PTSD symptoms, Insomnia, and Suicidal Ideation among Firefighters in Bangladesh: A Cross-sectional Study

Module 1: Demographic information of the respondent					
ID	**Name**	**1.2 Sex**	**1.3 Age**	**1.4 Marital status**	**1.5 Highest level of school attended**
		1. Male 2. Female 3. Third gender	In years	1. Married 2. Unmarried 3. Widowed 4. Divorced/Separated	1. Primary (1-5 years) 2. Secondary high school (6-10 years) 3. Higher secondary (11-12 years) 4. University or higher (>12 years) 5. Madrasa 6. No schooling

Module 2: Socio-economic information of the households				
2.1 No. of family members	**2.2 No. of children**	**2.3 No. of older people (> 60 years)**	**2.4 No. of adult earning person**	**2.5 Family monthly income (BDT)**

Module 3: Job related information							
3.1 Designation	**3.2 Working Hour**	**3.3 Working Year**	**3.4 No. of Operation Conducted**	**3.5 Overtime**	**3.6 Reward Policy**	**3.7 Health Insurance**	**3.8 Health Insurance**
				1. Yes 2. No 1	1. Yes 2. No	1. Yes 2. No	1. Yes 2. No
3.9 Risk Coverage	**3.10 Interpersonal Conflict**		**3.11 Training**				
1. Yes 2. No 1	1. Yes 2. No		1. Yes 2. No				
3.11a	If 3.**11** is **YES**, which training they have provided? Yes = 1; No = 2 *[Note: Multiple responses possible]*						
	CISM PTSD. Others……						
3.11b	**Do you think you need more training?** 1. Yes 2. No						

Module 4: Job satisfaction

Question	Very Unsatisfied 1	Unsatisfied 2	Neutral 3	Satisfied 4	Very Satisfied 5
4.1 Do you satisfy with your job?	☐	☐	☐	☐	☐

Module 5: Clinical treatment information

	Question	Options/Answers	
5.1	Do you have any chronic disease/condition?	1. Yes 2. No	☐
5.1a	If **5.1** is **YES**, what was/were the disease/ diseases? Yes = 1; No = 2 *[Note: Multiple responses possible]*		
	Diabetes ☐ High BP ☐ CKD ☐ CHD ☐ HTN ☐ Stroke/other CVD ☐ Chronic respiratory disease (Bronchitis/COPD/Asthma ☐ Others:_____		
5.1b	Are you taking any treatment/on the medication for the chronic disease?	1. Yes 2. No	☐
5.2	Has any of your household member have chronic disease?	1. Yes 2. No	☐
5.2a	If **5.2** is **YES**, Who has chronic disease in your family?	1.Mother 2.Father 3.Both 4.Don't have	☐
5.2b	What was/were the disease/ diseases? Yes = 1; No = 2 *[Note: Multiple responses possible]*		
	Diabetes ☐ High BP ☐ CKD ☐ CHD ☐ HTN ☐ Stroke/other CVD ☐ Chronic respiratory disease (Bronchitis/COPD/Asthma ☐ Others:_____		

Module 6: Lifestyle and behavior

	Question	Options/Answers	
6.1	Are you habitual to---	Tobacco ☐ Alcohol ☐ Pan/Jorda/Supari ☐ Others:_____	
6.2	Do you do exercise regularly?	1. Yes 2. No	☐
6.2a	If **6.2** is **YES**, which exercise do you do regularly? Yes = 1; No = 2 *[Note: Multiple responses possible]*		
	Meditation. ☐ Yoga ☐ Daily Exercise ☐ Others:_____		
6.3	Do you pray daily?	1. Yes 2. No	☐

Module 7: The Workplace Stress Scale

Thinking about your current job, how often does each of the following statements describe how you feel?

	Questions	Never 1	Rarely 2	Sometimes 3	Often 4	Very Often 5
7.1	Conditions at work are unpleasant or sometimes even unsafe	☐	☐	☐	☐	☐
7.2	I feel that my job is negatively affecting my physical or emotional well being	☐	☐	☐	☐	☐
7.3	I have too much work to do and/or too many unreasonable deadlines	☐	☐	☐	☐	☐
7.4	I find it difficult to express my opinions or feelings about my job conditions to my superiors	☐	☐	☐	☐	☐
7.5	I feel that job pressure interferes with my family or personal life	☐	☐	☐	☐	☐
	Questions	**5**	**4**	**3**	**2**	**1**
7.6	I have adequate control or input over my work duties	☐	☐	☐	☐	☐
7.7	I receive appropriate recognition or rewards for good performance	☐	☐	☐	☐	☐
7.8	I am able to utilize my skills and talents to the fullest extent at work	☐	☐	☐	☐	☐

Module 8: Short PTSD Rating Instrument Self Rated (SPRINT-SR)

Identify the most painful or traumatic event in your life that is still painful for you

	For each question, select the answer that most accurately expresses how you felt last week. If you have started treatment to relieve your pain, questions 9 and 10 apply to you and you can answer them. If not taking any treatment, answer questions 1 to 8 only.	Not at all 0	In small doses 1	Moderated or Tolerable 2	Enough Amount 3	Too much 4
8.1	To what extent are you affected or affected by unwanted memories, nightmares or flashbacks of past events?	☐	☐	☐	☐	☐
8.2	How much effort have you made to avoid thinking about, talking about, or doing things that remind you of the event?	☐	☐	☐	☐	☐
8.3	To what extent are you distancing yourself from people or not enjoying anything or having trouble feeling anything?	☐	☐	☐	☐	☐
8.4	How much has poor sleep, inattention, anxiety or nervousness, irritability, or feeling wary of your surroundings affected you?	☐	☐	☐	☐	☐
8.5	How much are you affected or affected physically and mentally by pain or fatigue?	☐	☐	☐	☐	☐
8.6	When you face stress or setbacks, how frustrated do you feel?	☐	☐	☐	☐	☐
8.7	To what extent are the above symptoms interfering with your performance or amount of daily activities?	☐	☐	☐	☐	☐

8.8	Are the above symptoms ruining your relationships with family, friends, or loved ones?	☐	☐	☐	☐	☐
Sum of Questions 7.1-7.8	☐☐					

8.9	If you have started or are undergoing treatment, how well have you been feeling since starting treatment? (Percentage) (%)									
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

8.10	How much has the above symptoms improved after starting the treatment?				
	Got worse 1	**Immutable 2**	**A little 3**	**Quite a bit 4**	**Much more 5**
	☐	☐	☐	☐	☐

Module 9: Insomnia Severity Index

Dear participant, the following questions are targeted to measure the severity of Insomnia. Please tick the best proper choice of answer code. Please rate the CURRENT (i.e. Last 2 Weeks) Severity of your insomnia problem.

Insomnia Problem		**None 0**	**Mild 1**	**Moderate 2**	**Severe 3**	**Very Severe 4**
9.1	Difficulty falling asleep?	☐	☐	☐	☐	☐
9.2	Difficulty staying asleep?	☐	☐	☐	☐	☐
9.3	Problems waking up too early?	☐	☐	☐	☐	☐

Question		**Very satisfied 0**	**Satisfied 1**	**Moderately satisfied 2**	**Dissatisfied 3**	**Very dissatisfied 4**
9.4	How satisfied / dissatisfied are you with your current sleep pattern?	☐	☐	☐	☐	☐

Question		**Not at all 0**	**Noticeable 1**	**A little 2**	**Somewhat 3**	**Very much noticeable 4**
9.5	How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?	☐	☐	☐	☐	☐

Question		**Not at all 0**	**Worried 1**	**A little 2**	**Somewhat 3**	**Very much worried 4**
9.6	How worried / distressed are you with your current sleep pattern?	☐	☐	☐	☐	☐

	Question	Not at all 0	Interfering 1	A little 2	Somewhat 3	Very much interfering 4
9.7	To what extent do you consider your sleep problem to interfere with your daily functioning (e.g. daytime fatigue, mood, ability to function at work / daily chores, concentration, memory, mood, etc) currently	☐	☐	☐	☐	☐

Module 10: Suicidal Ideation Attribute Scale (SIDAS)

10.1	In the past month, how often have you had thoughts about suicide? (0= Never, 10= Always)											
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
10.2	In the past month, how much control have you had over these thoughts? (0= No control, 10= Full control)											
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
10.3	In the past month, how close have you come to making a suicide attempt? (0= Not to close, 10= Made an attempt)											
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
10.4	In the past month, to what extent have you felt tormented by thoughts about suicide? (0= Not at all, 10= Extremely)											
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	
10.5	In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as works, household tasks, or social activities? (0= Not at all, 10= Extremely)											
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	