors to their PTSD symptom.

## **CHAPTER FOUR**

### **PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS**

#### **4.0. Introduction**

This chapter contains presentation, analysis and discussions of the findings. The chapter has extracts from the interviews, descriptive statistics, and cross tabulation analysis of the different variables of the study. This study was in light of investigating the Post LRA war consequences, PTSD symptoms, the relationship between the PLRA

war consequences and PTSD symptoms, and the role of counseling psychology and social support in rehabilitation of PTSD patients at GRRH in Northern Uganda.

**4.1. Presentation of the results**

The key focus was to establish the relationship between Post LRA war consequences and the PTSD symptoms among patients at GRRH in Northern Uganda.

**4.1.1. Respondents’ Participation**

The participation turn-up is shown in table 3. Out of the 189 interview guides issued 186 were filled and returned giving a response rate of 98.4%. Concerning the questionnaires, out of the 12 proposed questionnaires, 10 questionnaires were filled and returned giving a response rate of 83.3%. The response rate of the questionnaires and interviews were all considered representative because they all fell above 50% which is the minimum acceptable response rate. The overall average response rate was computed and revealed a value of 90.9% that showed that the responses were representative. This chapter will therefore, analyze the response data obtained from the research Sample (n = 196) at 90.9% as the responses rate.

**Table 3: The response rate**

Data collection tools	Sample size	Data collection tools returned	Data collection tool not returned	Percentage

Interviews	189	186	3	98.4%
Questionnaires	12	10	2	83.3%
<b>Total</b>	<b>201</b>	<b>196</b>	<b>5</b>	

#### 4.1.2. Respondent Characteristics

The respondent's characteristics is shown in table 4. More than a half 60.8% (113) of the respondents were females while 39.2% (73) of the respondents were males.

**Table 4: Gender of the respondents**

Gender	Frequency	Percent
Female	113	60.8
Male	73	39.2
<b>Total</b>	<b>186</b>	<b>100</b>

#### 4.1.3. Participants Age

Participant's age groups are shown in table 5. Most of the respondents 43% (80 participants) who participated in the study were in the age group of 21-30 years followed by those in the age group of 31-40 years 21.5% (40 participants), then those below 20 years of age 20.4% (38 participants), then those within the age group of 41-50 constituted 9.7% (18 participants) and the least represented were of the age group of 51-60 years 4.8% (9 participants) and above 60 years, 0.5% (1 participants) respectively.

**Table 5: Age group of the respondents**

<b>Age group</b>	<b>Frequency</b>	<b>Percent</b>
Below 20 years	38	20.4
21-30 years	80	43.0
31-40 years	40	21.5
41-50 years	18	9.7
51-60 years	9	4.8
61 years and above	1	0.5
<b>Total</b>	<b>186</b>	<b>100</b>

#### **4.1.4. Education Status**

The respondent's education status is shown in table 6. A larger proportion 31.7% (59 participants) of the respondents had primary education, 30.1% (56 participants) of the respondents had O level education status, followed by A level who were 10.2% (19 participants) then certificate holders who constituted 23.7% (44 participants) while, the least where degree and master holders who were 3.8% (7 participants) and 0.5% (1 participant) respectively.

**Table 6: Education status of the respondents**

<b>Education status</b>	<b>Frequency</b>	<b>Percent</b>
Primary level	59	31.7
O level	56	30.1
A level	19	10.2

Certificate	44	23.7
Degree	7	3.8
Masters	1	0.5
<b>Total</b>	<b>186</b>	<b>100</b>

#### 4.1.5. Occupations

The respondent's occupation status is shown in table 7. A greater percentage of 45% (84 participants) of the respondents were peasant farmers, followed by 34.4% (64 participants) who were in business, then civil servants who were 12.9% (24 participants) and the military and social workers had the least percentages represented by 7% (13 participants) and 0.5% (1 participants) respectively.

**Table 7: Occupation of respondents**

Occupation of respondent	Frequency	Percent
Peasant farmer	84	45.2
Business	64	34.4
civil servant	24	12.9
Social worker (NGO staff)	1	0.5
Military; army, police, prison	13	7.0
<b>Total</b>	<b>186</b>	<b>100</b>

#### 4.1.6. Duration taken on Mental Health Support

The duration the respondent took getting mental health support from Gulu regional referral hospital mental health unit is shown in table 8. Most 46.2% (86 participants)

of the respondents had suffered for 3-4 years, followed by 26.9% (50 participants) for 1-2 years, then 21.5% (40 participants) for 5-6 years. The least period on mental health support was 7-8 years and 9 years and above respectively who were 4.3% (8 participants) and 1.1% (2 participants) respectively.

**Table 8: Mental health support durations**

<b>Period patient has been on mental health support</b>	<b>Frequency</b>	<b>Percent</b>
1-2 years	50	26.9
3-4 years	86	46.2
5-6 years	40	21.5
7-8 years	8	4.3
9 and above years	2	1.1
<b>Total</b>	<b>186</b>	<b>100.0</b>

#### 4.1.7. Category of Patients

The respondents on treatment at the mental health unit groups is shown in table 9.

**Table 9: Patient's Category**

<b>Type of Patient</b>	<b>Frequency</b>	<b>Percent</b>
In-patient	56	30.1
Out-patient	130	69.9
<b>Total</b>	<b>186</b>	<b>100.0</b>

Almost three quarters 69.9% (130 participants) of the respondents were out-patients while the remaining 30.1% (56 participants) were in-patients. Out-patients were those commuting from their homes to receive mental health support from the facility, while the in-patients are those admitted and getting support from within the facility.

#### 4.2. To investigate the Post LRA War Consequences among patients in GRRH in Northern Uganda.

The post LRA war effect is shown in table 10.

**Table 10: Showing the post LRA war consequences**

Statement	SA	A	SD	D	U	Total
The patient lived in poverty (experienced deprivation of basic needs; Food, water, health care services and below one dollar a day) during the post LRA war?	166 (89.2%)	15, (8.1%)	0	5 (2.7%)	0	186, (100%)
Patient experienced Broken relationship during the post LRA war?	107, (57.5%)	17, (9.1%)	17, (9.1%)	16, (8.6%)	29, (15.6%)	186, (100%)
Patient experienced Domestic violence during the post LRA war?	150, (80.6%)	13, 7.0%	8, 4.3%	10, 5.4%	5, 2.7%	186, 100%

Patient lived in poverty: As indicated in the above table, majority of the respondents 89.2% (166 participants) strongly agreed that they lived in poverty, 8.1% (15

participants) Agreed, 2.7% (5 participants) disagreed, while none was undecided. Most of the respondents of the study strongly agreed that they lived in poverty probably due to the fact that they lost their property and could not access basic needs like food, water, health care services and lived below one dollar a day) during the post LRA war.

Broken relationships: As indicated in the above table, most of 57.5% (107 participants) of the respondents strongly agreed that broken relationships were PLRA war consequences among patients who sought mental health services at GRRH, 9.1% (17 participants), agreed, 9.1% (17 participants) strongly disagreed, 8.6% (16 participants) disagreed, while 15.6% (29 participants) were undecided. This therefore indicated that most of the respondents agreed that broken relationships were a post LRA war consequences among PTSD patients at GRRH. This could be attributed to the fact that they felt a great loss and failure in their lives that could never be recovered.

Domestic violence: Almost three thirds 80.6% (150 participants) of the respondents strongly agreed that domestic violence was a PLRA war consequence presenting PTSD symptoms among patients who sought mental health services at GRRH, 7.0% (13 participants) agreed, 4.3% (8), strongly disagreed, 5.4% (10 participants) disagreed while 2.7% (5 participants) were undecided. This implies that most of the respondents agreed that domestic violence was a major PLRA war consequence presenting with PTSD symptoms because it created permanent scar in the patients' lives that continuously reminded them of the former traumatic event experienced.

### 4.3. To access the PTSD Symptoms Among Patients in GRRH in Northern Uganda

The PTSD symptoms among the respondents is shown in table 11. Most of the respondents 78.5% (146 participants) strongly agreed that they suffered re-experiencing and 5.4% (10 participants), agreed to it while 6.5% (12 participants), and 6.5% (12 participants), strongly disagreed and disagreed respectively meanwhile, 3.2% (6 participants), were undecided. This implies that most of the patients who presented with re-experiencing that were relived in nightmares, flashbacks and intrusive thoughts probably continuously meditated over their post LRA war experiences and got reminded of their past trauma and re-enacted them automatically.

**Table 11: PTSD Symptoms Among Patients in GRRH**

Statement for PTSD symptoms	SA	A	SD	D	U	Total
Most of the patients suffered re-experiencing?	146, (8.5%)	10, (5.4%)	12, (6.5%)	12, (6.5%)	6, (3.2%)	186, (100%)
Most of the patients suffered Hyper arousal?	136, (73.1%)	14, (7.5)	12, (6.5%)	14 (7.5%)	10, (5.4%)	186, (100%)
Most of the patients suffered avoidance?	139, (74.7%)	9, (4.8%)	13, (7.0%)	14, (7.5%)	11, (5.9%)	186, (100%)

**Hyper arousal:** More to the above, most of the respondents strongly agreed that they suffered hyper arousal 73.1% (136 participants) and 7.5% (14 participants) agreed to it while 6.5% (12 participants) strongly disagreed and 7.5% (14 participants) disagreed and 5.4% (10 participants) were undecided. Most of them strongly agreed probably

because they were preoccupied with their safety by always keeping alert to avoid recurrence of the past trauma experiences. These were indicated in their presentation with hyper vigilant, anger and aggression, and startled response when frightened and in case they suspected any sense of insecurity.

**Avoidance:** As reflected above, most of the respondents strongly agreed that they suffered avoidance 72.7% (139 participants) and 4.8% (9 participants) agreed to it while 7% (13 participants) and 7.5% (14 participants) strongly disagreed and disagreed respectively and 5.9% (11 participants) were undecided. Most of the patients strongly agreed that they suffered avoidance probably because they significantly lost interest in the occupational and social activities that formerly appealed to them. This was purposely done to avoid being reminded of their past traumatic experiences and the associated impacts in their lives.

#### 4.4. To determine the Relationship Between the PLRA War Consequences and PTSD Symptoms Level Among Patients in GRRH in Northern Uganda.

The relationship between the PLRA war consequences and PTSD symptom among patients is shown in table 12.

**Table 12: Correlations of the PLRA war consequences and PTSD symptoms level Among Patients in GRRH**

<b>Correlation</b>	PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda					
	<b>SA</b>	<b>A</b>	<b>SD</b>	<b>D</b>	<b>U</b>	<b>Total</b>

Post LRA war consequences among patients in Gulu Regional Referral Hospital in Northern Uganda	144 (77%)	13 (7%)	12 (6%)	10 (5%)	7 (4%)	186 (100%)
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According to the results of the study above, 77% (144 participants) of the respondents strongly agreed that the post LRA war consequences among patients at GRRH had a strong relationship with the PTSD symptoms manifested. 7% (13 participants) of the respondents Agreed, 6% (12 participants) Strongly disagreed, 5% (10 participants) disagreed, 7.4% were undecided. The highest percentage (80%) of the respondents who strongly agreed and agreed probably points out that, the hyper-arousal, re-experiencing and avoidance were greatly associated to the consequences of the post LRA war. The few respondents who Strongly disagreed and disagreed probably attached the PTSD symptoms manifested to real life experiences they underwent that were not related to the war. For example, addictions and accidents amongst others.

**Table 13: correlation between the consequences of the PLRA war and the PSTD Symptoms among the Patients**

Correlations	Post LRA War Consequences		
	Poverty	Broken Relationship	Domestic violence
PTSD Symptoms	0.695	0.640	0.681

Re-experiencing	0.671	0.516	0.453
Flash back	0.675	0.478	0.447
Night mare	0.692	0.490	0.458
Intrusive thoughts	0.686	0.490	0.454
Hyper-arousal	0.761	0.545	0.484
Hyper-vigilance	0.674	0.477	0.446
Aggression & anger	0.935	0.681	0.675
Startle response	0.674	0.477	0.446
Avoidance	0.675	0.478	0.447
Occupational dysfunction	0.681	0.482	0.451
Social dysfunction	0.669	0.474	0.443

The relationship between the PLRA war consequences and PTSD symptoms level among Patients in GRRH is shown in Table 13 above. A very strong positive correlation coefficient ( $r=0.935$ ) exists between poverty and Aggression & Anger and a strong positive correlation was recorded between poverty and night mare ( $r=0.692$ ), poverty and intrusive thoughts ( $r= 0.686$ ), poverty and occupational dysfunction ( $r=0.681$ ), poverty and flash back ( $r=0.675$ ), poverty and hyper-vigilance and startle response ( $r=0.675$ ) and poverty and social dysfunction ( $r=0.669$ ).

A strong positive correlation was recorded between broken relationship and aggression and anger ( $r=0.681$ ). Meanwhile, a weak positive correlation exists between broken relationship and night mares and intrusive thoughts ( $r=0.490$ ), broken

relationship and occupational dysfunction ( $r=0.482$ ), broken relationship and flash back ( $r=0.478$ ), broken relationship and hypervigilance and startle response ( $r=0.477$ ) and broken relationship and social dysfunction ( $r=0.0474$ ).

A strong positive correlation existed between domestic violence and aggression and anger ( $r=0.675$ ). Meanwhile, a weak positive correlation exists between domestic violence and night mare ( $r=0.458$ ), domestic violence and intrusive thoughts ( $r=0.454$ ), domestic violence and occupational dysfunction ( $r=0.451$ ), domestic violence and flash back ( $r=0.447$ ), domestic violence and hypervigilance and startle response ( $r=0.446$ ), and domestic violence and social dysfunction ( $r=0.443$ ).

**Table 24: correlation between the impact of PLRA war and the PTSD Symptoms among the PTSD Patients**

correlations		PTSD Cluster Symptoms		
		Re-experiencing	Hyper-arousal	Avoidance
PLRA War Consequences		0.671	0.761	0.675
		0.516	0.545	0.478
		0.453	0.484	0.447
Poverty	0.695	0.683	0.728	0.685
Broken R/ship	0.640	0.578	0.5925	0.559
Domestic Violence	0.681	0.567	0.5825	0.564

In conclusion, a very strong positive correlation coefficient ( $r=0.728$ ) exists between the PLRA war consequence of poverty and the PTSD cluster symptom of hyper-arousal.

A strong positive correlation existed between poverty and avoidance ( $r=0.685$ ) and poverty and re-experiencing ( $r=0.683$ ).

A strong positive correlation exists between broken relationship and hyper-arousal ( $r=0.5925$ ), broken relationship and re-experiencing ( $r=0.578$ ), and broken relationship and avoidance ( $r=0.559$ ).

A strong positive correlation exists between domestic violence and hyper-arousal ( $r=0.5285$ ), domestic violence and re-experiencing ( $r=0.567$ ) and domestic violence and avoidance ( $r=0.564$ ).

#### **4.5. To determine the Role of Psychological Counseling and Social Support in Rehabilitation of the PTSD Patients in GRRH in Northern Uganda.**

The Role of Psychological Counseling and Social Support in Rehabilitation of the PTSD Patients is shown in table 13. Most, 60.8% (113 participants) of the respondents strongly agreed that the social support being rendered to PTSD patients to help them recover faster is effective, 17.2% (32 participants) agreed, 9.7% (8 participants) strongly disagreed, 4.3% (8 participants) disagreed, while 8.1% (15 participants) were undecided.

Counseling psychology: The highest proportion 68.5% (127 participants) (of the respondents strongly agreed that psychological counselling being rendered to PTSD patients to help them recover faster was effective, 18.8% (35 participants) agreed, 7% (13 participants), strongly disagreed, 4.3% (8 participants) disagreed, while 3 1.6% (3 participants) were undecided.

Most of the respondents strongly agreed or agreed because the counselling helped the patient change their attitudes and perception while the social support addressed their physical, emotional and spiritual needs thereby achieving positive responses in enhancing their recovery. Those who strongly disagreed and disagreed were probably because GRRH totally rely on the NGOs attached to the hospital for both psychological counseling and social support services to the patients. Since the NGOs strictly avail their services on certain week days and for certain numbers of patients, there seem unreliability and inadequacy in their service provision to all PTSD patients.

**Table 13: Showing Psychological counselling and social support provided to PTSD patients**

Statement	SA	A	SD	D	U	Total
Do you think the social support being rendered to the PTSD patients to help them recover faster is effective?	113, (60.8%)	32, (17.2%)	18, 9.7%	8, (4.3%)	15, (8.1%)	186, 100%
Do you think the psychological counselling being accorded to the PTSD symptom patients to help them recover faster is effective?	127, (68.5%)	35, (18.8%)	13, 7%	8, (4.3%)	3, (1.6%)	186, 100%

## CHAPTER FIVE

### DISCUSSION OF RESULTS

#### 5.0. Introduction

In this chapter, the summary and discussions of the study were presented according to the results and were appropriate. Existing literature were included in the discussions as below:

#### 5.1. Summary of findings

Chapter five presented objective by objective the summary of the results of the study following a descriptive and correlation analyses of the collected data in relation to the four objectives of the study.

##### 5.1.1. The Post LRA War Consequences

Under the first objective, the analysis of the quantitative data revealed that majority of the patients lived in poverty 89.2%, 57.9% experienced broken relationships and domestic violence were 80.6% during the post LRA war. The qualitative data highlighted that the poverty in the lives of the PTSD patients would increase the level of PTSD symptoms. This therefore indicated that increasing ways that strengthen the financial capacity of PTSD patients would significantly help in reducing the level of PTSD symptoms among the patients.

### **5.1.2. PTSD Symptoms Among Patients in GRRH**

The analysis of the quantitative data revealed that most of the patients were suffering from; Re-experiencing 78.5%, Hyper arousal, 73.1% and Avoidance 74.7% as PTSD symptoms. The qualitative data complemented the quantitative results above revealing that most of the PTSD patients presented with PTSD symptoms of Re-experiencing, Hyper arousal, and Avoidance. This can therefore be concluded that, there is a high level of PTSD symptom among patients in GRRH in Northern Uganda.

### **5.1.3. The Relationship Between the Consequences of the post LRA War and the Level of PTSD Symptoms Among Patients**

The analysis of the quantitative data revealed a strong correlation of 77% between the post LRA war consequences and the PTSD symptoms among patients at GRRH. Meanwhile, the Pearson Correlation coefficient revealed a very strong positive correlation coefficient ( $r=0.728$ ) between the PLRA war consequence of poverty and the PTSD cluster symptom of hyper-arousal. A strong positive correlation coefficient was revealed also between poverty and avoidance ( $r=0.685$ ) and poverty and re-experiencing ( $r=0.683$ )

A strong positive correlation exists between broken relationship and hyper-arousal ( $r=0.5925$ ), broken relationship and re-experiencing ( $r=0.578$ ), and broken relationship and avoidance ( $r=0.559$ ).

A strong positive correlation was also revealed between domestic violence and hyper-arousal ( $r=0.5285$ ), domestic violence and re-experiencing ( $r=0.567$ ) and domestic violence and avoidance ( $r=0.564$ ).

The correlation coefficient ( $r > 0.5$ ) signifies that the parameters in comparison have strong positive linkage where increase in one result is consequential to increase in the other. For instance, an increase in PLRA war consequence of poverty shall propel domestic violence and broken relationship. Similarly, when poverty intensifies, it results in to considerable increase of PTSD cluster symptoms of Re-experiencing, Hyper-arousal and avoidance, making life miserable for the patients.

The qualitative data similarly highlighted that the more post war consequences experienced by the patients, the more PTSD symptoms manifested among patients. This can therefore be concluded that, patients who experienced severe Post war consequences required more support and attention to recover from presenting PTSD symptoms.

#### **5.1.4. The Role of Counseling Psychology and Social Support in Rehabilitation of the PTSD Patients.**

The analysis of the quantitative data revealed that there is a positive moderate relationship between social support and psychological counselling being provided to the PTSD patients to help them recover faster. The qualitative data highlighted that the increased levels of social support and psychological counselling interventions to the PTSD patients would facilitate a faster recovery. This can therefore be concluded that PTSD patients need more social support and psychological counselling to recover faster.

## 5.2. Discussion of the study results

### 5.2.1. Introduction

This section presents a discussion of the key results of the study under the four objectives of the study as below:

### 5.2.2. The Post LRA War Consequences.

**Poverty:** The results of the study revealed very strong positive evidence of patients living in poverty as a consequence of the Post LRA war. Most of the respondents strongly agreed that they lived in poverty probably due to the fact that they lost their property and could not access basic needs like food, water, health care services and lived below one dollar a day during the post LRA war period.

More to that, the key informant interviews (KIs) also revealed that, most of the patients lost their valuable property during the war and starting from the scratch was difficult for them when they returned from the IDP camps after more than 20 years of displacement. When they ran for their lives to the IDP camps, they lost their houses, academic and important personal documents, businesses, and domestic animals that they greatly treasured as their major source of income. Upon return they lost their land due to land grabbing, interrupting their agricultural livelihoods hence their lives went from bad to worse.

Failure to provide for themselves and their families in terms of their basic needs (food, housing, clothing, and medical treatment) caused them great frustration and

led to relieve of flashbacks, intrusive thoughts and nightmares that kept unfolding as fresh reminders to their past trauma.

This finding was in agreement to that of Kim et al (2024), who ascertained that one's socio-economic state leads to the development of multiple anxiety disorders that manifest in re-experiencing. According to Kim et al (2024), financial scarcity acts as traumatic stressors where one's inability to pay for life expenses leads to intense emotional and mental challenges exhibited through flashbacks and upsetting memories. This was supported by Kigozi and Ssebunya (2009), who also agreed that poverty serves as a high-risk factor for mental disorder globally. Kigozi and Ssebunya (2009) identified poverty as a major risk factor for mental illness and at the same time as a strong causative and mediating factor for stress, frustrations, and depression leading to re-experiencing which are the major mental health problems in Uganda.

One of the respondents was quoted saying;

*“She was severely beaten by her brothers in law who forced her to hand over all the property that included; land, bank account numbers and her marital house left behind by her late husband. Her refusal attracted more verbal insults and physical violence resulting into a mental break down as she couldn't cope with the harsh treatment of the in laws, and the level of hardship and lack, envisioned in the future. She was therefore brought talking to herself and calling the names of her late husband and parents”.*

This verbatim clearly expressed the adverse consequences of the war in the lives of the patients with PTSD.

**Broken Relationship:** The results of the study pointed to moderate positive evidence of patients experiencing broken relationships. This therefore indicated that, probably most of the respondent agreed that broken relationships were one of the posts LRA war consequences. This could be attributed to the fact that they felt a great loss and failure in their lives that could never be recovered.

The Key informant interviews (KIIs) revealed that most of the patients who experienced broken relationships found it difficult to recover from the feeling of great loss and failure in their lives. They further added that PTSD patients felt supported by their spouses when they played their family roles, cared for, and provided for them. Losing a spouse therefore caused them a lot of regrets, insecurity and pain that they found themselves angry, aggressive, lonely and sad all the time.

This was in agreement with Allisson & Susan (2019), who argued that the loss of a significant relationship is one of the life's most difficult challenges in that, following relationship dissolution, many people manifest symptoms similar to those experienced by people who have survived highly stressful situations. Allisson & Susan (2019), postulated that, separation increased one's risk of distressful psychological symptoms such as hyper-arousal and suicidal behavior. She considered divorce and remarriage, as one of the greatest life stressors and argued that the trauma of divorce and remarriage can lead to relieve of PTSD symptoms like hyper-arousal. In review of the study, Allisson & Susan (2019), quoted a psychiatrist Dr. Susan Edelman who agreed

that the breakup of a relationship and remarriage could lead to worsening symptoms of post-traumatic stress disorder characterized by hyper-arousal presented in anger, irritability and aggression, re-experiencing of symptoms, including intrusive thoughts or dreams about the dissolution and avoidance behaviors and decreased psychological well-being.

One of the respondents commented that;

*“Since my husband was murdered in cold blood during the LRA war period, I failed to get over the fact that he was no more. I kept remembering the special days and close intimate friendship we used to have. To make the matters worse, the gifts he used to give me kept reminding me of him. Now days I find myself feeling insecure, frightened, angry and aggressive at anyone who comes close to me holding a gun or army uniform.”*

This verbatim clearly expressed the adverse consequences of the war in the lives of the patients with PTSD.

**Domestic violence:** The results of the study revealed very strong positive evidence of patients suffering from domestic violence as a consequence of the Post LRA war. This implies that most of the respondents agreed that domestic violence was a major precipitating factor to PTSD symptoms because, it created permanent scar in their lives that continuously reminded them of the former traumatic event experienced.

Patients who were victims of domestic violence lost trust in people, isolated themselves, became anxious, depressed and hopeless again. Even though the war was over, it never ended in their minds.

This finding is in agreement with Gluck (2021), who argued that there is a similarity between domestic violence and PTSD symptoms like avoidance among others in which victims present avoidance behaviors by isolating themselves from others or losing interest in activities formerly enjoyed, yet others totally forgot, or could not at all express any key issues in their traumatic experiences. Consequently, they became numb or moody with other people. This was supported by the National Center for Post Traumatic Stress Disorder (2011), who ascertained that domestic violence affects both the body and the mind of the affected people through both direct ways like wounds and injuries and indirect path ways like the psychological consequences of PTSD. For instance, being victims of domestic violence earned a person a name like “the battered one” which continuously reminded the victims about the past violence experienced that returned them to the hell they suffered leading to manifestation of re-experiencing, hyper arousal and avoidance symptoms. This was agreed by Hoge et al (2007), who ascertained that domestic violence violates the integrity of the victim and lower their self-esteem. Meanwhile, the pain inflicted in domestic violence through the act of name calling, criticism, degradation, manipulation, battering and belittling among others, destroy one’s self image and instill guilt among others, consequent to Post traumatic disorder symptom expressed in anger outburst, being easily startled, negative thoughts, insomnia, nightmares, flash backs and increased heartbeat.

One of the respondents was quoted saying;

*“I hate every memory I had during the LRA war, I was first tightly tied in three-piece suits (kandoya), poured water on, and rigorously beaten, kicked and starved inhumanely. Later on, I was thrown in a cage full of fangless snakes and there after raped by those who kidnapped me. As if that was not enough, my spouse is violent and vulgar when I made any mistake. I hate it when I fight with my spouse, it brings back all those memories afresh and makes me want to stay alone or commit suicide”.*

### **5.2.3. PTSD Symptoms Among Patients in GRRH**

Re-experiencing: The results of the study revealed strong positive evidence of re-experiencing suffered by the majority of the respondents who strongly agreed that they relieved night mares, intrusive thoughts and flashbacks most of the time. This implies that the patients probably continuously meditated over their post LRA war consequences which could have ignited re-experiencing as if the trauma had freshly happened again. The experiences made them powerless over their thoughts hence automatic discharge of intrusive thoughts, night mare and flashback episodes among patients. This study agrees with similar findings by the Veterans’ Health Service (2014) report which postulated that in re-experiencing, traumatic memories can come back when they are unexpected and people get vivid ‘flashbacks in their relief of intrusive memories. Similarly, Ferry et al (2014), also ascertained that Northern Ireland for many years experienced exposure to traumatic stress in which many people developed PTSD symptoms. She argued that despite the patients’ struggle to

conquer the threat imposed, the recollection never ceased and would manifest in its full force at the most awkward times. This indicated that their memory remained so clear that it seems as if the trauma continuously happens every day, whether it is in the day time or at night. In spite of this, Ferry et al (2014) expressed that, nightmares were disturbing their sleep and they woke up to find themselves drenched in sweat.

**More to that, regarding Hyper arousal:** A strong positive (73%) evidence of patients suffered hyper-arousal that presented with hyper vigilant, anger and aggression, and startled response as PTSD symptoms. This was probably because they were preoccupied with their safety indicated in their continuous alertness to avoid reoccurrence of the past trauma experiences. Being hyper-vigilant is an indicator that the patient is suspicious of insecurity, followed by startle response when patient felt terrified and anger and aggression came as a defense for attainment of security. This finding agrees with the National Center for Post Traumatic Stress Disorder (2011), who ascertained that PTSD patients normally experience hyper-arousal that presents with anxiety, irritability or outbursts of anger, jumpiness and startled responses over loud noises. In support of the above argument, Chemtob et al (1997), argued that patients with PTSD feel that the best response to extreme threat is to act aggressively to protect themselves. Similarly, Gray et al (2010), documented that irritability and anger outbursts are prevalent among the patients with PTSD and the manifestation are normally associated with interpersonal violence. According to Kuipers et al (2014), hyper-arousal presents with hyper-vigilant symptoms or constantly looking out for danger or threats, isolation from others and loss of trust in mankind.

A respondent commented that;

*“I always keep a sharpened machete under my bed and carry sharp knives everywhere because I imagine that people could be having gun or anything that could threaten my life. I also keep a closer look at what anyone is carrying wherever I am at all times for my safety.”*

Avoidance: Strong positive evidence of patients relieved avoidance as a PTSD symptom among patients at GRRH probably because they had sense of foreshortened future and hopelessness. This consequently contributed to significant loss of interest in the occupational and social activities that were formerly of great value to the patients, and they mostly avoided places, people, thoughts and any social gatherings that could bring fresh memories of their past traumatic experiences. These patients always were isolated and depressed.

The KIIs revealed that social and occupational dysfunction among patients occurred when many of them got tormented and were yelled at. These made them felt more afraid, belittled, humiliated and hopeless. Consequently, they responded in exaggerated startles, guilt, shame, outburst of anger, withdrawal from others and Loss of self-esteem. This finding is in agreement with, the National Center for Post Traumatic Stress Disorder (2011), who argued that PTSD patients often avoided recollections of any traumatic experiences in terms of people, thoughts, or any reminder of their traumatic experiences. In support, the Veterans’ Health Service (2014) report ascertained that, patients also lose interest in significant activities they formerly enjoyed. According to Sripada et al (2013), PTSD patients also portrayed

restricted range of affect, and experienced sense of foreshortened future that normally led them to suicide and avoidance symptom which leads to social and occupational dysfunction in the patients.

A respondent commented that;

*“When my boss shouts at me at work because I reached late, it makes me recall my former husband while in the LRA camp during the war. He used to kick and beat me up using his gun and threatens me with a knife while abusing me with foul language. That’s why I stopped going to work and attending church services since my boss at work never misses going to church. I got tired of the boss; I rather remain home and take care of my children since their work is to hurt people all the time.”*

This evidently pointed out that the role of Post war consequences cannot be ignored while providing treatment for PTSD patients.

#### **5.2.4. Relationship Between the Consequences of the Post LRA War and the Level of PTSD Symptoms Among Patients**

The results of the study revealed that there is a strong positive relationship between the post LRA war consequences and the PTSD symptoms among patients at GRRH. The highest percentage of (80%) who strongly agreed and agreed and the Pearson Correlation coefficient ( $r=0.728$ ) between the PLRA war consequence of poverty and the PTSD cluster symptom of hyper-arousal ( $r=0.685$ ), between poverty and avoidance and poverty and re-experiencing ( $r=0.683$ ). Broken relationship and hyper-arousal

( $r=0.5925$ ), broken relationship and re-experiencing ( $r=0.578$ ), broken relationship and avoidance ( $r=0.559$ ). Lastly between domestic violence and hyper-arousal ( $r=0.5285$ ), domestic violence and re-experiencing ( $r=0.567$ ) and domestic violence and avoidance ( $r=0.564$ ).

These findings showed a strong positive linkage between the PLRA war consequences and the PTSD symptoms and clearly pointed out that hyper-arousal, re-experiencing and avoidance as PTSD symptoms were greatly associated with the post LRA war consequences among patients at GRRH. The few respondents who Strongly disagreed and disagreed probably attached their PTSD symptoms' presentation to their real-life experiences that were not related to the war. For example, terminal illnesses and accidents among others. Our findings agreed with many authors who ascertained that hyper-arousal, re-experiencing and avoidance as PTSD symptoms were greatly associated with post war consequences such as poverty, divorce and remarriage, and domestic violence among patients (Kim et al., 2024; Gluck, 2021; Allisson, 2022; National Center for Post Traumatic Stress Disorder, 2011; Kigozi & Ssebunya, 2009; Hoge et al., 2007).

#### **5.2.5. The Role of Psychological Counseling and Social Support in Rehabilitation of the PTSD Patients**

The results of the study revealed a moderate positive relationship between psychological counseling and social support in rehabilitation of the PTSD patients. Most of the respondents strongly agreed or agreed because the counselling helps the patient change their attitudes, perception and reinforced a healthy coping strategy.

On the other hand, social support addressed physical, emotional and spiritual needs of the patients henceforth enhancing their recovery.

The KIIs during the study revealed that the patients were being supported with free psychological counselling and social support which enabled them to recover faster. However, they were experiencing high cases of relapse because when the patients went back to their homes, they experienced various challenges that reminded them of the previous war experiences causing them to return to the hospital for support. It is also important to note that even if the health facility is doing its best, GRRH depends on the NGOs counselors and social support services which are sometimes unreliable and are inadequate since there is a huge number of patients from all the northern districts, other parts of Uganda and South Sudan since they are closer to Uganda and have experience war for a long time.

This finding is in agreement with, Coventry et al (2020), who argued that psychological counseling is one of the best solutions for those who have developed PTSD symptoms as it gives them an avenue to express their feelings to be heard, hence reducing PTSD symptoms in the community. This was supported by Taylor (2019), who ascertained that therapy has proven helpful for mental health patients who are going through divorce and those who have gone through it. Taylor (2019), further commented that, a mental health patient can be helped but they need to be open for support and reach out for it. Similarly, Coventry et al (2020), expressed that having a strong social support system such as; reaching out to family and friends, joining a support group or seeking out a therapist, and learning effective coping

strategies are important to a trauma patient. Coventry ascertained that a strong social network for a PTSD person indicates that the PTSD patient is not alone in his/her struggle with mental disorder. This was supported by Casey et al (2022), who argued that supportive behavior modifies the patients' environment and facilitate intrapersonal coping such as in helping the individual meet immediate physical safety and security needs, removing or reducing stressors not directly tied to the trauma and delivering of justice may positively impact intrapersonal efforts and further enhance recovery.

One of the respondents said that;

*“I am a poor and deserted childless widow, majority of my relatives died during the war and I am currently alone with no one to support me. When I come to the hospital the health worker provides me counselling and medication to help me recover faster and get discharged. But when I reach home, I lack someone to provide emotional and material support and that causes me to fall sick again and return to the hospital”.*

This shows how strongly continual psychological counseling and social support in rehabilitation of the PTSD patients is needed until the patient completely recovered.

## CHAPTER SIX

### CONCLUSIONS AND RECOMMENDATIONS

#### 6.0. Introduction

In this chapter, conclusions and recommendation of the study were presented according to the results and where appropriate, existing literature were included in the discussions.

#### 6.1. Conclusions on study results

From this study, it can be concluded that most of the patients suffered poverty, broken relationships and domestic violence. Majority of PTSD patients lived under a dollar a day, lacked access to basic needs like food, clothing, health care, suffered divorce, and experienced challenges in remarrying, as well as physical and psychological abuse. Thus poverty, broken relationship and Domestic violence were the Post LRA war consequences experienced by PTSD patients at GRRH in Northern Uganda. A reduction in the level of these consequences would improve their quality of life and wellbeing and sustain their recovery.

Most of the patients presented with re-experiencing symptom that were relieved in flashback, night mare and intrusive thoughts, hyper-arousal symptom that presented with hyper vigilant, aggression and anger, and startle response, and in avoidance symptoms that manifested in social and occupational dysfunction of patients. Hence, re-experiencing, Hyper arousal and avoidance are the PTSD symptoms that manifested

among the patients at GRRH. Supporting these patients socially and psychologically would help them recover from presenting these PTSD symptoms.

Strong positive relationship exists between the consequences of the LRA war and the level of PTSD symptoms among patients which showed that the post LRA war consequences precipitated the level of PTSD symptoms among patients at Gulu Regional Referral Hospital in Northern Uganda.

Moderate positive relationship between psychological counseling and social support in rehabilitation of the PTSD patients shows that, patients who experienced severe Post war consequences require more social and psychological support to recover from presenting PTSD symptoms by a half difference.

## **6.2. Recommendations**

The following recommendations are proposed to key stakeholders for implementation to address the problems of post LRA war consequences on PTSD symptoms among patients at GRRH in Northern Uganda:

In reference to poverty, the government and non-governmental organizations should strengthen and gear their interventions and support towards increasing household and personal income of the PTSD patients. This can be possible when they are engaged in VSLA groups to extend financial and credit services to them, empower them with Income Generating Activities (IGAs) and entrepreneurship skills. Having access to income by the patients would empower them to access basic needs and social services that would reduce presentation of the PTSD symptoms among patients in GRRH.

The government, the non-governmental organizations and social institutions may strengthen the psychological counseling and social support services, to the patients to enable them have stable relationships thereby reducing the level of broken relationships among patients. More to that, strengthening the social and the religious system to provide social support for their community members, to enhance the social and emotional needs of their members. Besides, the human rights-based approach, gender-based violence counselling and mental health awareness should be mainstreamed in all work places in Northern Uganda where effects of the insurgency can still be traced. Mainstreaming these work approaches at work places would reduce levels of domestic violence both at work, home and eventually the community at large hence, reducing the presentation of the PTSD symptoms among patients.

More awareness meetings and dialogues on conflict and alternative dispute resolutions on peaceful means of handling conflicts in the community and family should be done. This will enhance a conducive environment for recovery and reduce reoccurrence of PTSD symptoms among patients.

The government and relevant stakeholders are called upon to strengthen and integrate a holistic treatment approach that entails medical treatment, psychological and spiritual counseling and healing, psycho-education, material and social support services among others to help patients develop better coping methods and resilience to the PLRA war consequences. This will in turn enhance better results and higher recovery rates among the patients presenting PTSD symptoms in GRRH. Ministry of health should also employ counselors for the government hospitals.

### **6.3. Contributions of the study**

The study pointed out that all the patients needed to access psychological counselling and social support as coping strategy against the post LRA war consequences in order to maintain recovery. The manifestation of the PTSD symptoms among patients should not be ignored. However, patients should be referred for immediate health support and care.

The study contributed in pointing out that the post LRA war had adverse consequences that contributed to PTSD symptoms level among patients at GRRH.

The study revealed that psychological counselling and social support services moderately helped in reducing the PTSD symptoms among patients. This therefore implies that increasing the level of psychological counselling and social support would increase the chances of recovery of a PTSD patient by a half.

### **6.4. Areas of recommended further research**

Considering the literature reviewed, methodology used, and the results of the study, the researcher finds it imperative to recommend the following areas for further research;

More research needs to be done on this same subject using other study designs like longitudinal study design to find out whether the same results will be generated. further research on Post LRA War consequences on PTSD patients should be done within a period of 10 years for analysis after the war to portray the real state and progress in the lives of the people and returnees in Northern Uganda, to evaluate if

their mental state has picked up with the rest of the country after the 25years of war in northern Uganda.

Further research needs to be done on this same subject but considering a wider scope of all PTSD patients in the whole greater north to provide a wider and acceptable outlook instead of zeroing to only GRRH in Gulu district. Hence, the study would then give a national out look of the post LRA war consequences on PTSD symptoms among patients in Northern Uganda.

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**APPENDICES**

**APPENDIX A: QUESTIONNAIRE**

Dear respondent, I am a student of Uganda Christian University Mukono carrying out a research study on the Post LRA war consequences on PTSD symptom among patients in GRRH in Gulu district for partial fulfillment of the requirement for the award of Masters of arts in Counselling Psychology. You have been chosen to participate in this study and your positive response will be highly appreciated. Any information obtained in this study will be treated with uttermost confidentiality. Are you willing to participate in this study?

Yes

No

**SECTION A: RESPONDENT CHARACTERISTICS**

1. Where is your place of residence?

District; .....

Sub county: .....

Village: .....

2 What is your place of origin?

District; .....

Sub county: .....

Village: .....

Age group	Response (Tick as appropriate)	Age group	Response (Tick as appropriate)
Below 20years		41-50	
21-30		51-60	
31-40		60 and above	

3 What age group do you belong to?

4 What is your occupation?

Respondent Level of employment characteristics	Response (Tick as appropriate)
Subsistence farmer	
Petty business trader	
Manual laborer	
Health worker	
Social worker (NGO staff)	
Military/Police	
Others.....	

5 What is your highest level of Education attainment?

<b>Respondent Level of Education</b>	<b><i>Response (Tick as appropriate)</i></b>
Primary education	
O level	
A level	
Certificate	
Diploma	
Bachelor's degree	
Master's degree	

6 What is your marital status?

<b>Respondent marital status</b>	<b><i>Response (Tick as appropriate)</i></b>
Single	
Married	
Divorced/Separated	
Widow/Widower	

7. Which Religious affiliation do you belong to?

<b>Respondent's religious affiliation</b>	<b><i>Response (Tick as appropriate)</i></b>
Catholic	

Protestant	
Moslem	
Others; specify.....	

**SECTION B: POST LRA WAR CONSEQUENCES**

8 Did patients experience Post LRA war consequences?

Yes No

**8a. Post LRA war consequences**

Poverty	SA	A	U	D	SD
The patients lived in poverty during post LRA war?					
The patients experienced broken relationships during the post LRA war?					
The patients experienced domestic violence during the post LRA war?					

**SECTION C: PTSD SYMPTOMS AMONG THE PATIENTS IN THE MENTAL UNIT AT GRRH**

9 Are patients at the mental unit at GRRH manifesting PTSD symptoms?

Yes No

9a. PTSD symptoms among patients at GRRH in Gulu district.

Statement	SA	A	UD	D	SD
9a.1. Most of the mental health patients suffering re-experiencing is a result of the Post LRA war consequences?					
9a.2. Most of the mental health patients suffering Hyper arousal is a result of the Post LRA war consequences?					
9a.3. Most of the mental health patients suffering avoidance is a result of the Post LRA war consequences?					

**SECTION D: THE CONSEQUENCES OF THE PLRA WAR AND THE LEVEL OF PTSD SYMPTOMS AMONG PATIENTS IN GULU REGIONAL REFERRAL HOSPITAL**

10 Is there a relationship between the consequences of the PLRA war and the level of PTSD symptoms among patients in Gulu Regional Referral Hospital in Northern Uganda?

Yes No

10a. Could you please mention them and explain why?

**SECTION E: THE ROLES OF COUNSELING AND SOCIAL SUPPORT IN REHABILITATION OF THE PTSD PATIENTS IN GULU REGIONAL REFERRAL HOSPITAL IN NORTHERN UGANDA**

11a. Does psychological counseling and social support play a role in rehabilitation of the PTSD patients in Gulu Regional Referral Hospital in Northern Uganda?

Yes No

11b. If yes, could you please explain how

11c. The roles of psychosocial counseling and social support in rehabilitation of the PTSD patients

Statement	SA	A	UD	D	SD
Does psychosocial counseling and social support play a role in rehabilitation of the PTSD patients in Gulu Regional Referral Hospital in Northern Uganda					

12 Any other comment

.....

.....

.....

**Thank you for participating in the study**

## Appendix B: INTERVIEW GUIDE

Dear respondent, I am a student of Uganda Christian University Mukono carrying out a research study on the Post LRA war consequences on PTSD symptom among patients in GRRH in Gulu in Northern Uganda for partial fulfillment of the requirement for the award of Masters of arts in Counselling Psychology. You have been chosen to participate in this study and your positive response will be highly appreciated. Any information obtained in this study will be treated with uttermost confidentiality. Are you willing to participate in this study?

Yes

No

### **SECTION A: RESPONDENT CHARACTERISTICS**

1. Where is your place of residence? District, Sub County, Village.....
2. What is your place of origin? District, Sub County, Village.....
3. What age bracket do you belong to?
4. What is your occupation/Title?
5. What is your highest level of educational attainment?
6. What is your marital status?
7. Which Religious affiliation do you belong to?

### **SECTION B: POST LRA WAR CONSEQUENCES**

8. What are the Post LRA war consequences that have led to post-traumatic stress disorder symptoms among patients in Gulu Regional Referral Hospital?

### **SECTION C: PSTDS SYMPTOMS AMONG PATIENTS AT GRRH**

9a. What are some of the signs and symptoms of PTSD that are manifested among patients at GRRH?

### **SECTION D: RELATIONSHIP BETWEEN THE POSTLRA WAR CONSEQUENCES AND PTSD SYMPTOMS**

10a. Do you think the PTSD symptoms among patients at GRRH are rooted to the Post LRA war consequences?                      Yes      No

10b. How are the PTSD symptoms among patients associated to the post LRA war consequences experienced by the patients?

### **SECTION D: THE ROLES OF COUNSELING AND SOCIAL SUPPORT IN REHABILITATION OF THE PTSD PATIENTS**

11a. Are the patients experiencing PTSD symptom being provided psychological counselling and social support at GRRH?

Yes      No

11b. If yes who is providing the psychological counseling and social support to the patients with PTSD symptom at GRRH?

11c. Do the psychological counseling and social support provided play an adequate role in rehabilitation of the PTSD patients at GRRH in Gulu district?

Yes No

11d. If yes, could you please explain how

Any other comments

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# UGANDA CHRISTIAN UNIVERSITY

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SCHOOL OF RESEARCH & POSTGRADUATE STUDIES

## DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date: .....17<sup>th</sup> September. 2025.....

Name of Candidate: ...Olweny Kevin.....

Reg. No: ...RM10M03/601.....

Title of Dissertation ...Post Lord's Resistance Army (PLRA) War Consequences and PTSD Symptoms Among Patients in Gulu Regional Referral Hospital in Northern Uganda.....

SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	STATEMENT OF THE PROBLEM RESEARCH QUESTIONS / HYPOTHESIS The problem statement includes aspects that the study could not provide measurable indicators of depression and erectile dysfunctions. It is advised to rewrite the problem statement on conditions that can provide measurable	Necessary changes were done where depression and erectile dysfunction was replaced by mental and medical conditions as reflected in the justification of the study. some summaries were also made in the problem statement  Research question 2 correlates with the study objective and the research topic. I therefore request	Page 8 corrected  Page 10-11, requested for consideration

	<p>conditions</p> <p>Research questions 2 &amp; 4 are not valid for this study. Should be removed in all relevant sections of data collection, analysis, and discussion</p>	<p>that it remains as it is</p> <p>Research questions 4 correlates with the objective of the study and the intervening variable in the conceptual frame work of the study reflected in page 17-19. I therefore request that it remains as it is.</p>	
2	<p>CHAPTER IV: PRESENTATION &amp; ANALYSIS OF DATA</p> <p>Well done. However, exclude presentation of data from Q.2 &amp; Q. 4 as suggested</p>	<p>Since research questions 1&amp;4 correlate to the study objectives, the research topic and the intervening variable of the study, I request that it is included in the data presentation in chapter IV</p>	<p>Presentation of data from research questions 2&amp;4 are requested for consideration in chapter IV</p>
3	<p>CHAPTER V: DISCUSSION OF FINDINGS</p> <p>Well done. However, exclude presentation of data from Q.2 &amp; Q. 4 as suggested</p>	<p>Since research questions 1&amp;4 correlate to the study objectives, the research topic and the intervening variable of the study, I request that the data presentation is reflected in the discussion of findings</p>	<p>Discussions of findings using data from research questions 2&amp;4 are requested for consideration in Chapter V</p>
4	<p>CHAPTER VI Conclusion and Recommendations</p> <p>Revise conclusion based on revised chapter IV &amp; V</p>	<p>I request for consideration for the same reasons.</p>	
5			

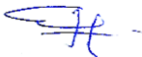
SN	COMMENTS BY INTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	<p>Overall structure and presentation.</p> <p>APA 7<sup>th</sup> edition writing style should be adhered to</p>	<p>Additional revision was made in the APA 7<sup>th</sup> edition where certain items and particulars of the author and the book or the journal were included, citation was entered one by one from the first page to the last page manually and it automatically generated the References.</p>	<p>All the citation from Page 1 to the last page and the references are generated by the APA seventh edition software</p>
2	<p>Chapter One: Introduction</p> <p>Statement of the problem needed more precision, was articulated better in the justification of the study</p> <p>Key protocols in diagnosing PTSD need to be introduced here, as it is a key element on the study.</p> <p>Some operational definition of terms should include citations</p>	<p>Some changes reflecting on the justification of the study was made in the problem statement</p> <p>Criterion for PTSD diagnosis was inserted in the background of the study.</p> <p>Some citations were made in the operational definition of terms</p>	<p>Page 8 was corrected</p> <p>Page 1 was adjusted</p> <p>Page 14-17 was corrected</p>
3	<p>Chapter Two: Literature Review</p> <p>Include numbering and subheading 2.2.2 Hyper Arousal</p>	<p>Numbering and subheading 2.2.2 Hyper Arousal was done</p>	<p>Page 24 corrected</p>
4	<p>Chapter Three: Methodology.</p> <p>Not clear on the source of quotations</p>	<p>Sources of quotations in chapter III are indicated in the references</p>	<p>Page 82, 86, 87 and 88 corrected</p>
5	<p>Chapter Four: Presentation and Analysis of Data</p> <p>No narrative for re-experiencing under 4.3</p>	<p>Narrative for re-experiencing under 4.3 inserted</p>	<p>Page 55 corrected</p>
6	<p>Chapter Five: Discussion of Results</p>	<p>Paragraph created in page 70</p>	<p>Page 70 corrected</p>

	No paragraphs- Pg 70		
	Chapter Six: Conclusions and Recommendations Recommendations do not satisfactorily handle risk and protective factors	Recommendation was adjusted to handle risk and protective factors	Page 79 corrected

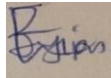
SN	COMMENTS BY VIVA VOCE PANNEL	ACTION TAKEN	INDICATOR
1	Objective 3 indicating the relationship between consequences of war and PTSD should be the most important objective and should have been reported in terms of Pearson Correlation coefficient, not percentages only. The student should have pursued the third objective further and performed a regression to find the contribution of consequences of war on PTSD.	The method for further analysis using Pearson Correlation coefficient to find a regression is shown in Chapter III, presentation of the data is done in Chapter IV and was further reflected in discussion of results in chapter V that clearly indicated the contribution of the PLRA war consequences on PTSD symptoms.	Page 44 Chapter III, Page 57-60, chapter IV and Chapter V page 63-64 corrected
2	The result for the third objective needs to be well indicated showing how the student analyzed and clarity on what was found.	Findings of the third objective have been stated more clearly, and further explanations made on the parameters	Page 73 of Chapter V corrected
3	Objectives should be numbered not bulleted	Objectives in the research are numbered	Page 10
4	The results should be presented concurrently indicating both qualitative and quantitative information.	The results are presented concurrently and they indicated both qualitative and quantitative information in Chapter V	Page 58-60

5			
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...Olweny Kevin.....

  
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..... Betty Enyipu Akurut (PhD)



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Candidate's Name

Signature

Supervisor's Name

Signature