

Forced displacement and mental health problems in refugees residing in Quetta for decades

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Abstract

Objective: to study the prevalence of common Mental health disorders among forcibly displaced people and comparing with the common mental health disorders among host community members.

Study Design: Analytical study

The setting of Study: OPD services of BIPBS, Quetta, Baluchistan – Pakistan

Methodology: The OPD of BIPBS in SPH and BMCH of Quetta-Balochistan attends around 800 to 1000 patients per month from both host communities and refugees, the data of the OPD of both hospitals was collected from the OPD register for January to May 2022 the data was analyzed to numerate both the host community members and refugees out of 4120 for 354 refugee patients presented using their POR card and for 3776 of host community members using their CNIC, next the data was analyzed to differentiate the prevalence of different mental health disorders among them within 5 months of 2022.

Results: Balochistan hosts around 27% of all (1.4million) of displaced afghan refugees, This study states that Afghan Refugees presented to OPD services of BIPBS, 47% of them were diagnosed as MDD with/without psychosis, 19% with GAD, 5% diagnosed as BAD with/without psychosis, 5% With schizophrenia, 4% as PTSD, 3% as migraine headache, 3% conversion disorder, 2% OCD, 1% somatoform disorder and 10% of them presented with other mental health disorders, while in host community 21% were diagnosed as MDD with/without psychosis, 24% as GAD, 12% as somatoform disorder, 10% as OCD, 8% as migraine headache, 7% as conversion disorder, 4% as BAD with/without psychosis, 3% as Schizophrenia, 3% as MBD due to substance misuse and rest of 7% presented with other Mental health disorders.

Conclusion: The conclusion of this study states that mental health disorders are more common among them than in other populations, the result of this study shows that there is a big difference in the prevalence of mental health disorders among displaced people and the rest of the population, some of the Mental health disorders are present in higher percentage among displaced people rather than among host community, while some other disorders are present in lower percentage among displaced people rather than among host community, this study also highlights that further studies are needed to determine, risk and protective factors within the host community

Keywords: Forced displacement, mental health problems, refugees, Quetta

INTRODUCTION:

As written by Warsan Shire, “no one leaves home until the home is the mouth of a shark”. UNHCR defines forced displacement as “displaced because of persecution, conflict, generalized violence or human rights violations” (online)

Displacement/Migration has been increasing at the international level, specifically in the last decade. Based on a report by UNHCR, in 2014 it was estimated that 59.9 million people were displaced internationally. (Online) While in 2019, 3.4% of the populations around the globe, making 214 million people, were known as internationally displaced people. Due to increasing conflicts and social diversity, this number may rise drastically in the upcoming days. (2. Mental health of migrants with pre-migration exposure to armed conflict. Cristina Mesa- Vieira)

Among the people displaced worldwide, Afghans are one of the nations displaced forcefully, out of which 1.4 million registered Afghan refugees are hosted by Pakistan, including Balochistan which hosts around 27% of all (1.4million) afghan refugees, 57% of them living within Quetta and 43% are living in peripheries in refugee villages. (2021) Displacement can be of two types, both voluntary and forced.

Volunteer displacement is a simple change in life, but the International Organization for Migration defines it as “any person migrating to escape persecution, conflict, repression, natural and human-made disasters, ecological degradation, or other situations that endanger their lives, freedom or livelihood.” (Migration and mental illness. Jones)

A displaced person (DP) also known as a displaced migrant is referred to as a forcibly displaced person who left his/her place of origin. if the person is displaced within the country from one place to other referred to as an "internally displaced person" (IDP). While those displaced persons who migrate and travel internationally and may be receiving legal protection from their country of residence or international organizations may be referred to as refugees. All types of displacements are rising due to armed conflict, economic crisis, and many other reasons. (Migration and mental illness. Jones)

Any change in life can bring certain challenges and opportunities while talking about forced displacement brings both bearing pressure of force and adjusting to displacement. Meanwhile, it can give a lot of opportunities, with loss bringing gain as well. The distress brings resilience, displacement brings the art of adjustment, depression of thinking about the past brings a vision for a better tomorrow, the trauma of isolation brings hope for safety, leaving a lot of good behind brings the art of invention, and the loss of occupation teaches the art of rehabilitation, the loss of childhood gives a strong will for change, and the post-traumatic disorder brings posttraumatic growth.

But when it comes to what is on the ground, a person's capacity for growth is far less than the force of displacement and problems it brings. A migrant learns rehabilitation at the cost of losing all that they had in the past, and they buy opportunities with opportunities and a sense of being lost, they gain resilience with the cost of lifelong psychological Traumas, and they get a strong will for change with a long-lasting depression. A migrant child buys a vision for tomorrow with the cost of their childhood, a migrant university scholar bought the achievements with the distress of being taunted and the feeling of not having the right of inclusion, forced displacement

leads to lots of mental health problems depending on the pre-displacement exposures, problems they face during their journey, and re-adjustment in new locations. (.Jones) Multiple factors determine the effects of displacement on mental health, but there is a strong association between Mental health with causes of displacement which are as follows: (.Jones)

1. Natural causes of forced displacement include floods, earthquakes, climate change, tsunamis, slide land, land use changes, and so on.
2. Man-made causes of forced displacement include conflicts, human trafficking, criminal organizations, and political entities.

The process of displacement has three stages. The first is the pre-displacement stage: this is when the individuals decide and plan to migrate. The second stage involves the process of displacement, which is the physical transition from one area to another, involving all the stages of adjustments and other psychosocial steps. The third stage is post-displacement, this is when the individuals try to adjust to the different culture, social structure, and environmental factors of the host community. (Jones)

A study conducted in 2013 concluded that mental health disorders such as posttraumatic stress disorder (PTSD), anxiety, and depression were more prevalent among displaced persons rather than non-displaced (Forced migration and mental health: Prolonged internal displacement)

PRE-DISPLACEMENT EXPOSURE (FORCES AND PROBLEMS LEADING TO DISPLACEMENTS)

Any change needs adjustment, which can be both within a few days or more than its normal duration which then can be changed into adjustment disorder and some other psychiatric disorders. While forced displacement is a huge change in one's life. The more violent the pre-displacement exposure the more drastically would be the consequents mental health issues.

Regarding the pre-migration exposure and causes of displacement; exposure to manmade causes specifically exposure to war/armed conflicts are the leading cause of displacement. A systemic review published by The Lancet in 2013 shows that people with pre-displacement exposure to armed conflicts are more prone to different Mental health disorders such as PTSD was the most prevalent disorder. PTSD had a current prevalence of 31% with a lifetime prevalence of 32%. Major depressive disorder had a current prevalence of 25%, with a lifetime prevalence of 28%. While generalized anxiety disorder had a current prevalence of 14%. (Stewart)

Disasters are the other factors that migrants could be exposed to before displacement so there is an association between disasters and the mental health of the displaced population and a negative impact on them. Along with the various losses in the context of socioeconomic, the affected communities experience emotional and mental health instability with an outcome of developing post-traumatic stress disorder, anxiety, and depression. Generally, disasters are mostly considered the cause of socioeconomic damage, but meanwhile, mental health and emotional instability must not be ignored in such conditions. (Migration and mental health. H. G. Virupaksha)

PROCESS OF MIGRATION (THE PHYSICAL TRANSITION FROM ONE PLACE TO ANOTHER)

The process of displacement is including the start of the physical transition of forcibly displaced people from the place of origin to a new location which can also be filled with troubles and difficulties.

There are multiple factors related to the migration phase such as experiencing a loss (e.g., loss in relationships, assets of life, and values), grief, and being traumatized. The research was conducted on Latino migration to the US regarding traveling with children. It is identified that being displaced and traveling with children is more stressful for parents which makes the displaced parents more vulnerable to mental health disorders. It is also stated that the length of displacement and migration has also an impact on increasing stress, but it requires further studies. (The migration journey and mental health. Haley Carroll)

Tyhurst described the concept of “social-displacement syndrome”. This study stated that migration has an impact on individuals. He described that this phenomenon consists of the following two sets of characteristics.

1. The periods of escape and psychological stress such as nostalgia, helplessness, anger, fear, etc.; and
2. Some severe clusters of symptoms include paranoia, hypochondriacal ideas, and sleep disturbances in association with anxiety and depression. (10)

POST-DISPLACEMENT (RESETTLEMENT IN NEW SOCIETY)

Post-displacement phase is when forcibly displaced people reach a new location and a period of actual adjustment to a change of culture, place, surroundings, circumstances, and hopelessness of losing what they had started.

Displacement not only has an impact of exacerbating the mental health disorders of already disordered people but also contributes to the development of new disorders such as depression or PTSD. One review of existing studies identified that 30% of the displaced population who were exposed to conflicts develop depression and PTSD.

A study conducted in Colombia concluded that the prevalence of anxiety and depression was more than twice common among displaced teenagers as compared to non-displaced teenagers. Suicide attempts among displaced teenagers were 4.5 times more common. While the prevalence of PTSD was six times more common. (Banner: A teacher in Jamboli camp)

METHODOLOGY:

The outpatient departments of psychiatry department in sandmen provincial hospital and Bolan medical complex hospital of Quetta-Balochistan are functional on daily basis and overall attends around 800 to 1000 patients per month of both host community and refugees, the data of outpatient department (OPD) of both hospitals was collected from OPD register for the months of January to May 2022 the data was analyzed to numerate both the host community members and refugees out of 4124 for 354 refugee patients presented with mental health disorder using their proof of registration and for

remaining 3776 host community members with mental health disorder using their computerized national identity card, next the data was analyzed to differentiate the prevalence of different mental health disorders presented to outpatient departments of psychiatry within 5 months, using international classification of disorders (ICD-10) out of 354 patients of refugee community presented, 47% of them were diagnosed as major Depressive disorder with/without psychosis, 19% diagnosed as generalized anxiety disorder, 5% diagnosed as bipolar affective disorder, 5% schizophrenia, 4% post-traumatic stress disorder (PTSD), 3% migraine headache, 3% conversion disorder, 2% Obsessive Compulsive disorder, 1% somatoform disorder and 10% other mental health disorders, while in host community out of 3770 patients, 21% presented with Depressive disorder, 24% presented with Generalized Anxiety disorder, 12% with somatoform disorder, 10% with obsessive compulsive disorder, 8% with migraine, 7% with conversion disorder, 4% with bipolar Affective disorder, 3% with Schizophrenia, 3% with mental and behavioral disorder due to substance misuse and the rest of 7% presented with other Mental health disorders.

Study Design & Setting: The present Analytical study outpatient department of Baluchistan institute of psychiatry and behavioral sciences, in Sandmen provincial hospital and Bolan medical complex hospital, Quetta, Baluchistan – Pakistan

Duration of Study: 5 months of duration, (January 2022 to May 2022)

Sample Size: 4124 Patients out of 354 patients were Afghan Refugee patients and 3770 were host community patients.

SAMPLING TECHNIQUE:

After informed consent, and a letter of authentication from the Balochistan institute of psychiatry and behavioral sciences, the data of patients who were consulting through outpatient departments of the two tertiary care hospitals (Sandmen provincial hospital and Bolan medical complex hospital) was collected, and samples were divided into two groups of host community by using their computerized National Identity card and Proof of registration/Afghan Citizen card into a forcibly displaced population, the patients were diagnosed by using ICD-10 criteria.

SAMPLE SELECTION:

Inclusion Criteria

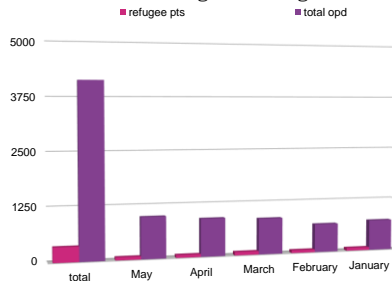
- All patients came to BMCH and SPH outpatient services.
 - Meeting criteria of ICD-10 for mental health disorders.
 - All the patients whose diagnosis were established and kept on medication on an outpatient basis.
 - Afghan patients living in Quetta with proof of registration/Afghan Citizen card.
 - All host community patients consulting in psychiatry outpatient services who have a computerized National Identity card (CNIC)
- ##### **Exclusion Criteria**
- Diagnosed cases other than psychiatric disorders
 - Afghan patients without proof of registration.

- Afghan refugees shifted newly due to regime change
- All host community patients who do not have a computerized National Identity card (CNIC).

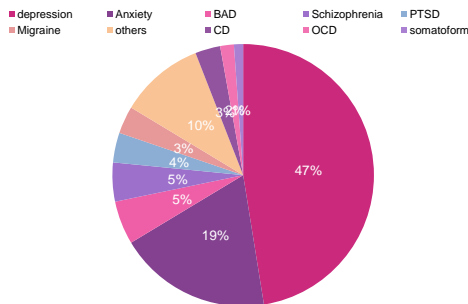
RESULTS:

Among the people displaced worldwide, Afghans are one of the nations displaced forcefully, out of which 1.4 million registered Afghan refugees are hosted by Pakistan Balochistan hosts around 27% of all(1.4million) of displaced afghan refugees, 57% of them living within Quetta and 43% living in peripheries in refugee villages. This study states that 354 Afghan Refugees and 3770 patients holding Pakistan Nationality presented to outpatient department (OPD) services of Balochistan institute of psychiatry and behavioral sciences(BIPBS)

Total OPD visits Vs Afghan Refugee OPD visits

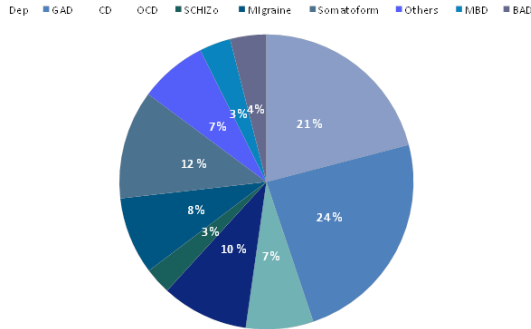


Out of which 47% of them were diagnosed as Major depressive disorder(MDD) with/without psychosis, 19% with Generalized Anxiety Disorder(GAD), 5% diagnosed as Bipolar Affective Disorder(BAD) with/without psychosis, 5% With schizophrenia, 4% as Post Traumatic stress disorder(PTSD), 3% as migraine headache, 3% conversion disorder, 2% Obsessive Compulsive Disorder(OCD), 1% somatoform disorder and 10% of them presented with other mental health disorders.



While in host community 21% were diagnosed as Major depressive disorder(MDD) with/without psychosis, 24% as Generalized Anxiety Disorder(GAD), 12% as

somatoform disorder, 10% as Obsessive Compulsive Disorder(OCD), 8% as migraine headache, 7% as conversion disorder, 4% as Bipolar Affective Disorder(BAD) with/without psychosis, 3% as Schizophrenia, 3% as MBD due to substance misuse and rest of 7% presented with other Mental health disorders.



CONCLUSION/DISCUSSION:

The conclusion of the topic states that around 3.1% which make up more than 2.14 million of the global population, are internationally displaced, and mental health disorders are more common among them than in other populations (Forced migration and mental health: Prolonged internal displacement).

Risk of developing mental disorders such as depression, anxiety, PTSD, and psychoses are greater among displaced populations than that of stable populations. As per different studies, displaced populations are more at risk of mental health disorders than non-displaced populations. In Ukraine, 25% of IDPs suffered from depressive disorder while in the rest of the population it was around 14%, while globally the prevalence of depression is 3.4% which indicates that the displaced population is 9 times more at risk of depression than the rest of the community (Banner: A teacher in Jamboli camp).

This indicates that post-displacement adjustment also ends with developing mental health disorders. A study in Colombia shows that anxiety and depression were twice more prevalent, suicide was 4.5 times and PTSD was 6 times more prevalent among displaced teenagers (Banner: A teacher in Jamboli camp).

To conclude, forced displacement leads to certain mental health issues while developing coping skills among people and improving resilience can contribute as a positive factor to decreasing mental health issues among displaced populations, which are subject to further analysis and studies. And it needs further evaluation in cities of Pakistan other than Quetta, to have further data on forcibly displaced people all over Pakistan, and to compare the circumstances, facilities, socio-cultural variations, language differences and sameness, and climate effects as risk and protective factors for developing Mental health disorders.

Limitations:

Collecting the retrospective data was a time-consuming limitation and applying the full criteria in the outpatient department setup with limited time.

Acknowledgment:

Would like to acknowledge and pay a vote of thanks to the Baluchistan Institute of psychiatry and behavioral sciences,

Ethical Approval:

Ethical Approval was acquired from Ethical Review Committee, Balochistan Institute of psychiatry and behavioral sciences, Quetta – Balochistan, Pakistan.

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