GENDER DIFFERENCES IN THE MENTAL HEALTH CONDITION OF INTERNALLY DISPLACED PERSONS AND CONTROLS

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Abstract

Since 2000, more than 250,000 people who used to reside in the border communities between Cross River and Akwa Ibom states have been displaced and now reside in Central Calabar, with the possibility of many presenting with mental health challenges due to trauma experienced during the communal conflicts and the sudden relocation to an unfamiliar territory. The mental health status of these internally displaced persons (IDPs) in most settings in Nigeria, especially the IDP Camp in Calabar, has not been empirically documented, making psychological ameliorative intervention impossible. Using a standardized battery of tests, this study assessed the gender differences in the mental health status 100 IDPs and 100 Controls from the Ikot Offiong resettlement camp in Cross River state. Using t- independent analysis, results indicated that the IDPs had significantly lower scores than the Controls on Somatisation, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism, Neuroticism, and Denial of problems. Female IDPs differed significantly from male IDPs in only Death Anxiety, while the female Controls had significantly higher scores than female IDPs in 10 domains of mental health but male IDPs significantly deferred from male Controls in 4 domains. The discussions of the results centered around possible use of the denial defense mechanism which accounted for the IDPs having relatively lower scores on Denial than non IDPs. The study emphasized the need for individual/group psychotherapy to ameliorate the mental health of the IDPS.

Keywords: Internally displaced persons, mental health, gender

Introduction

Until recently, there has not been a direct response from the United Nations on the issues of internal displacement. A colony of displaced persons is growing in leaps and bound all over the African continent being produced by similar conditions that give rise to refugees globally. The internally displaced persons (IDPs) have remained in their country of origin not crossing any international border unlike the refugees. However the government under whose leadership they remain may have also been responsible for their predicament (Internal Displacement Monitoring Center: IDMC, 2012), a position earlier confirmed by Kampala Declarations on IDPs (Lawrence, Anastasi & Lawsy, 2007). The Kampala convention was the first major framework in addressing and preventing the humanitarian crises of IDP on the African continent and the year 2009 was a milestone in this regard.

As at 2011, it was revealed that about 24.6 million IDPs exist around the world. On further examination of this figure, the United Nations Refugee Agency (UNHCR)declared that 14.9 million exist inAfrica and Asia (UNHCR, 2012), largely due to wars and natural disasters (IDMC, 2012). This condition seem not to be abating as further reports released by IDMC (2017) indicates that more than 31 million people are displaced in their own country.

In Africa, specifically Nigeria, the recurring crises in the North East and the perennial flooding and other forms of disasters, have created a large numbers of IDPs. In the course of the crises which produce IDPs properties are looted and destroyed while the displaced persons move on in some instances to take refuge in schools or makeshift centers or public buildings within their neighboring communities since they have been deprived of their homes and, sometimes, their land and livelihoods (Alhassan, 2011). Further, IDPs in Nigeria face all manner of discomfort and insecurity including exploitation. In most cases their camp appears to be congested and inhospitable. It is also observed that IDPs are separated from their families with their needs largely unmet because in some instances the humanitarian responses are poorly coordinated.

The issue of displacement has placed the society at a huge risk of mental illness. Many displaced persons develop very low capacity to cope or adjust to their environments with little or no interest in skills acquisition. The conditions that brought about displacement and the IDPs experiences in course of this movement create some psychological disablement which affects their mental health, such imbalances may be occasioned by feelings of fear, terror, anguish and uncertainty over survival. The emotional state of IDPs may have also been worsened by their traumatic experiences (Cohen & Francis, 1998).

Brody (1994) defines mental health broadly as an individual's optimal functioning, well-being and capacity to adapt to the socio-cultural context. As a result of the many experiences of IDPs, which seem to affect their lives, it is doubted if most IDPs can meet the state of mental health as defined by Brody. In a similar vein, WHO (2014) defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Many displaced persons are at high risk for mental health problems as a direct result of their experiences due to, among other factors, a shattered illusion of safety and a penetrating awareness of vulnerability, leaving behind all that is familiar and starting a new life in an environment with a different language and culture. Several studies have been conducted on the impact of being an IDP on the mental health of individuals. Schmidt, Kravic and Ehlert (2008) in a comparative study of adjustment to trauma in refugee, displaced and non-displaced Bosnian women, assessed respondents on PTSD and self-concept. Data was collected from 29 Bosnian women, 26 women who have been internally displaced and non-displaced women. The Bosman Trauma Questionnaire and four scales assessing self-esteem, perceived incompetence, externality of control attribution, and persistence were used in data collection. The IDPs scored significantly higher on PTSD symptoms, externality of control attribution and perceived incompetence,

they were lower on self-esteem than the other women. PTSD, and symptom severity were most strongly predicted by level of education, with displacement types and exposure to violence during the war. In the study an inconsistency was noted in the interaction of self-concept with displacement and psychopathology, while displacement type predicted control attribution, but not other aspect of self-concept and PTSD symptoms being partly related to perceived incompetence and self-esteem.

Taiwo, Mohammed, Agunbiade, Ike, Ebiti and Adekeye (2011), using a cross-sectional systematic sampling method assessed psychiatric morbidity among IDPs (n = 258) after the post-election crisis in Kaduna state, Nigeria, found that 59.7% of the IDPs had probable depression and 42(16.3%) had definite depression. Fox (2000), using the Harvard Trauma Questionnaire to assess experiences of trauma, torture and their psychiatric implications among a sample of 55 Sierra Leonine refugees. Findings indicated that more than 90% of the respondents reported experiencing forced separation from family, being close to their own death and witnessing the murder of family members and friends. 50% met the criteria for PTSD and four-fifth (4/5) had appreciable scores well above the cut-off for anxiety and depression (Fox & Tang, 2000).

The Punch Newspaper observed that, since 2000, more than 250,000 1kot Offiong indigenes of Cross Rivers people who reside at the borders between Cross River and Akwa Ibom states have been displaced and now to reside in Central Calabar, with many of them suffering from major psychiatric disorders such as post-traumatic stress disorder (PTSD) as a result of trauma experienced during the communal conflicts (Punch, 2012). The mental health status of these IDPs as well as gender differences in their mental health status have not been empirically documented. The aim of this study, therefore, is to comparatively assess the mental health status of IDPs and non-IDPs in Calabar as well as to explore possible gender differences in mental health of the two groups. We, therefore, hypothesized that non-IDP participants would fare significantly better the IDPs on all measures of mental health and that there

would be significant gender difference across the domains.

Method

Setting / Participants

The IDPs camp used in the study is located in Calabar, Cross Rivers state, Nigeria. The camp is made up of people of Ikot Offiong descent naturally located close to the Odukpani people residing at the border communities between Akwa Ibom and Cross River states. The camp was originally a housing project of Cross River state that was abandoned, and later restructured to accommodate the IDPs. In addition to accommodating the IDPs, the Camp has offices, make-shift health center, and structures having semblance of a market and a sport arena. The camp appears dilapidated, with the environment having a general picture of a slum. Purposive sampling technique was used to select 200 participants for the study (100 IDPs and 100 non-IDPs made up of 50 males and 50 females in the respective groups). Participants' ages ranged from 18 to 68 years.

Measures

Three major psychiatric/psychological instruments were administered for data collection in course of this study. The instruments include: Symptom Distress Checklist 90 (Sch-90); Illness Behaviour Questionnaire (IBQ); Death Anxiety Scale (DAS).

Symptom Distress Checklist (SCL – 90) is a 90-item inventory. It was developed by Derogatis, Lipman and Covi to assess 10 primary domains of symptoms associated with distress among psychiatric out patients and with the experience of anguish arising from the problem of living among people in general population.

The ten (10) domains are categorized as follows:

a. Somatisation – body pain, discomfort and dysfunction.
b. Obsessive – compulsive – irresistible, thoughts, impulses and actions.
c. Interpersonal Sensitivity – discomfort in social situations.
d. Depression – loss of vital energy, interest and motivation.
e. Anxiety – restlessness, nervousness

and tension.

f. Hostility – feelings of anger, hatred, repression and unfriendliness.
g. Phobic anxiety – irrational fear and avoidance of objects, places and situation.
h. Paranoid ideation – suspiciousness, distrustfulness and blaming others.
I. Psychoticism – hallucinations, delusions and externally manipulated thoughts.
j. Neuroticism – poor sleep and appetite, feelings of unwellness.

The alpha internal consistency reliability coefficients of the inventory ranged from .77 (psychoticism) to .90 (depression), and the test-retest reliability coefficient ranged from .78 (hostility) to .90 (phobic anxiety) in a psychiatric population. In establishing a construct validity of the instrument, a retirement stress inventory as developed by Omoluabi (1996) was used for this comparison which yielded a significant coefficient, with subscales of SCL-90 ranging from 26 (Hostility) and 47 for neuroticism. The SCL-90 has been revalidated in Nigeria and has been used extensively by researchers in Nigeria (Erinoso, 1996, Onigbaiye, 1996).

The illness Behaviour Questionnaire (IBQ) was developed by Pilowsky and Spence (1983) with as an instrument to assess Self-perceived manifestations of physical and mental illness; Somatisation disorder (Scales A & D); Hyochondriasis (Scale C) and Conversion disorder (Scale H).The instrument has a 62-item inventory designed to measure those dimensions of attitude, belief and behaviour that an individual displays to the self and others when ill. The various dimensions of the scale are as follows:

a. Disease conviction – There is a preoccupation with one's bodily function arising from a strong conviction that one's body is diseased.
b. Irritability – Poor interpersonal relationship as a result of anger and visible intolerant reactions to other persons.
c. General hypochondriasis – Excessive concern over one's health and the fear of picking up disease.
d. Psychological versus somatic perception of illness – Attributing the

cause of illness to either psychological factors or external factors.

e. Affective inhibition – Inability to discuss feelings and worries concerning illness with others.

f. Denial of problems – Being unable to accept the psychological problems associated with illness.

g. General illness reaction – Reactions arising from the perception of oneself and others during illness.

The instrument was normed using the mean scores obtained by healthy adult Nigerians (Nworah, 1999). Pilowsky and Spence (1983) reported a 12 week test-retest reliability coefficient for the IBQ scale ranging from 67 – 85, while Adebakin (1990) reported a reliability coefficient ranging from 02 to 28 using a 3 week test retest.

The Death Anxiety Scale (DAS) was developed by Templar (1970) to measure death anxiety as a clinical condition. It has a 15-item inventory designed to measure the concern of persons relating to fear, apprehensions, and foreboding, as they relate to dying. The norming was achieved by the mean scores obtained by the groups and gender. Templar (1970) reported the following reliability coefficient: KR – 20 internal consistency = .76; 3 week test-retest = .83; Adebakin's (1990) 3 week test-retest = .15, a convergent validity coefficient of .74 and .45 were obtained by Templar (1970) and Adebakin (1990) respectively when DAS was correlated with Fear of Perusal Death Scale (FPDS: Florian & Kravetz,1983). The DAS scale has been revalidated for use among Nigerian populations (Adebakin, 1990; Erinoso 1996; Uzosike, 1998).

Procedure

The three instruments SCL -90, IBQ and DAS were collectively administered to each patient after establishing adequate rapport with them. The administration for the IDPs took place at the Ikot Offiong resettlement camp in Calabar, Cross River State, Nigeria while that of the non-IDPs took the neighbouring communities. The participants were encouraged to complete the instruments by reading the instructions on each of the test forms. The test forms were completed at the respondent's own

pace as no time limit was observed. The tests were scored according to the instructions in the manual of each test.

Results

This section contains the outcome of the variables studied in the process of testing the various postulations. The results are presented in two major sections. The first section reported the use of descriptive statistics (mean and standard deviation) in analyzing the data collected while the second section presents the analysis of the data collected using inferential statistics, the students t-test (independent).

Table 1: Mean and Standard Deviation Analysis

	Male IDPs N = 50		Male Non IDPs N = 50		Female IDPs N = 50		Female Non IDPs N = 50		Male IDPs N = 50		Female Non IDPs N = 50		ALL IDPs Group N = 100		All Non IDPs Group N = 100	
Measures	***Mean***	***SD***	***Mean***	***SD***	***Mean***	***SD***	***Mean***	***SD***	***Mean***	***SD***	***Mean***	***SD***	***Mean***	***SD***	***Mean***	***SD***
A	11.82	8.79	11.64	8.90	11.64	8.90	21.22	14.23	11.82	8.79	11.64	8.90	11.73	8.80	19.69	13.55
B	10.02	7.08	11.92	8.54	11.92	8.54	17.44	9.75	10.02	7.08	11.92	8.54	10.97	7.87	16.50	9.58
C	39.74	198.41	12.36	7.10	12.36	7.10	14.82	8.10	39.74	198.41	12.36	7.10	26.05	140.38	13.39	7.10
D	14.52	8.92	16.76	9.29	16.76	9.29	19.90	14.47	14.52	8.92	16.76	9.29	15.64	9.13	18.24	10.52
E	8.96	6.98	7.82	7.19	7.82	7.19	17.96	11.89	8.96	6.98	7.82	7.19	8.39	7.07	15.49	11.19
F	5.94	5.60	6.36	6.10	6.36	6.10	9.82	6.83	5.94	5.60	6.36	6.10	6.15	5.83	8.54	6.64
G	6.14	6.69	6.62	4.54	6.62	4.54	10.92	8.42	6.14	6.69	6.62	4.54	6.38	5.69	8.97	7.67
H	9.08	5.45	7.70	5.43	7.70	5.43	11.92	5.11	9.08	5.45	7.70	5.43	8.39	5.48	10.79	5.16
I	9.88	7.45	11.38	9.22	11.38	9.22	17.20	11.10	9.88	7.45	11.38	9.22	10.63	8.37	14.89	10.97
J	8.22	5.95	8.56	6.56	8.56	6.56	11.68	7.45	8.22	5.95	8.56	6.56	8.39	6.22	10.31	6.73
IBQ																
A	.74	.88	.65	.76	.65	.76	.80	.70	.74	.88	.56	.76	.65	.92	.75	.75
B	2.02	1.37	2.00	1.39	2.00	1.39	1.84	1.04	2.02	1.37	2.00	1.39	.56	1.36	1.91	1.16
C	3.83	1.81	3.82	2.15	3.82	2.15	3.94	2.27	3.83	1.81	3.82	2.15	3.82	1.96	3.87	2.13
D	2.28	1.09	2.20	.93	2.20	.93	2.42	1.28	2.28	1.09	2.20	.93	2.24	1.01	2.35	1.15
E	1.62	1.61	1.62	1.63	1.62	1.63	1.86	1.33	1.62	1.61	1.62	1.63	1.62	1.61	1.91	1.35
F	2.54	1.33	2.63	1.21	2.63	1.21	2.36	1.27	2.54	1.33	2.62	1.21	2.58	2.58	1.26	1.38
G	2.16	1.35	1.94	1.24	1.94	1.24	2.48	1.58	2.16	1.35	1.94	1.24	1.29	2.05	2.51	1.53
H	9.68	3.07	9.00	3.38	9.00	3.38	10.26	3.21	9.68	3.07	9.00	3.38	3.23	9.34	10.9	3.48
DAS	6.38	2.61	7.22	2.23	7.22	2.23	6.54	2.10	6.38	2.61	7.22	2.23	2.45	6.80	7.00	2.27

From the table 1, result indicated that male IDPs significantly deferred from male non – IDPs in only SCL -90: A, B and E and Death Anxiety. Female non – IDPs had significantly higher scores in 10 of the 19 domains which are SCL – 90: A, B, E, F, G, H, I, J IBQ: G and H. It was also found that female non – IDPs reported significantly higher on measures of general psychopathology (SCL – 90), IBQ and DAS than female IDPs. Result also indicated that female IDPs differed significantly from the male IDPs in only Death Anxiety. Result further shows that all IDPs had significantly lower scores than the all non – IDPs in ten (10) of the 19 measures.

Mean scores of the female non IDPs group are generally higher than those of other groups most of the domains (except 6 which are SCL – 90: C, IBQ: B, E, F, G and DAS). The male non-IDPs have the highest mean

scores in the following 8 measures, SCL – 90: A, B, E, F, G, H, I and J.

To establish if the observed differences between the groups are statistically significant, t-test (independent) was used to compare the mean scores of (a) male IDPs and male non-IDPs (b) female non IDPs and female IDPs, (c) male IDPs and female IDPs; and (d) All IDPs group and all non-IDPs group. The results are presented below:

Table 2: Summary of t-test Comparison of the 6 Groups on the 19 measures

Measures	**Male IDPs N=50**	**Female IDPs N = 50**	**Male non IDPs N=50**	**Female non IDPs N=50**	**All IDPs N=100**	**All non IDPs N=100**
SCL 90 A – **J**			A – 2.87* B – 3.32* E – 2.36*	A – 4.04* B – 3.01* E – 5.16* F – 2.67* G – 3.18* H – 3.99* I – 2.72* J – 2.22*		A – 4.91* B – 4.46* D – 1.87* E – 5.37* F – 2.71* G – 2.71* H – 3.19* I – 3.09* J – 2.10*
IBQ A - H						G – 2.30*
DAS		1.73*	2.18*			
Note: * Significant df = 48 critical t = 1.68 P <0.05		* Significant df = 98 critical t = 1.66 P <0.05				

Based on the analyses, male non – IDPs demonstrated higher levels of psychopathology in four measures (SCL-90): A, B, E and DAS; female non-IDPs reported more psychiatric/psychological difficulties relative to female IDPs but female IDPs reported higher on the measure of death anxiety; the IDPs relative to non-IDPs reported lower on the measures of psychopathology.

Discussion And Conclusions

We found similarity in mental health status of both IDPs and non-IDPs across gender, a

finding we consider to be a reminder to people in the normal population who erroneously believe that psychological or psychiatric difficulties are limited to special populations or psychiatric populations only. The finding that female non IDPs reported higher presence of psychopathologies confirms our postulation, pointing to the fact that female IDPs experience more psychopathological tendencies than male IDPs. The work of Taiwo et al (2011) succinctly documented this tendency. According to Taiwo et al (2011), a combination of factors ranging from the changing roles of women in the normal society as well as the bastardization of deprivation in social norms serves to worsen the mental state of the female non IDPs to whom denial of problems may not really be an answer to their "unhealthy" traumatic experiences. The above findings also agree with the work of Lawrence et al., (2007) who reported that for the general United State population of non-displaced persons, women are more likely to experience stress and depression. The finding which demonstrated the presence of elevated level of death anxiety in female IDPs is consistent with and lends credence to Taiwo et al's (2011) position that the female IDPs are more overwhelmed by the debilitating nature of their existence as IDPs, hence the thought of death remains a recurring decimal in their lives.

Unexpectedly, we found that IDPs, relative to non-IDPs reported lower on many of the domains of psychopathology. The use of defense mechanism may have been a key factor in the finding, where denial of problems appears paramount on the part of the IDPs in spite of their overwhelming and uncongenial living conditions. Many IDPs are faced with a vast amount of novel information about their host communities where they really have never been to, until the point of seeking refuge or relocation or might never have wanted to be. It is also plausible that the community where the IDP Camp is situated (and where the non-IDP participants were drawn from) feel invaded, with resultant effect of the depletion of their resources coupled with other unfavourable socio-economic factors such as unemployment and poor living conditions.

The present study represents an attempt at empirically assessing the relative mental

health status of the internally displaced persons (IDPs). Based on findings indicating elevated scores on mental health issues across all domains examined among IDPs and non-IDPs, we conclude that mental health issue is a problem among the IDPs and people in the neighbouring communities as well as the general population. We also conclude that IDPs did not fare worse than the normal Controls on most domains of mental health. We also did not find a significant gender difference in mental health status of participants, except on death anxiety where females reported significantly elevated scores. These findings lend credence to the ubiquitous nature of mental health and the need for mental health focus to be all-encompassing rather than limiting it to an issue of concern among special populations alone.

In attempting to improve the mental health of IDPs, Governments and non-governmental organizations (NGOs) should formulate plans that will assist in the total rehabilitation of the IDPs while opportunities should be created for their resettlement as this will not only give them a sense of belonging but also restore their mental balance. Qualified and competent psychologists and psychotherapists should be employed in IDP camps with the aim of using evidence-based and validated procedures to alleviate psychological morbidity and improve mental health of IDPs and people in the host communities. Given the array of psychological, social, economic and physical stressors that IDPs are daily bombarded with, the need for regular individual and group psychotherapy in IDP camps cannot be overemphasized. It is also obvious that the normal population is immune to mental health issues. Therefore, we recommend that non-IDPs and people in the general population should seek and access psychological services.

The battery of psychological tests administered to participants was considered very lengthy, discouraging many potential participants to decline participation. Being a cross-sectional survey, manipulation and control of variables and study setting was not possible, making it plausible that the findings, probably, might have been different had the study utilized and experimental approach been adopted. Nevertheless, we are convinced that these

limitations are not sufficiently potent to be capable of vitiating the findings of the study and (or) the conclusions drawn therefrom.

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