

# The Awareness of PTSD in Military Personnel among Clinical Social Workers and Psychologists in Health-Care Centers

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## Abstract

The actual number of Saudi Arabian military members diagnosed with post-traumatic stress disorder (PTSD) is unknown, and sociological research on the subject is crucial. Furthermore, clinical social workers and psychologists must get a better understanding of PTSD symptoms in veterans. The most recent study sought to identify what the most important factor was in increasing PTSD awareness among clinical social workers and psychologists, and to check whether there was a disparity in awareness between individuals who completed an abroad qualification and those who had not. Clinical social workers and psychologists in the health-care field were polled to see how much they knew about PTSD. Purposive and snowball sampling approaches were used to disseminate an online survey to N = 144 participants to meet the research objectives. The findings revealed a link between education, self-development, and organizational development and the amount of PTSD awareness among the study participants. There were no statistically significant changes in awareness levels based on whether the certification was obtained inside or outside Saudi Arabia. The results of this study revealed that the level of awareness among the study sample varied significantly.

## Keywords

Awareness, Post-Traumatic Disorder, Saudi's Military Personnel, Clinical Social Workers, Psychologists

## 1. Introduction

Military personnel and their families are subjected to a variety of pressures and social issues that are not applicable to the general population, putting them in a unique and challenging situation. Some military personnel suffer from com-

bat-related physical injuries, resulting in disability or causing them to leave the service early, which in turn has an economic and social impact on their families. Some service members, on the other hand, return from war with psychological wounds and injuries such as post-traumatic stress disorder (PTSD). According to the National Center for PTSD in the United States, PTSD affects 11 - 20 out of every 100 veterans who served in Iraq. PTSD affects 12% of Gulf War veterans, while 30% of Vietnam War veterans have been diagnosed with the disorder [National Center for PTSD \(2018\)](#).

In comparison with the statistics above, the number of Saudi personnel with PTSD is still unclear or undetermined, raising concerns about the awareness among Saudi veterans and their families of PTSD symptoms. On a larger scale, the lack of data about PTSD raises concerns about the availability of practical and feasible PTSD information in Saudi society, particularly among practitioners in health-care centers.

Clinical social workers and psychologists are usually trained to provide professional systemic intervention, advocacy, and counseling, and they must receive qualification to do so ([Faust, 2008](#)). Because they may encounter military personnel suffering from PTSD during their work, they need a thorough understanding of the condition. Clinical social workers and psychologists must know whether their patients are veterans and whether their symptoms are related to their military experience. Thus, the researcher believes that clinical social workers and psychologists must improve their understanding of PTSD in military service members and become familiar with their specific health demands to interact with them effectively and address their needs.

To summarize, the study's main goals are to 1) Determine which factor (self-development, education, or organizational development) is most important in raising awareness among the study sample; 2) Determine whether there is a difference in awareness between individuals who have completed an abroad qualification and those who have not completed an abroad qualification; 3) Determine how well Saudi Arabian clinical social workers and psychologists understand PTSD in military personnel.

Before going any further, it is important to mention that Saudi Arabia provides free health care to all citizens. More specifically, according to data from the Health Ministry statistical yearbook in 2018 ([Health Ministry, 2018](#)), there are roughly 47 governmental hospitals, including military hospitals, that are only for personnel of the military sector and their families. Physical, psychological, and social health-care services in all areas are provided by military hospitals. Because clinical social work and psychology are integral parts of the treatment plan, they are some of the most important services in hospitals. Treating the patients' social difficulties is just as vital as treating their health complications. Furthermore, with the south of Saudi Arabia currently an active combat zone adding to the possibility of soldiers suffering from post-traumatic stress disorder, PTSD awareness today is more important than ever.

### 1.1. PTSD Knowledge among Health-Care Professionals

As a result, clinical social workers and psychologists need to improve their knowledge of PTSD symptoms among veterans and seek educational preparation to understand the needs of service members (Cooper et al., 2016), keeping in mind the delicateness of their past or current situation as armed forces personnel (Kiernan et al., 2016). According to Finnegan et al. (2017) military members and their families require social care practitioners who are familiar with their unique status and condition and who have the ability to address these concerns in a manner that veterans and their families understand. As a result, the veterans' reluctance to seek professional help is primarily due the practitioners' unfamiliarity with the needs of veterans. Finnegan et al. (2017) found that veterans do not reveal information about their combat experiences to clinicians because the veterans feel clinicians do not understand. Mansfield et al. (2005) also found that veterans are reluctant to seek help because they perceive numerous barriers to doing so, and they do not trust health-care professionals. Furthermore, according to Kiernan et al. (2016) despite a growing awareness of the potential barriers to care for veterans, and a developing understanding of their specific needs, veterans are not sufficiently included in health-care education. Furthermore, both Engward & Fleuty (2019) and Kiernan et al. (2016) stated that health service policymakers, councilors, and practitioners struggle to truly understand the unique experiences and challenges of the veteran's life and are unclear on the course of treatment or guidance suitable for veterans and their families. Subsequently, these uncertainties become major barriers for veterans in accessing health care. Thus, a growing body of literature (Engward & Fleuty, 2019; Finnegan et al., 2017; Kiernan et al., 2016) suggests that to make a significant difference in the care of veterans and their families, to address the social health care knowledge gap, and to raise awareness about the needs and experience of the veteran community, a culture of understanding regarding veteran health care must be established through graduate and even undergraduate education. Fundamental curriculum elements, for example, must be based on empirical evidence; must include a systematic and structured educational portfolio, pilot schemes, and other educational initiatives; and must provide training courses that include veterans' health as a core component of their curricula (Finnegan et al., 2017).

### 1.2. Perceived Barriers that Prevent Veterans with PTSD from Seeking Social Care

To pave the way for PTSD veterans to seek professional help, it is critical to address the perceived barriers that could prevent them from doing so, such as stigma, the military culture of toxic masculinity, the lack of PTSD awareness, and the lack of access to health care. Scambler (2009) defined *stigma* as a social process marked by exclusion and blame as the result of a person's impression or reasonable expectation of an undesirable social judgment about them based on

an enduring element of identity bestowed by a health problem or health-related condition. Furthermore, both [Stana et al. \(2017\)](#) and [Iversen et al. \(2011\)](#) suggested that stigma related to the pursuit of mental health treatment may be more distressing among military personnel than for most civilians. The greatest obstacle to care provision across the military force's population, according to [Iversen et al. \(2011\)](#), is the stigma associated with seeking help for mental health concerns. Both [Major & O'Brien \(2005\)](#) and [Stana et al. \(2017\)](#) agreed that admitting to mental illness could be construed as malingering, which could put a veteran's military career and reputation in jeopardy. [Mansfield et al. \(2005\)](#) highlighted the viewpoint that for male military service members, seeking help would threaten their ability to function independently. Nevertheless, it could be argued that feeling stigmatized has much to do with the masculinity of military culture, as [Stana et al. \(2017\)](#) has explained. That is, veterans seek to match perceived social norms commonly associated with men because masculinity is defined as invulnerability and stoicism in conduct. To clarify this concept, a soldier who is coping with military stressors is classified as a real man, and there is no room inside military culture to admit weakness or difficulty ([Green et al., 2010](#)). In contrast, [Caddick et al. \(2015\)](#) believed that in PTSD treatment settings, services that promote male health may be recognized and supported when masculinity is not seen as an issue. Furthermore, [Caddick et al. \(2015\)](#) stated that veterans can be involved in relationships and narrative systems that support and value these new masculine orientations. A lack of PTSD understanding among veterans, in addition to stigmatization and the military culture's barriers due to toxic masculinity, may hinder veterans from seeking professional care and raise the risk of PTSD symptoms.

It may be difficult for soldiers to speak about some especially distressing events such as warfare, according to [Green et al. \(2010\)](#), and this may delay the recognition and treatment of mental health concerns. Another point of view is that veterans may not consider their situation serious enough to require expert assistance ([Mansfield et al., 2005](#)). One study found that postponing a diagnosis of PTSD among veterans makes treatment more difficult ([Hermes et al., 2015](#)). Furthermore, according to [Hermes et al. \(2015\)](#), the period following a traumatic event and prior to the onset of symptoms and an understanding of their context can be lengthy and psychologically significant. As a result, [Engward & Fleuty \(2019\)](#) suggested that more education and encouragement for veterans and their families may be required to improve the awareness of why veteran status is crucial for care. Finally, according to [Mansfield et al. \(2005\)](#), financial constraints, a lack of insurance, a lack of transportation, a lack of awareness about the types of assistance available, and a lack of trust in care providers can all discourage people from seeking assistance.

Increasing awareness of PTSD as a treatable disorder may encourage veterans to seek professional help. PTSD-related depression, according to [Olenick et al. \(2015\)](#), is a treatable illness with an 80 - 90 percent success rate, with eight out of

ten veterans effectively treated. According to [Olenick et al. \(2015\)](#), there are several social resources for increasing PTSD care among veterans, such as rehabilitation care, which includes vocational programs and physical, social, and mental therapy. Moreover, several researchers ([Green et al., 2010](#); [Johnson et al., 2013](#); [Kintzle, et al. 2018](#); [Olenick et al., 2015](#); [Stana et al., 2017](#)) have found that family or group therapy, stress reduction, guided imagery therapy, cognitive behavioral therapy, and social support are the most effective non-pharmaceutical treatments for PTSD. Both [Caddick et al. \(2015\)](#) and [Bowler et al. \(2010\)](#) have claimed that an expanding number of outdoor activities, such as horseback riding, fly fishing, horticulture, walking, water sports, and narrative setting can have positive benefits on a veteran's physical and mental health.

### 1.3. Psychological and Social Problems Related to PTSD

Several studies ([Johnson et al., 2013](#); [Olenick, 2015](#); [Semaan et al., 2016](#)) noted a variety of physiological and social challenges that veterans face as a result of PTSD. One issue is that veterans are more likely to experience PTSD-induced psychiatric symptoms such as depression, negative thoughts and sensations, mistrust, suicide, and social alienation. Furthermore, [Kintzle et al. \(2018\)](#) emphasized that those veterans who had been exposed to combat have more intense pain and, as a result, more intense PTSD and depression symptoms than veterans who had not been exposed to combat. In accordance with [Kintzle et al. \(2018\)](#), [Olenick et al. \(2015\)](#) mentioned that 8% of nonmilitary men versus 36% of male veterans have been linked to depression symptoms. Even though veterans are more likely to be diagnosed with depression, Olenick claims that they are less likely to commit suicide than nonveterans, which he attributes to better understanding and acceptance of PTSD. Moreover, the transition of veterans to civilian life is a major social complication, according to [Finnegan et al. \(2017\)](#), [Kintzle et al. \(2018\)](#), and [Semaan et al. \(2016\)](#). The veteran transition experience can be complicated after they are deployed to a war zone and witness a horrific event, and there is a stark difference in normative structures and values between military and civilian society. Veterans may suffer from PTSD, become homeless, get divorced, or change careers after returning home, according to [Engward & Fleuty \(2019\)](#), and [Semaan et al. \(2016\)](#). In the United States today, there are 19.6 million veterans, and 22 veterans commit suicide every day. [Semaan et al. \(2016\)](#), [Olenick et al. \(2015\)](#), and [Johnson et al. \(2013\)](#) indicated that homelessness as a result of veteran's transition to civilian life is a serious societal problem. Almost 50,000 veterans are homeless ([Semaan et al., 2016](#)), with more than 51% having disabilities and 50% suffering from a serious mental illness such as traumatic brain injury (TBI) or PTSD ([Olenick et al., 2015](#)). To sum up, [Engward & Fleuty \(2019\)](#), [Kiernan et al. \(2016\)](#), [Finnegan et al. \(2017\)](#), and [Cooper et al. \(2016\)](#) have recommended that to ensure that appropriate care and support is offered to veterans, studies of the potential health needs of veterans and their families should become integral elements of educational training for health-care

professionals. Lastly, a culture should be developed to permeate a military emphasis throughout the health-care fields in universities (Engward & Fleuty, 2019). Thus, it was predicted the significant role of veteran PTSD awareness among the healthcare professionals.

#### **1.4. Research Key Terms**

##### **1.4.1. Post-Traumatic Stress Disorder among Veterans**

It is necessary here to clarify exactly what is meant by PTSD. According to Shiromani (2009), PTSD is defined as a reaction to a major threat of damage or death, followed by feelings of great anxiety, helplessness, or horror. PTSD's effect on interpersonal relationships, emotional health, physical health, and societal effects all add to the condition's overall expenses. Furthermore, in the current article, PTSD among Saudi military members is described in terms of veterans with PTSD. Military service members and civilians may be exposed to several potentially traumatic events during war or conflict, according to the National Center for PTSD (2020). As a result of this exposure, they are more prone to acquire PTSD or other mental health difficulties.

##### **1.4.2. Awareness among Health-Care Practitioners**

Although the term "awareness" is commonly used in the literature, health-care professionals such as clinical social workers and psychologists have yet to agree on a formal definition of PTSD awareness. PTSD awareness could be defined as a branch of general mental health awareness that has resulted in the creation of dedicated services to assist military personnel coping with emotional, social, and psychological issues related to PTSD. Such awareness may also help caregivers learn how to detect and treat patients who have been exposed to war and combat zones.

##### **1.4.3. Population and Sampling**

The first stage in the sampling process is to clearly define the target population. Population commonly refers to the number of people living in a particular country (Taherdoost, 2016: p. 19). This study focuses on clinical social workers and psychologists who have already worked or volunteered in health-care organizations, third-party sectors, or social-psychological practices. The sample for this study was selected using the nonprobability sampling strategies of judgmental and snowball sampling because of the study's descriptive nature and limited resources. Unlike random sampling, judgmental sampling, commonly known as purposive sampling according to Taherdoost (2016), is the selection of people based on the information available about them as well as specified study goals. Snowball sampling, according to Babbie (2007), is often employed in field research, and it involves asking each person interviewed to suggest additional potential participants, a procedure that is appropriate when members of a special population are difficult to locate (p. 205). In addition, participants must have worked in health care anywhere in Saudi Arabia, and have a bachelor's, master's, or doctoral degree in sociology, social work, or psychology.

## 2. Method

The current study is based on quantitative investigation, using a descriptive research design. The descriptive approach is defined as a technique for gathering facts and interpreting how the facts relate to the topic being investigated (Babbie, 2007). Descriptive research tries to characterize the research problem, population, or condition to comprehend its existence rather than to explore why it occurred in the first place. So far, the study's main goals are to 1) Determine which factor (self-development, education, or organizational development) is most important in raising awareness among the study sample. 2) Determine whether there is a difference in awareness between individuals who have completed an abroad qualification and those who have not completed an abroad qualification. 3) Determine how well Saudi Arabian clinical social workers and psychologists understand PTSD in military personnel.

### 2.1. Measurement Instrument

In this study, the survey questionnaire is used as an instrument. The chosen instrument is typically used for descriptive reasons, such as in studies where people are the unit of analysis. Also, employing a questionnaire to collect data is useful for analysis (Babbie, 2007). The knowledge questionnaire was built based on the information from related literature reviews, as well as from known PTSD symptoms, and covers facts about PTSD among military personnel that health-care professionals are expected to know. The self-report instrument tool has three categories written in Arabic (because the participants were Arabic speakers) then translated to English for statistical use. The first category contains sociodemographic information: gender, nationality, age, level of education, major, whether the participant has ever received a qualification from one of the aboard countries (A degree or certificate from a country other than Saudi Arabia) without specifying the most recent degree, the number of years of experience as a clinical social worker or psychologist, organization affiliation, whether the participant is full- or part-time or a volunteer, and the total number of military personnel with PTSD they have seen during their years practicing health care. The second category is for specifying resources such as education, training provided by the organization about the problems facing military personnel in general, and conversations with military personnel with PTSD themselves. It contains seven items and uses the three-point Likert scale of agreement (agree = 3, neutral = 2, disagree = 1). The final category measures the level of knowledge of PTSD in military personnel and was developed by the researcher after gaining appropriate information from reviewing relevant literature that uses the Mental Health Literacy Scale (MHLS). The literature includes studies by O'Connor & Casey (2015), Spagnolo et al. (2018), Chao et al. (2020), as well as books about the most common PTSD symptoms among veterans. This measure contains 19 items and uses the three-point Likert scale of frequency (always = 3, often = 2, never = 1). The scale includes questions about PTSD symptoms that a practitioner should be aware of while consulting patients.

## 2.2. Validity and Reliability

The questionnaire was sent to six professors in the Social Studies Department at King Saud University for criterion validation to ensure the validity of the assessment tools and content. The academics were picked based on their research interests (two are statisticians, two are criminal sociologists, one is a social-psychologist, and the last is a sociologist of development).

The surveys were subsequently pilot tested on a group of sixteen people (eight clinical social workers and eight psychologists) who worked at either the King Fahad National Guard Hospital in Jeddah, the Erada Complex for Mental Health, or the King Abdullah Specialist Children Hospital in Riyadh. The purpose of this pilot testing was to locate items that were unclear or perplexing. The average time it took to answer the scale was less than 15 minutes. The internal consistency of the questionnaires was evaluated with Cronbach's alpha correlation. The Cronbach's alpha for the level of knowledge of PTSD in military personnel on a scale of 19 items was .952 and was regarded as satisfactory, See the following [Table 1](#).

## 2.3. Data Collection

The research took place in Saudi Arabia during September-November of 2021. In addition to purposive sampling, snowball sample recruiting strategies were used to ensure that the population of clinical social workers and psychologists in health-care organizations, practices, and third-party sectors was representative. Through the official researcher email at King Saud University, the questionnaires were also distributed to the heads of clinical social worker and psychological departments at several hospitals around Saudi Arabia. Lastly, no personally identifiable information such as names, addresses, or email addresses was ever requested or saved.

## 2.4. Data Analysis

This section will show, analyze, and discuss the data and outcomes obtained from the questionnaire and will demonstrate how the tool's output is efficient and purposeful, meeting its goals in accepting or rejecting the study's hypotheses through the analysis that follows.

The survey was done using an online Google Form that was only accessible to the researcher and to no one else. In the first week of November 2021, the responses were downloaded into the Statistical Program for the Social Sciences—Version (28.0; 190) for analysis.

The descriptive statistics frequencies and percentages were calculated for sociodemographic data, such as gender, level of education, and years of experience, as shown in [Table 2](#). The approximate number of military personnel with PTSD seen by the participants during their years of experience is shown in [Table 3](#), using range and mean.

For the second category, which includes the resources of knowledge of PTSD, mean, standard deviation, and a one-sample test were used. A one-way ANOVA



**Table 1.** Reliability statistics.

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N
0.950	0.952	19

**Table 2.** The sample's demographic characteristics.

Variable	F	%
<b>Gender</b>	Male	40 27.8
	Female	104 72.2
<b>Nationality</b>	Saudi	143 99.3
	Non-Saudi	1 0.7
<b>Level of Education</b>	Diploma	2 1.4
	Bachelor	93 64.6
	Master	40 27.8
	Doctoral	9 6.3
<b>Major</b>	Sociology	34 23.6
	Psychology	26 18.1
	Social Work	78 54.2
<b>Receiving aboard qualification</b>	Other	6 4.2
	Yes	16 11.1
<b>Years of experience</b>	No	128 88.9
	5 years - less	63 43.8
	6 - 10	34 23.6
	11 - more	47 32.6
<b>Organization type</b>	Governmental Organization	94 65.3
	Privet Organization	42 29.2
	Charity Organizations	8 5.6
<b>Work time type</b>	Full-time	118 81.9
	Part-time	13 9.0
	Volunteer	13 9.0
<b>Total</b>	144	

**Table 3.** Significance of coefficients

Item	Range	Minimum	Maximum	Mean
The total number of military personnel with PTSD seen for whole experience years	100	0	100	6.51
Valid	Frequency		%	
0	73		50.7	
1 - 50	66		46	
51 - 100	5		3.3	
Total	144		100	

analysis was performed to determine the effect of education, self-development, and organizational development on the level of awareness.

Finally, standard deviation, mean, and a one-sample T test were used for the 19 item measure (described above) of PTSD symptoms that practitioners should be aware of while consulting patients.

### 3. Result

#### 3.1. Sociodemographic Characteristics

The N = 144 clinical social workers and psychologists who worked or volunteered in health-care centers or third-party sectors made up the total sample for this study. For the responses, there is no missing data.

The sample's demographic characteristics in **Table 2** suggest that more than half of the sample is female (72.2%), and the bulk of the sample is Saudi (99.3%). Only 6.3% have a PhD, whereas 64.6% have a bachelor's degree, and 27.8% have a master's degree. Over half the participants (54.2%) have a social work degree, followed by degrees in sociology (23.6%) and psychology (23.6%) with 4.2% having degrees with a different focus. In addition, just 11.1% of the participants have acquired abroad certification (United States, United Kingdom, Sudan, Egypt, Jordan, Bahrain, or Kuwait). Nearly half the participants (43.8%) have 5 or fewer years of experience as social workers or psychologists, while 32.6% have more than 11 years of experience. Almost two-thirds of the participants (65.3%) worked for a government health-care organization, with the remaining 34.8% working for private or charitable organizations. Of the 144 respondents, 81.9% have a full-time job, 9.0% work part time, and 9.0% volunteer.

Finally, the approximate number of military people with PTSD seen by the participants during their experience years is shown in **Table 3**.

#### 3.2. Sources for Information on PTSD in the Military

The following **Table 4**, **Table 5** will address one of the fundamental issues in this research paper: Which component is more essential in raising awareness within the study sample: self-development, education, or organizational development?

Using a one-sample T test statistical analysis, we can explain the differences in sources for information on PTSD in the military:

As can be seen in the table above, there was a statistically significant difference in the study sample of respondents, where  $\text{sig} = 0.001$  was less than 0.05, and the T statistic was 3.289 with a degree of freedom of 143.

Regression analysis was used to represent the effect of education on awareness levels:

The value of correlation R equal to 0.455 in **Table 6** indicates that there was a positive relationship between education and awareness. In addition, as seen in the R square column, education explains 20.7 % of the change in the level of awareness.

The level of significance (sig) in the **Table 7** above is 0.000, which is less than 0.05, indicating that the regression model is significant.

**Table 4.** Arithmetic means and standard deviations of the study variables.

items	Mean	Std. Deviation	Phrase direction
I have an interest in self-development on the problems facing the military after returning from the war:	2.77	0.484	Agree
I have knowledge through my education of the social problems facing the military after returning from the war:	2.51	0.710	Agree
I have knowledge through my education of PTSD that military personnel develop after a war:	2.37	0.773	Agree
I have attended specialized post-traumatic stress disorder training courses for the military over the past 12 months:	1.37	0.656	Disagree
During my years of work, I attended specialized post-traumatic stress disorder training courses for the military:	1.43	0.716	Disagree
My workplace provides awareness courses/trainings and initiatives on the problems facing the military after the war, during the past year:	1.36	0.654	Disagree
My workplace offers specialized courses and initiatives in the military's PTSD, during my years of experience at the foundation:	1.36	0.633	Disagree

**Table 5.** The differences in (sources for information on PTSD in the military) using one-sample T Test.

Mean	Std. Deviation	Test Value = 14			
		t	df	Sig. (2-tailed)	Mean Difference
13.1667	3.04052	-3.289	143	0.001	-0.83333

**Table 6.** The effect of education on the level of awareness.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.455 <sup>a</sup>	0.207	0.201	9.48934

a. Predictors: (Constant), Education.

**Table 7.** The effect of education on the level of awareness.

ANOVA <sup>a</sup>						
	Model	Sum of Squares	df	Mean Square	F	Sig.
	Regression	3331.891	1	3331.891	37.001	0.000 <sup>b</sup>
1	Residual	12786.769	142	90.048		
	Total	16118.660	143			

The importance of the education variable is shown by the value of the educational significance level,  $\text{sig} = 0.000$ , which is less than 0.05 in the **Table 8** above. Therefore, the regression model will be as follows:

$$\hat{y} = \hat{\alpha} + \hat{\beta}x$$

$$\hat{y} = 28.433 + 3.568x$$

One-way ANOVA (**Table 9**) can be used to explain the difference between self-development and level of awareness:

The significance of F (P-value) is 0.000 in **Table 9**, which is significant because it is less than the criterion value of 0.05. As a result, there was a substantial difference in the means in the sample score (agree, neutral, disagree) when compared to the level of awareness. Using the following multiple comparisons (**Table 10**) with a less significant difference (LSD) technique, the difference score can be found:

There is a considerable difference between all sample scores, disagree and neutral, disagree and agree, neutral and agree, as seen in the table above. This is explained in the sig column because all the results have a sig less than 0.05.

Regression analysis was used to explain the impact of organizational development on awareness levels on the **Table 11** below.

As can be observed in the R square column, the degree of correlation  $R = 0.237$  indicates that there is a positive association between organizational development and level of awareness, and the result reveals that organizational development explains the change in the level of awareness by 5.6%.

**Table 12** explains the effect of organizational development on awareness level:

The level of significance,  $\text{sig} = 0.004$ , which is less than 0.05, indicates that the regression model is significant, as seen in the **Table 12** below.

As seen in the **Table 13** below, the organizational development significance level,  $\text{sig} = 0.004$ , which is less than 0.05, shows that the organizational development variable is significant. Therefore, the regression model will be as follows:

$$\hat{y} = \hat{\alpha} + \hat{\beta}x$$

$$\hat{y} = 39.458 + 1.154x$$

### 3.3. The Differences in the Level of Awareness between Those Who Obtained a Qualification from Inside or Outside Saudi Arabia

The study's second main research question was whether there were any variations in awareness between participants who had completed an abroad qualification and those who had not, and was expressed as the following hypothesis, shown on **Table 14**:

- Alternative Hypothesis (1): Those who received qualifications from within or from outside Saudi Arabia have different levels of knowledge.
- Null Hypothesis (1): There are no differences in the level of awareness between participants who earned a qualification from Saudi Arabia (from within or outside the country).

**Table 8.** Significant of the Coefficients<sup>a</sup>.

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1 (Constant)	28.433	2.967		9.584	0.000
Education	3.568	0.587	0.455	6.083	0.000

a. Dependent Variable: A level of Awareness.

**Table 9.** The difference between self-development alternative.

ANOVA					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2546.428	2	1273.214	13.227	0.000
Within Groups	13572.232	141	96.257		
Total	16118.660		143		

**Table 10.** The differences between developments alternative.

I have an interest in self-development on the problems facing the military after returning from the war:	I have an interest in self-development on the problems facing the military after returning from the war:	Mean Difference (I-J)	Std. Error	Sig.
Disagree	Neutral	-18.49000-*	5.28342	0.001
	Agree	-23.62391-*	4.99012	0.000
Neutral	Agree	-5.13391-*	2.16502	0.019

**Table 11.** Model summary.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.237 <sup>a</sup>	0.056	0.049	10.35176

a. Predictors: (Constant), organizational development.

**Table 12.** The effect of the development on the level of awareness.

ANOVA <sup>a</sup>					
Model	Sum of Squares	df	Mean Square	F	Sig.
1 Regression	902.084	1	902.084	8.418	0.004 <sup>b</sup>
Residual	15216.576	142	107.159		
Total	16118.660	143			

a. Dependent Variable: a level of Awareness; b. Predictors: (Constant), organizational development.

**Table 13.** Significance of coefficients.

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	39.458	2.358		16.731	0.000
<sup>1</sup> Organizational development	1.154	0.398	0.237	2.901	0.004

**Table 14.** Group statistics.

	Major	N	Mean	Std. Deviation	Std. Error Mean
The level of awareness	Outside KSA	16	44.8125	13.78027	3.44507
	Inside KSA	128	45.9531	10.21490	0.90288

The independent-samples T test (**Table 15**) explains the variations in the level of awareness between individuals who received a qualification from within or from outside Saudi Arabia:

The Levin's test for equal variance reveal that sig = 0.084, which is greater than 0.05, indicating that the variance is homogeneous, implying that the findings of the first row, which are presumed to represent equal variances, will be accepted. Furthermore, the T value is 0.404 with a degree of freedom (df) of 142 and a level of significance of 0.687, which is a value greater than 0.05, indicating that there are no statistically significant differences in levels of awareness based on where the qualification was obtained (inside or outside Saudi Arabia). As a result, the null hypothesis will be accepted, and the alternative hypothesis will be rejected.

### 3.4. Knowledge Level of PTSD in the Military

How well do Saudi Arabian professional social workers and psychologists understand PTSD in military personnel? That is the concluding question in this study report.

The following (**Table 16**) shows arithmetic means and standard deviations of the research variables, which will be used to answer the question:

A one-sample T test was used to explain differences in PTSD knowledge level in the military (**Table 17**).

As indicated in the table above, there was a statistically significant difference in the respondent's research sample, where sig = 0.000, which is less than 0.05, because the mean difference was 7.82639, and the t statistic was 8.846 with a degree of freedom of 143.

## 4. Discussion

This study identified the level of awareness of PTSD in Saudi Arabian military personnel among clinical social workers and psychologists, as well as the most important sources for PTSD awareness. This research reveals three key findings.

**Table 15.** Independent samples test.

		Lavene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
The level of awareness	Equal variances assumed	3.035	0.084	-0.404-	142	0.687	-1.14063-	2.82350
	Equal variances not assumed			-0.320-	17.122	0.753	-1.14063-	3.56142

**Table 16.** The arithmetic means and standard deviations of the research variables

Items	Std. Deviation	Mean	Phrase direction
I can detect the symptoms of PTSD in the military personnel patients':	0.614	2.09	sometimes
I use PTSD scale for military personnel patients:	0.737	1.62	Never
I asked for the patients' medical and phycological reports:	0.608	2.69	always
I ask the patients with disability if it's caused by an accident of war:	0.644	2.68	always
I inquire if the patient's financial problems were caused by his deployment to a combat zone:	0.660	2.61	always
I ask the patients who have sleeping disorder if he had been into combat zone:	0.709	2.51	always
I ask the patients who have nightmares if he had been into combat zone:	0.729	2.50	always
I ask the patients who feel loneliness and isolation if he had been into combat zone:	0.738	2.47	always
I ask the patients who have depression if he had been into combat zone:	0.748	2.48	always
I ask the patients who have stress disorder if he had been into combat zone:	0.719	2.51	always
I ask the patients who have lost the desire of communication with others if he had been into combat zone:	0.738	2.47	always
I ask the patients who violent or feel violence if he had been into combat zone:	0.709	2.53	always
I ask the patients who have panic disorder if he had been into combat zone:	0.719	2.50	always
I ask the patients are substance use if he had been into combat zone:	0.767	2.39	always
I ask the patients who stopped praying if he had been into combat zone:	0.774	2.21	sometimes
I ask the patients who have moved into a new place if it for being in war zone:	0.810	2.13	sometimes
I ask the patients who expressing sadness because of friend deaths', if he lost him during war:	0.710	2.49	always
I ask the patients who were a way for a long time of period from his family if he were deployed to combat zone:	0.710	2.50	always
I ask the patients who are aggressive if he had been into combat zone:	0.727	2.44	always

**Table 17.** Test value = 38.

Mean	Std. Deviation	t	df	Sig. (2-tailed)	Mean Difference
45.8264	10.61687	8.846	143	0.000	7.82639

To begin with, the findings of this study show a significant difference ( $t = 3.289$ ,  $\text{sig} = 0.001$ ) between the sources of information about PTSD among military people. Education as a source for knowledge of PTSD was shown to have a substantial link with the level of awareness among the sample ( $R = 0.4555$ , 20.7%), followed by self-development ( $P\text{-value} = 0.000$ ), and finally organizational development ( $R = 0.237$ , 5.6%).

Surprisingly, these findings contradict those of [Kiernan et al. \(2016\)](#), who claimed that veterans' needs are not well addressed in health-care education, potentially preventing veterans from seeking care. However, the current study's findings, particularly the most beneficial influence on the level of awareness among health-care practitioners, have never been described before.

This study did not discover a significant difference between those who earned qualifications abroad and those who obtained qualifications locally, contrary to expectations. According to the current study, there were no statistically significant differences in levels of awareness based on whether the qualification was acquired inside or outside Saudi Arabia ( $\text{sig} = 0.687$ ). This finding was surprising and may be due to the unification of social studies and psychology curricula in universities. Nonetheless, until recently, there was no reliable evidence that education in the social sciences about PTSD among military personnel was insufficient.

Another significant finding was that the level of awareness among study samples differed significantly ( $\text{sig} = 0.000$ ,  $\text{mean} = 7.82639$ ). Participants who claimed that "they sometimes can detect the symptoms of PTSD among military members" had a  $\text{mean} = 2.09$  and  $\text{std} = 0.614$ , while participants who stated that "they never use the PTSD scale" had a  $\text{mean} = 1.62$  and  $\text{std} = 0.737$ . These two findings differ from previous study findings, which showed a strong correlation between education, self-development, and organizational development; however, they are broadly consistent with earlier studies ([Engward & Fleuty, 2019](#); [Kiernan et al., 2016](#)), which found that health service policymakers, councilors, and practitioners struggle to truly understand the unique experiences and challenges of the veteran's life and are unclear on the course of treatment. Whenever these findings are compared to the rest of the scale's results in [Table 16](#), it is possible that the study instrument is a source of self-reporting bias.

One expected finding, as indicated in [Table 3](#), is that nearly half the participants reported seeing no military patients with PTSD over their experience years, which might be justified in two ways based on two different aspects. First, this study endorses the findings of [Iversen et al. \(2011\)](#), [Major & O'Brien \(2005\)](#), and [Stana et al. \(2017\)](#), who claimed that stigma is one of the perceived barriers to seeking social care among PTSD veterans. These findings furthermore support the results of [Finnegan et al. \(2017\)](#) who found that veterans do not inform clinicians about their combat experiences because the clinicians "do not understand," and also support the findings of [Mansfield et al. \(2005\)](#), who suggested that veterans are hesitant to seek help because they do not trust health-care professionals. The second justification is that, as shown in [Table 16](#), most profes-



sional social workers and psychologists do not use the PTSD scale when diagnosing their patients, making it difficult to detect PTSD symptoms and leaving the number of positive cases with PTSD unknown.

## 5. Conclusion

The focus of this research was to find the most essential component in boosting PTSD awareness among clinical social workers and psychologists. The current study also aimed to see whether there is a difference in awareness between those who have finished an abroad qualification and those who have not. Finally, the current research aimed to assess the level of PTSD awareness among clinical social workers and psychologists in the health-care field.

This study has found that generally there is a significant relationship between the study variables (education, self-development, and organizational development) and the level of PTSD awareness among the study sample. The most obvious finding to emerge from this study is that there is an equality of awareness among those who earned qualifications abroad and those who obtained qualifications locally. Finally, this study has shown that there are significant differences in the levels of overall awareness among the study sample.

## 6. Limitations

As with any study, the research results need to be assessed in light of the data's strengths and weaknesses. In terms of limitations, the data collection instrument is an online self-report questionnaire. According to [de Leeuw \(2008\)](#), online self-report surveys have various drawbacks, including an increased likelihood of prematurely terminating the survey and of distraction due to multitasking. Furthermore, the participants' honesty regarding their knowledge and experience, as well as the number of military individuals treated by the participants, may have influenced the level of knowledge of PTSD in military personnel.

As far as the researcher knows, there is no specific scale to measure the level of knowledge of PTSD in military personnel. The researcher developed the scale after gathering relevant information from literature reviews that used the Mental Health Literacy Scale, including studies from [O'Connor & Casey \(2015\)](#), [Spagnolo et al. \(2018\)](#), and [Chao et al. \(2020\)](#). Because of the study's modest sample size of  $N = 144$ , caution should be exercised. The findings of this generated scale may not be reliable, and the scale must be further tested.

These findings have certain limitations in terms of generalizability. The current study only included clinical social workers and psychologists who worked or volunteered in health-care organizations, facilities, or third-party sectors, implying that the findings may not be applicable to all Saudi social workers and psychologists. Because almost 99% of the participants were Saudi, the sample was nationally representative of Saudi clinical social workers and psychologists. However, non-Saudi participants would be omitted.

The study was restricted by the lack of formal data on the number of Saudi

military members diagnosed with PTSD during the Yemen War; this lack is likely due to security reasons given that the war is still ongoing.

In addition, the study aimed to investigate how education affected participants who have a degree in sociology, social work, psychology, or a related major such as family and marriage consulting. As a result, the researcher discovered that unrelated majors such as computer science, nursing, and pharmacology, which account for 4.2% of the total sample, may have influenced the validity of the comparison with other study factors such as self-development and organizational development, as well as the effect of education on awareness levels.

Moreover, several questions about the psychological and social issues that Saudi military soldiers experienced after being deployed from the Yemen combat zone remain unaddressed. Future research should be able to further evaluate the perceived barriers to obtaining social support among Saudi military members suffering from PTSD, according to the findings.

More research is needed to investigate the roles of education and organizations in improving PTSD awareness by using an interview research approach or a mixed method (quantitative and qualitative) approach to gain knowledge. Because access to participants is restricted, government organizations, private sector partnerships, and local community participation are all needed to assist social research and remove any barriers that may occur during data collection.

Despite these limitations, the study features several positive aspects. The current study is expected to contribute to a growing body of knowledge about PTSD among health-care professionals, particularly social workers and psychologists.

More importantly, the researcher believes this is the first time a scale for the level of understanding of PTSD in military people has been developed with outstanding validity and reliability (Cronbach's Alpha = 0.950). Similarly, one of the study's significant characteristics is that it considers PTSD among Saudi military members as a research topic in the social studies.

The current findings also contribute to our understanding of the critical function of education in boosting PTSD awareness among military personnel. According to the current study's findings, 63.2% of the sample agreed that they had knowledge of the social problems that military personnel face after returning from a war through their education, and 54.9% agreed that they had gained knowledge through their education about PTSD that military personnel developed after a war.

Finally, during the years of experience at the organization, 73.5% of the sample disagreed that their workplace provides awareness courses or trainings on the problems facing the military after the war, and 72.2% of the sample disagreed that their workplace offers specialized courses in PTSD caused by military service.

These findings were unexpected, and they suggest that colleges and health institutions should teach their students how to connect more effectively with PTSD patients, especially in the fields of social work and psychology. Finally, these recommendations are in line with the suggestions of Engward & Fleuty

(2019), Kiernan et al. (2016), Finnegan et al. (2017), and Cooper et al. (2016), which recommend that to ensure that veterans receive appropriate care and support, the potential health needs of veterans and their families should become an integral part of professional education and training in health care. These findings also recommend creating a culture in which knowledge of the military pervades all aspects of health care in institutions.

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## Conflicts of Interest

The author declares no conflict of interest.

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