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Cover Story:

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Source: *UNHCR Canada, June 25, 2015. www.unhcr.ca/treacherous-crossing/*

CHIBOK GIRLS KIDNAPPED BY BOKO HARAM, NIGERIA.

Source: http://nation.com.pk/national/15-Aug-2016/boko-haram-video-shows-missing-nigerian-girls

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ABOUT THE AFRICAN JOURNAL OF TRAUMATIC STRESS

The African Journal of Traumatic Stress (AJTS) was established after the long realization of the need for all workers caring for traumatized people in Africa, to communicate to each other, to share experiences, knowledge, skills and to support each other. It was realized that there was a need to document and communicate all this knowledge to a wider audience beyond the African continent for the world to know, appreciate and help the traumatized peoples of Africa in the context of the now globalized increase of torture and organized violence as well as other man-made and natural disasters.

The primary objective of the AJTS is to provide a forum for discussion and presentation of papers to enhance the care and rehabilitation of the traumatized people's of Africa and beyond and ultimately to contribute to prevention efforts to eradicate this evil of torture and organized violence from Africa and the world at large.

The AJTS will publish original papers from wide and far-reaching multi-disciplinary backgrounds, including research papers, field experiences, new innovations in care, reports, commentaries, book reviews and even personal stories. Evidence-based papers will be of paramount importance. Short communications, newsworthy reports, review papers, cross cutting issues as well as picture-stories will all be welcome. The AJTS does not espouse any particularly ideology/philosophical view but believes in the universal respect to human rights for all, in good participatory democratic governance and in the empowerment and protection of vulnerable groups and all peoples from exploitation and oppression and advocates for an end to warfare and all its industry; and for peace, freedom and justice for all the peoples for the world irrespective of race, colour, creed, ethnicity, religion, gender, age or political persuasion.

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ABOUT THE PETER C. ALDERMAN FOUNDATION

The Peter C. Alderman Foundation is a non-profit organization established by Dr. Steven and Mrs. Elizabeth Alderman to help traumatized survivors the world over to heal from the mental health effects of trauma.

The Foundation is named after Peter C. Alderman, the second son of the Aldermans who was killed in the September 11, 2001 terrorist attacks on the World Trade Centre, New York City, USA. He was at the tender age of 25. In memory of their son, the Aldermans, together with friends and relatives, decided to do something positive about their grief, hence the Foundation.

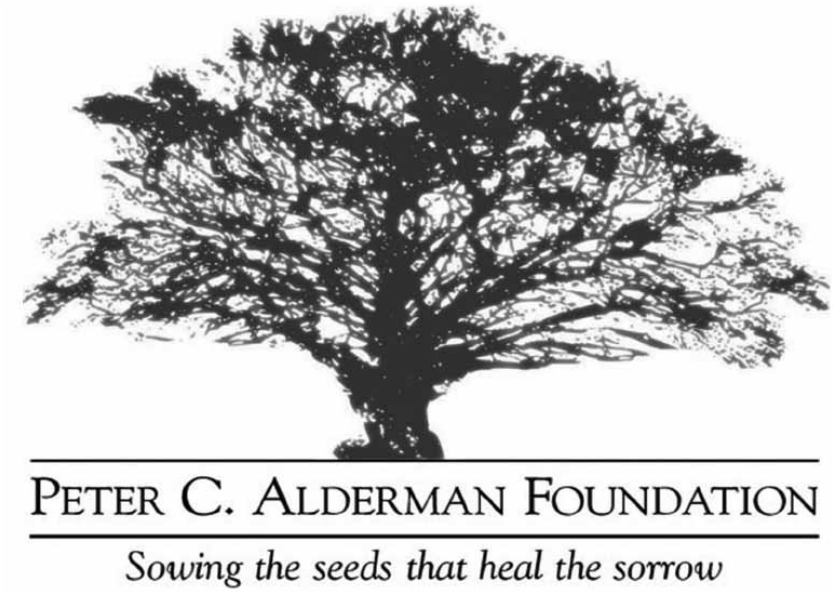
The Foundation's mission statement is "To heal the emotional wounds of victims of terrorism and mass violence by training doctors and establishing trauma treatment centres in post-conflict countries around the globe."

As part of its mission, the Foundation works to alleviate the suffering of war survivors in communities affected by conflict. The Foundation aims to provide holistic mental health care including (but not limited to) physicians, psychiatric clinical officers, psychiatric nurses, counselors and psychiatric social workers in these areas and to equip them with the tools to treat mental disorder using western medical therapies in combination with local healing traditions.

To fulfill this mission; the Foundation provides services in the areas of:

1. Mental health care to war affected persons through supporting "Trauma Treatment Clinics."
2. Psychosocial support to vulnerable peoples like formerly abducted children, former child soldiers, victims of rape, war widows, single mothers and HIV/AIDS patients in the war affected communities.
3. Training health workers in the war affected areas in the management of the mental health effects of war.
4. Awareness raising, sensitization, mobilization and holding training workshops on Management of Trauma.
5. Research in the mental health effects of war trauma on the population.

To achieve these objectives the Foundation works with and within the existing Ministry of Health structures of the host country. In Africa, the Foundation currently supports work in Uganda (three trauma clinics and soon to open a fourth clinic) and Rwanda (one clinic) and is soon to open up a service in Liberia and Kenya.



EDITORIAL

Refugee Mental Health

Today, the world continues in its relentless pursuit of violence. Whether in Africa, the Middle East, Europe, Asia, Australasia or in the Americas, untold violence rages on. With such mass violence has emerged a worldwide unprecedented upsurge in the numbers of refugees, asylum seekers and internally displaced peoples (IDPs), hence creating the world's immigration crisis of today. No country is spared. With this have come nationalistic, isolationist and xenophobic sentiments as well as protectionist politics which tear people apart the world over.

The 2015 UNHCR global trend on forced displacement estimated the global population of forcibly displaced people today to be larger than the entire population of the United Kingdom. The report showed that the forcibly displaced population to have increased by 75% in the past two decades, from 37.3 million in 1996 to 65.3 million in 2015. An estimated 11.7 million Syrians were displaced and were seeking protection within Syria or abroad. The rest of the Arab spring is said to have generated 4.9 million refugees, 6.6 million IDPs, and nearly 250,000 asylum-seekers by end of 2015. In the same year, about 2 million people including Afghans, Colombians, Congolese, Iraqis, Nigerians, Somalis, Sudanese, South Sudanese, Burundians, Eritreans, Ethiopians and Yemenis were displaced, either internally or as refugees or asylum-seekers. Developing regions hosted 86 per cent of the world's refugees under UNHCR's mandate. The Least Developed Countries provided asylum to 4.2 million refugees or about 26 per cent of the global total where the available mental health services are already overstretched.

Whatever the cause, fighting and violence cause panic and fear in the people who are left with no option but to run in search of safety and security. These are the refugees, immigrants and IDPs, the bulk of whom are children, women and the elderly. They often suffer traumatic events not only in their countries of origin but also in their countries of resettlement. Moreover, the bitter pangs of exile, past and continued trauma, as well as the stigma and discrimination they face make refugees and immigrants vulnerable to development of mental health problems, not only as individuals but also in families and communities wherever they have gone. This has always been the story of war and displacement. However the tides of today's massive immigration and displacement has caught many countries unprepared and with not enough resources or mental health services available to service this ever increasing need and demand.

Seggane Musisi
Editor-in-Chief

Mental health problems are related to various phases of displacement experience including preflight, flight, and resettlement. The preflight phase may include, physical and emotional trauma to the individual or family, the witnessing of murder, and social upheaval. Flight involves an uncertain journey from the host country to the resettlement site and may involve arduous travel, refugee camps, and/or detention centers. The resettlement process includes challenges such as the loss of culture, community, and language as well as the need to adapt to a new and foreign environment. These experiences are risk factors to mental health problems. The more common mental health diagnoses associated with refugee populations include post-traumatic stress disorder (PTSD), major depression, generalized anxiety, panic attacks, adjustment disorder, somatization and substance abuse. The incidence of diagnoses varies with different populations and their experiences. Different studies have shown rates of PTSD and major depression in settled refugees to range from 10-40% and 5-15%, respectively. Children and adolescents often have higher levels with various studies revealing rates of PTSD from 50-90% and major depression from 6-40%.

Refugee mental health has a number of challenges including;

i. Lack of services and funding
ii. Lack of personnel and skill sets to deal with the numerous mental health problems
iii. Absence of appropriate culture-specific interventions for particular refugees/immigrants
iv. An insensitivity to the needs of refugees/immigrants by the host community/country.
v. Stigma, discrimination and exclusion as well as intolerance of the different/other.
vi. Overwhelming large numbers of refugees/immigrants of different ages, gender and ethnicities
vii. A mix of former enemies/antagonists in the same camps or areas of resettlement.
viii. Different types and severities of the traumas experienced by the refugees/immigrants before and after fleeing e.g. rapes, defilements, beatings, cuttings, loss of property/friends/ /neighbors/family/relatives etc

In this issue of the African Journal of Traumatic Stress (AJTS), we present papers on conflicts, trauma, refugee mental health in IDP camps, the mental health of those refugees in exile (in Western countries) and also evidence that man-made disasters (wars, terrorism, riots etc) cause more intractable mental health problems than natural disasters. The question begs: Will African Refugee Mental Health ever be able to cope with the ever increasing numbers? Shall we not just get caught up in the vicious trans-generational cycles of violence and warfare which will never solve Africa's problems? These questions abound but the answers elusive. At the WACP 2015 Annual General Assembly, in Puerto Vallarta, Mexico, in its Position Statement on the World Migration Crisis, the World Association of Cultural Psychiatry (WACP) challenged us (worldwide) with "A Call for Action"

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Prevalence Of Violence-Related Traumatic Events And Symptoms Of Post-Traumatic Stress Disorder Among The Congolese Refugees In Uganda.

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ABSTRACT

Introduction: *Following the waves of violence in Congo after the 1994 genocide in Rwanda, there has been an influx of Congolese refugees into Uganda and more have continued to flock into the country up to date. These refugees were exposed to multiple traumatic events that continue to be detrimental to their psychological wellbeing. Whereas there has been vast research on the prevalence of Post-traumatic Stress Disorder (PTSD) based on a single most traumatizing event, literature on the relative contribution of cumulative exposure to different traumatic events and PTSD symptom severity is still scanty in refugee or trauma studies.*

Objective: *In this study, we investigated the prevalence and association of violence-related traumatic events of war to PTSD symptom severity among the Congolese refugees in Nakivale refugee settlement in Uganda.*

Methods: *Using the Post-traumatic Symptom Scale Interview (PSSI)and a prepared checklist of war and non-war traumatic events, exposure to different types of traumatic events and their association with PTSD symptom severity was assessed.*

Results: *We found a high prevalence of different types of violence-related traumatic events among our sample of the Congolese refugees with 99%, 98.2% and 98.2% of the participants having experienced or witnessed War, Community, and Family related traumatic events respectively. Additionally the prevalence of Community and Family related traumatic events within one month prior to the interview was at 84.7% and 57.7% respectively. PTSD symptom severity was positively associated with a higher number of and the type of traumatic events.*

Conclusion: *Congolese refugees experienced a number of violence-related traumatic events and they continued to experience the same in the form of community and family related traumatic events in re-settlement. Repeated number of traumatic events was associated with increasing severity of PTSD symptoms. Our results highlighted the need for better provision of psychological services among refugee populations as well as their protection against continued violence-related traumatic events in their families and communities of resettlement.*

Keywords: *Refugees, cumulative traumatic events.*

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INTRODUCTION

The presence of various rebel groups in the eastern province of the Democratic Republic of Congo, DRC, coupled with frequent terrorist attacks has culminated into Congolese civilians fleeing their country over the last 17+ years. As of January 2013, UNHCR had reported over 509,000 Congolese refugees and 56,000 Congolese asylum seekers residing outside the Congo and approximately 2.6 million internally displaced citizens (UNHCR, 2013b). Many of the Congolese refugees have been settled in Uganda. In most cases the refugees' lives have been affected by violence-related traumatic events of war, family, and community. This has

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been especially true with the refugees from the DRC. Many of them have witnessed their fellow citizens being killed, kidnapped, sexually abused, enslaved or tortured (Bastick, Grimm, & Kunz, 2007).

The assertion that many of the DRC refugees experience or witness different traumatic events was supported by evidence from a study by Onyut et al in 2009 which was carried out among the DRC refugees in Nakivale Refugee Settlement in Uganda. Onyut et al (2009) found that 73% of their respondents reported to have witnessed dead or mutilated bodies, 69.3% reported witnessing shelling or bomb attacks; 67.7% witnessed injury with a weapon; 60.3% experienced crossfire or sniper attacks and 60.2% reported witnessing burning houses. The gap between the needed intervention and what was available to reduce the negative impact of these severe experiences was quite wide, hence underscoring the importance of the current study. Indeed, other similar studies in the field have indicated that traumatic experiences in form of interpersonal abuses, exposure to organized violence, threatened death, torture, genocide, political violence, sexual violence, domestic violence, combat situations, and bombardments are not only emotionally shocking but are detrimental to the psychological wellbeing of affected individuals (Scheper-Hughes & Bourgois, 2004). The consequences of these events were enormous. Besides individuals witnessing or experiencing the undesired events, families and communities suffered adversely such as the entire community's economic breakdown, death of loved ones, separation from families and friends, resulting in refugees suffering various mental disorders especially Post Traumatic Stress Disorder, substance abuse and depression (Onyut et al., 2009; Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Karunakara, et al., 2004; Maedl, Schauer, Odenwald, Elbert, 2010; Hecker, Fetz, Herbert & Elbert, 2015).

Studies in war and crisis regions have indicated a strong association between the number of traumatic events and the development of PTSD symptoms (Kolassa et al., 2010). As a result of this dose-response correlation, the risk for mental ill health increases with the number of experienced traumatic events and often leads to high PTSD rates. This has often been described by trauma researchers as the "building block effect" (Neuner, et al., 2004; Schauer, et al., 2003; Steel, Silove, Phan & Bauman, 2002). Earlier studies by Kendall, Tackett, Williams, and Finkelhor (1993) reported that exposure to traumatic events had far reaching effects both in the immediate short-term and also in the long term with the affected individuals developing pervasive mental health problems for months or even years. In this case, exposure to traumatic experiences is said to result into PTSD, depression and other related disorders (Orcutt et al., 2004; Gabbay, Oatis, Silva, & Hirch, 2004; Rothbaum et al., 2000). Taking into consideration the high degree of exposure to traumatic events by the refugees, it is not surprising that the reported prevalence of PTSD among refugees in different countries remains very high. For instance PTSD among the Tuareg refugees in Burkina Faso was found at 60%, and 55.2% among Turkish refugees (Carta et al., 2013).We therefore argue that in many African wars, civilians are often targeted and this has not only resulted in the demise of many people but also caused untold suffering to people of all ages (Musisi et al, 2004 & 2005). Indeed, epidemiological findings have indicated a high prevalence of PTSD symptomatology ranging from 31.1% to 47% among the Rwandan and Somali refugees respectively (Onyut et al., 2009). In the same way, the study of exposure to traumatic experiences by Creamer, Burgess, and McFarlane (2001) estimated that 65% of men and 50% of women from their sample had experienced at least one PTSD qualifying event over their lives.

Research on PTSD and traumatic events, over the past few years, has criticized the assessment of PTSD symptomatology based on a single traumatizing event but to calculate the relative contribution of number of potentially traumatizing events for the probability of PTSD symptom severity. Our study aimed at investigating the prevalence of violent-related traumatic events, their numbers, types and hence their relative contribution to the development of PTSD symptom severity. We hypothised that in addition in to the high prevalence of different violence-related traumatic events, the number of traumatic event types would be positively associated with PTSD symptom severity among the Congolese refugees

living in Nakivale refugee settlement Uganda.

METHODS

Participants

This was a cross-sectional descriptive study. Between March and June 2013, we consecutively interviewed a sample of 325 persons in Nakivale Refugee Settlement in Western Uganda. This settlement had recently received a high influx of refugees from the DRC. In March 2014 the population of the settlement was 60,992 persons, of which 32,455 were Congolese (UNHCR Uganda, 2015). Only refugees from DRC who arrived in the settlement after January 2012 were interviewed and both adult (>18years) men and women were interviewed. This inclusion criterion was validated at the beginning of each interview. Of the included sample, 182 (56%) were female. Mean age was 31.28 with age range of 18-65. All of them reported having fled from Eastern DRC because of the threats they were facing due to the conflict in their home country.

Procedures

Three psychologists and a social scientist from the Congolese refugee community conducted the semi-structured interviews. All interviewers were extensively trained in psychological assessment. All interviews were conducted in Swahili, which is the lingua franca both in the Eastern DRC and in Nakivale refugee camp. The interviewers practiced the assessment in joint interviews to accomplish high inter-rater reliability. Two English-speaking interpreters facilitated communication. Voluntary informed consent was obtained from all participants after explaining the study, its purpose, risks and benefits. No incentives were given.

The interviews took place in private in the different parts of the Refugee Settlement camps. We first contacted the local authorities of the settlement's sub-divisions. After giving their consent, the authorities announced our arrival in their communities and gathered suitable persons. Using snowball sampling we returned to the respective places until no more persons fulfilling the inclusion criteria appeared. After that we went to the next subdivisions where recent arrivals were living. We collected oral and written informed consent from the participants to ensure comprehension and full awareness of the content. Illiterate participants gave their thumb prints instead of signature. Each participant was interviewed in a calm and private setting. At the end of the interview, each participant received a bar of soap and a package of salt as compensation. The Institutional Review Board of the Mbarara University of Science and Technology as well as the Ugandan National Council for Science and Technology approved this study.

Measures

Socio-demographic Characteristics: All assessment instruments were applied as semi-structured interviews. After informed consent, we collected socio-demographic information using a pre-prepared standard form (e.g., age, sex, marital status, educational background etc).

Traumatic Events And Other Violence-Related Experiences: Exposure to traumatic experiences and other adverse experiences was assessed using a checklist of 30 war- and non-war-event types (e.g., natural catastrophes, physical assault, sexual assault) and 21 items related to exposure to family and community violence. This checklist was an adapted version of a checklist by Neuner, Schauer, Karunakara, et al., (2004), which had previously shown high test-retest reliability and statistically significant concordance with the event list of the Composite International Diagnostic Interview (CIDI) in a study in Uganda (Ertl et al., 2010). It has also been successfully used in studies in the DRC (Hermenau, Hecker, Schaal, Maedl, & Elbert, 2013) and with Congolese refugees in Nakivale refugee camp (Hecker, Fetz, Ainamani, & Elbert, 2015). The number of times a specific event had been experienced was not assessed as measuring event types provides a more accurate and practical measure of trauma experiences (Wilker et al., 2015). We calculated a sum score of lifetime exposure to traumatic and adverse experiences by summing up all items (range: 0-51).

Description of the Study Measures

PTSD Symptom Severity: The PTSD Symptom Scale–Interview, PSS-I (Foa, Riggs, Dancu, & Rothbaum, 1993) was utilized to determine PTSD symptom severity. The 17 symptom criteria for PTSD were

assessed with one question for each symptom in reference to the previous two weeks.

The answers were coded on a 4-point Likert scale ranging from not at all (0) to five or more times per week/very much (3). The PSSI has been shown to have good psychometric properties (Cronbach's α = .86, inter-rater reliability = .93; Foa & Tolin, 2000). The instrument has been validated for use in Uganda (Ertl et al., 2010) and had been previously successfully used in the DRC (Hecker et al., 2013) and with Congolese refugees in Nakivale refugee camp (Hecker et al., 2015). We computed dimensional PTSD severity scores by adding the scores of each question, resulting in a sum score ranging from 0 to 51. Cronbach's alpha coefficient in present sample was .96. Respondents were asked if, in the past month, they had had recurring nightmares or unwanted thoughts about the crisis; if they had tried hard not to think about it or went out of their way to avoid situations that reminded them of it; if they were constantly on guard, watchful, or easily startled and whether they felt numb or detached from others, activities, or their surroundings since the crisis. A positive response to three or more questions indicated presence of PTSD.

Data analysis

The generated data was entered and analyzed using SPSS 21 for Mac. Frequencies and percentages were computed for the prevalence of potentially traumatic events while Chi square was used to test for the associations between the variables. Linear regression analysis was used to analyse the association between the number of traumatic event types and PTSD symptoms severity. Chi Square was used to test for association between categorical variables while logistic regression analysis was carried out on factors associated with presence of PTSD symptoms. Statistical significance level was set at $p \leq 0.05$ at 95% CI.

RESULTS

The sample consisted of 325 refugees of which 182 (56%) were female, giving a male: female ratio of 1.13:1. Mean age was 31.28 with age range of 18-65 years. Children of <18 years old were excluded from the study by design.

The results indicated that participants had a mean age of 31.28 years (SD = 9.13), and a mean of 35.87 (SD = 1.12) on the total scores of traumatic events; a mean of 18.92 (SD = 3.94) on the war related traumatic events, which implied that on average, refugees who were interviewed experienced 18 war related events. The mean of total score for family related trauma was 5.27 (SD = 2.51), the mean of community related trauma was 5.88 (SD = 2.64) and a mean of 35.87 (SD = 13.28) for the combined traumatic events. The mean of PSS-I total scores was 35.87 (SD = 12.20).

Prevalence of violent and pontetially Traumatic event types Among the Refugees

In general, total traumatic event types that the participants were likely to have experienced or witnessed were first summarized in terms of total scores for war, community and family ever experienced in the participant's lifetime. Additionally, the occurrence of both community and family experienced or witnessed traumatic events within the last month prior to the interview were analysed. Results revealed that the majority of the participants had witnessed or experienced war related traumatic event types (99%). A close percentage (97.9%) reported having experienced community related traumatic events ever in their life. Three hundred nineteen (98.2%) witnessed or experienced family related traumatic events ever in their life. Additionally, 225 (84.7%) participants endured community related traumatic events within one month prior to the interview and more than half (57.7%) reported to have experienced or witnessed family related events within one month prior the interview. Generally, more female participants reported to have ever experienced family related traumatic events in their life (55.4%) compared to men (42.8%, $\chi 2 = 15.930$, $p = .064$) although the finding was not significant. Table 1 below summarizes all these results.

Table 1: Prevalence Of Traumatic Event Types Among Congolese Refugees In Nakivale Refugee Settlement

Traumatic Event Type	Male		Female		Total			
	n	%	n	%	N	%	$\chi 2$	P
War related events ever	143	44.0	181	55.0	324	99.0	23.861	0.249
Community events ever	138	42.5	180	55.4	318	97.9	10.022	0.439
Family events ever	139	42.8	180	55.4	319	98.2	15.930	0.064
Community events last month	118	42.3	136	42.4	254	84.7	16.127	0.320
Family events last month	82	25.2	104	32.5	186	57.7	7.004	0.320

Prevalence of War-Related Traumatic Events Among the Refugees

In total, majority of the participants (96.9%) reported to have experienced at least one type of war related traumatic event during their lifetime. The most experienced event was witnessing harassment by armed personnel and experiencing dangerous flight (96.9%), being close to combat (95.7%), being close to cross-fire and shootings (96.3%), witnessing robbery/ looting by armed personnel in combat situation (96.3%) and many participants reported seeing people with dead bodies (96.3%) . In addition, 88.9% of the participants reported to have been close to burning houses, 89.5% reported having been harassed by armed personnel and 95.4% witnessed someone who was severely injured by a weapon. In the same way, 85.2% reported having been forced to pay money to armed personnel, 87.1% reported being victim of robbery or looting by armed personnel and 84.9% reported to have witnessed abduction or forced recruitment. More than half (67.1%) of the participants witnessed sexual slavery, and 65.2% had experienced sexual assault. Most participants (75.1%) reported to have witnessed someone who was murdered. The least reported event was fighting in the combat with 9.9%. These Results are reported in Tables 2 and 3 below.-

Table 2
Prevalence of War-Related Traumatic Events Among the Congolese Refugees in Nakivale Refugee Settlement.

Event	Male		Female		Total			
	n	%	n	%	n	%	χ^2	p
Being close to combat	139	42.8	174	53.5	313	96.3	0.58	.56
Close to cross fire/shootings	135	41.5	176	54.2	311	95.7	1.03	.411
Close to burning houses	132	45.7	157	54.3	289	88.9	2.97	.049
Close to grenade/bomb attack	118	36.3	148	45.5	266	81.8	0.08	.885
Experiencing dangerous flight	139	42.8	176	55.9	54.2	96.9	0.07	1.00
Deprived of food	134	41.2	175	53.8	309	95.1	1.03	.439
Witnessed harassment by armed personnel experienced	141	43.4	174	53.5	315	96.9	2.41	.195
Harassment by armed personnel Experienced	131	40.3	160	49.2	291	89.5	1.17	.362
Forced to pay taxes by armed personnel	127	39.1	150	46.2	277	85.2	2.60	.117
Witnessing robbery/looting by armed personnel	139	42.8	174	53.5	313	96.3	0.58	.560
Being victim of robbery/ looting by armed personnel between men	125	38.5	158	48.6	283	87.1	0.03	1.00

Note. $\chi 2$ = Pearson's Chi-Square statistics, $p \leq .01$.

We found a significant difference between males and females in terms of witnessing traumatic events e.g. witnessing the burning of houses with males having witnessed more burning of houses than females (92.3% vs 88.9% respectively, $\chi 2 = 2.97$, $p = .048$); experiencing torture and severe beating, with results revealing males being more than females (85.3% vs 69.8% respectively, $\chi 2 = 11.100$, $p = .004$). However, significantly more often female participants reported having witnessed someone being abducted than males (89.0% vs 79.7% respectively, $\chi 2 = 540$, $p =. 028$). With exposure to sexual slavery, the results revealed significantly more females witnessing/experiencing this trauma more than males and female participants (73.1% vs 59.4% respectively, $\chi 2 = 6.74$, $p =. 012$). Similarly women participants significantly reported having experienced sexual assault more than males (72% vs 47.6% respectively, $\chi 2 = 20.13$, $p <. 001$); witnessing more rape events (70.9% vs 58.0% respectively, $\chi 2 = 65.2$, $p < .019$) and experiencing more rape events itself (56.6% vs 15.4% respectively, $\chi 2 = 57.46$, $p < .001$). Significantly, more men than women reported experiencing being in prison (53.1% vs 33.5% respectively, $\chi 2 = 12.66$, $p < .001$) as was fighting in combat (14.7% vs 6.0% respectively, $\chi 2 = 6.74$, $p =. 014$) as Table 2 and 3 show.

Table 3
Prevalence of War-Related Traumatic Events Among the Congolese Refugees

Event	Male		Female		Total			
	n	%	n	%	n	%	$\chi 2$	p
Severe torture experienced	122	37.5	127	39.1	249	76.6	11.100	.004
Injured by a weapon witnessed	134	41.2	176	54.2	310	95.4	1.63	.287
Injured by a weapon	63	19.4	69	21.2	132	40.6	1.253	.306
Abduction witnessed	114	35.1	162	49.8	276	84.9	5.40	.028
Abduction experienced	49	15.1	45	13.8	94	28.9	3.55	.065
Witnessed sexual slavery	85	26.2	133	40.9	218	67.1	6.74	.012
Witnessed rape	83	25.5	129	39.7	212	65.2	5.82	.019
Sexual assault experienced	68	20.9	131	40.3	199	61.2	20.13	.000
Rape experienced	22	6.8	103	31.7	125	38.5	57.46	.000
Seeing dead bodies	138	42.5	175	53.8	313	96.3	0.03	1.00
Murder witnessed	102	31.4	142	43.7	244	75.1	1.92	.197
Having been imprisoned	76	23.4	61	18.8	137	42.2	12.66	.000
Fighting in the combat	21	6.5	11	3.4	32	9.9	6.74	.014
Note. $\chi 2$ = Persons Chi-Square statistics, $p \leq .01$								

As shown in Table 4 below our results showed that the majority of the participants 266 (81.8%) reported having been shouted at by a family member in their life time while participants totaling to 67 (20.6%) participants reported having experienced the same event over the last month. This was followed by 81.2% of the participants who reported to have witnessed physical assault by a family member over their lifetime and 36.3% who witnessed the same event over the last month. One hundred and ninety three participants (59.4%) witnessed someone who was humiliated by a family member over their lifetime and 17.5% over the last month. One hundred seventy four (53.5%) indicated that a family member had ever socially excluded them and 14.8% had experienced this event within the last month. One hundred sixty seven participants (51.4%) indicated that they had witnessed somebody being assaulted with a weapon by a family member over their lifetime and 7.1% had experienced the event over the last month.

In addition, results indicated a significant difference between men and women in terms of being shouted at by a family member with more women reporting to have experienced the event (76.2% vs 86.3% respectively, $\chi 2 = 5.43$, $p = .021$) and similarly to being humiliated by a family member (48.4% vs 68.1% respectively, $\chi 2=13.12$, $p < .001$). This same trend was reported for the event with in the last month with more women participants reporting to have experienced the event (11.2% vs 22.5% respectively, $\chi 2 = 7.12$, $p = .008$). Witnessing physical trauma by a family member with a weapon from a family member was reported more by women compared to men (86% vs 77.5% respectively, $\chi 2 = 7.79$, $p = .007$). It was also revealed that more women compared to men, had significantly witnessed sexual assault from a family member (10.5% vs 22.5%) $\chi 2= 4.996$, $p = .017$).

Table 4
Prevalence of Family Related Traumatic Events Among Congolese Refugees in Nakivale Refugee Settlement

Event	Ever					Last month				
	Male	Females	Total			Male	Female	Total		
	n(%)	n(%)	n(%)	χ2	p	n(%)	n(%)	n(%)	χ2	P
Shouted at by a family member	**109(33.5)**	**157(48.3)**	**266(8.8)**	**5.433**	**.021**	**24(7.4)**	**43(13.2)**	**67(20.6)**	**2.29**	**.167**
Humiliated by a family member	**69(21.2)**	**124(38.5)**	**193(59.4)**	**13.12**	**.0002**	**16(4.9)**	**41(12.6)**	**57(17.5)**	**7.12**	**.008**
Socially excluded by a family member	**70(21.5)**	**104(32.0)**	**174 (53.9)**	**2.160**	**.147**	**20(6.2)**	**28(8.6)**	**48 (14.8)**	**0.12**	**.755**
Witnessing physical assault by family member	**123(37.8)**	**141(43.4)**	**264(81.2)**	**3.832**	**0.62**	**55(16.9)**	**63(19.4)**	**118(36.3)**	**0.512**	**.488**
Experienced Physical assault by family member	**105(32.3**	**145(44.6)**	**250 (76.9)**	**58.0**	**.188**	**07(2.2)**	**18(5.5)**	**25 (7.7)**	**2.81**	**.141**
Witnessed assault with a weapon by a family member	47(14.5)	71(21.8)	118(36.3)	7.86	.007	03(.9)	05(1.5)	8(2.5)	.141	.500
Assaulted with a weapon by family member	23(7.1)	48(14.8)	71 (21.9)	4.966	.017	03(.3)	06(1.8)	8 (2.5)	1.853	.174
Sexual assault witnessed by family member	47(14.5)	71(21.8)	118 (36.3)	4.966	.296	01(.9)	05(1.5)	06(1.8)	0.14	1.00
Experienced sexual assault by family member	15(4.6)	39(12.0)	54(16.6)	1.307	0.010	03(.9)	09(2.8)	12(3.7)	1.83	.24
Threatened to be killed by family member	69 (21.2)	69(26.8)	156(48%)	6.149	1.000	23(7.1)	22(6.8)	45(13.8)	1.07	.334

Note. χ2= Pearson's Chi-Square statistics. p ≤ .01.

Prevalence of Community Related Traumatic Events Among the Congolese Refugees in Nakivale Refugee Settlement.

The prevalence of community related traumatic events participants experienced or witnessed ever in their lifetime or with in the last month are presented in Table 5.

In total, 80.5% of the participants reported to have ever witnessed physical assault by a community member and 44% witnessed the same event within the last month. This was followed by being shouted at by a community member ever, reported by 70.7%, and 83.3% of the participants reported having witnessed the event within the last month.

Results indicated that 68.9% of the participants reported to have ever experienced an assault with a weapon by a community member and 25.8% experienced this same event within the last month. Two hundred and twenty two participants (68.4%) reported to have ever experienced physical assault by a community member and 12.6% witnessed the same event within the last month. Participants totaling to 194 (59.7%) reported to have been ever humiliated by a community member and 72 (22.1%) participants reported to have experienced the same event within the last month. Other participants numbering 177 (54.5%) reported to have ever been socially excluded by a community member and 84 (29.9%) experienced the same event within the last month. Almost half of the sample (45.5%) reported to have ever been assaulted with a weapon by a community member and (5.3%) reported to have experienced the same event within the last month. More than half of the participants reported having

Table 5

Prevalence of Community Related Traumatic Events Among the Congolese Refugees in Nakivale Refugee Settlement

Event	Ever					Last month				
	Male	Female	Total			Male	Female	Total		
	n (%)	n(%)	n(%)	χ2	p	n(%)	n(%)	n(%)	χ2	p
Shouted at by a community member	95(29.2)	135(41.5)	230(52.7)	2.32	.14	41(31.4)	68(20.9)	1093(3.5)	2.71	.124
Humiliated by a community member	87(26.8)	107(32.9)	194(59.7)	0.14	.73	32(9.8)	40(12.3)	72(22.2)	0.007	1.00
Socially excluded by community member	79(24.3)	98(30.2)	177(54.5)	0.063	.82	37(11.4)	47(14.5)	84(25.8)	.000	1.00
Witnessing physical assault by community member	128(39.4)	153(47.1)	281(86.5)	2.028	.19	78(24.0)	65(20.0)	143(44)	11.53	.001
Experiencing physical assault by community member	98(30.2)	124(38.2)	222 (68.3)	0.006	.00	14(4.3)	27(8.3)	41(12.6	1.849	.183
Witnessing assault with a weapon by family member	61(18.8)	106(32.6)	167	7.78	.004	8(2.5)	15(4.6)	23	.653	.4242
Assaulted with Weapon by a family member	47(14.5)	71(21.8)	118	1.307	.152	81(24.9)	51(15.7)	81	2.123	.092
Sexual assault witnessed by community member	48(14.8)	86(26.5)	134	6.19	0.02	07(2.2)	10(3.1)	17	0.06	1.00
Experienced sexual assault by community member	38(11.7)	83(25.5)	121	12.411	.003	09(2.8)	17(5.2)	26	1.01	0.411
Threatened to be killed by community member	86(26.5)	95(29.2)	181	2.047	0.18	36(11.1)	33(10.2)	69	2.38	0.134

Note. χ2 = Pearson's Chi-Square statistics. p ≤ .01.

been threatened to be killed by a community member over their life time (55.7%) and participants totaling to 69 (21.3%) experienced this event within the last month. In the same way 134 (41.3%) participants reported to have witnessed sexual assault by a community member

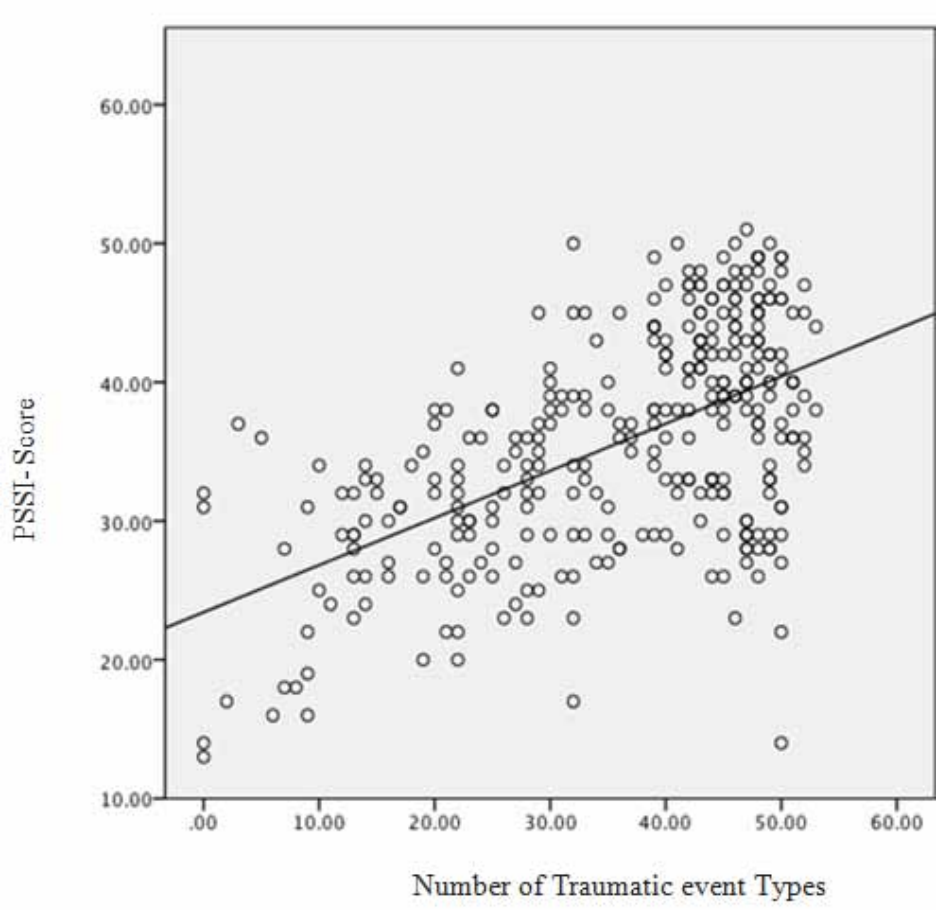
Table 6

Showing the Association Between the Number of Traumatic Event Types and PTSD Symptoms Severity

Model	PSSI-Score				
	B	SE of B	B	T	P
Step 1					
Sex	4.503	1.340	.185	3.360	.001
Age	-2.824	.973	-.156	-2.902	.004
Somatic complaints	.498	.321	.085	1.548	.123
Step 2					
Sex	4.109	1.135	.169	3.619	.000
Age	-1.754	.830	-.097	-2.114	.035
Somatic complaints	-.037	.276	-.006	-.133	.894
Number of traumatic event types	.786	.070	.526	11.263	.000

Note. B = unstandardized regression weight, SE = standard error, β = standardizeds regression weight, t = t-test statistic.

Figure 1. Scatter plot of the association between the number of traumatic event types reported for the whole life time and PTSD Symptom severity (Dose response Effect).



within their life time and seventeen participants (5.3%) reported to have witnessed this event with in the last month. In the same way, more than a quarter of the participants (37.7%) reported to have experienced sexual assault by a community member in their life time and (8%) participants reported to have experienced this event within the last month.

Additionally, analysis, results revealed gender differences, in terms of witnessing sexual assault by a community member ($\chi 2$ = 6.19, p = .017) with more women reporting to have witnessed the event (47.3%) than men (33.6%). In the same way, results revealed gender differences between women and men as far as experiencing sexual assault from a community member was concerned ($\chi 2$= 12.4, p < .001) with women reporting higher events (45.6%) than men (26.6%). As for the traumatic events experienced or witnessed within the last month, only physical assault by a family member witnessed was significant ($\chi 2$ = 1.823, p = .0109) with more men reporting to have experienced the event (54.5%) than women (35.7%).

Association Between the Number of Traumatic Event Types and PTSD Symptom Severity

To investigate the association between the number of traumatic event types and PTSD symptom severity, PSSI –scores were regressed on the number of traumatic event types. In the first step, sex (male 0; female1), age of the respondent at the time of the worst event and somatic complaints as potential co- founders based on prior findings and correlation with PTSD were entered in the regression model. The model explained 7% of the variability of PSSI-Score (R2 = .078), F (3,319) = 8.966, p < .001. Age of the respondent negatively correlated with PTSD Symptom severity. This implies that PTSD symptoms severity reduced with participants who had more years of age at the time of the worst event.

Adding the number of traumatic event types as an additional predictor, improved the model

significantly by explaining 34% of the variability of PTSD Symptom severity, $\Delta R2 < .001$, $F (4, 318) = 41.114$, $p < .001$. Age maintained its inverse relationship with scores of PSSI. The number of traumatic event types potentially experienced or witnessed over the participant's lifetime significantly associated with PTSD symptom severity, thus replicating the building block effect of cumulative exposure to traumatic events and PTSD symptom severity. Results are presented in Table 6 below.

Dose-Response Effect Of Traumatic Events

The scatter plot above confirms the "dose response effect" of traumatic event types. It showed that any additional exposure to any traumatic event, heightens the risk of developing PTSD symptom severity among the sample of the Congolese refugees investigated in our study.

DISCUSSION

Prevalence of Traumatic Experiences Among the Congolese Refugees

Our study focused on establishing the prevalence of war, community and family related traumatic events among the Congolese refugees living in Nakivale Refugee Settlement. It was revealed that majority of the refugees endured high levels of traumatic events with nearly 100% participants experiencing or witnessing most of the events. For example the majority of the participants (97.0%) indicated having been close to gunfire or shootings. Almost all participants 324 (99%) reported to have experienced or witnessed war related traumatic events, 318 (97.9%) respondents reported to have endured community related traumatic events ever in their life and 254 (84.7%) reported to have experienced or witnessed community violence with in the last four weeks prior to the interview. Additionally 319 (98.2%) and 186 (57.7%) participants reported to have experienced or witnessed family related traumatic events over their entire life and with in the past month respectively. In line with Silove et al (1998), similar potentially traumatic events revealed by this study could be the reasons why citizens migrate from their countries of origin and subsequently becoming refugees abroad.

In consonance with prior studies that have reported sexual related traumatic experiences of men and women among the samples of refugees (Melhado, 2010; Nshemererwe, 2013; UNHCR, 2013), the findings of this study indicate that both male and female participants were exposed to sexually traumatic events and violence in form of rape, sexual torture or witnessing of family members being sexually violated. In this study for example, a total number of 182 female participants and 143 male participants were interviewed and 125 (38.5%) respondents indicated having experienced rape. Out of this number, 22 (15.4%) participants were men and the rest, 103 (56.6%) were women. When estimates of refugee sexual violence in this sample were compared to other findings from the DRC, it was observed that 45.3% of the Congolese women and men had at least experienced a sexually related violent event ever in their lifetime (Johnson et al., 2013).

The other most frequent traumatic events that were revealed by the current data are: experiencing beatings, torture by armed personnel (76.6%), being close to bomb or grenade attack (81.8%), witnessing robbery or looting by armed personnel (96.6%) including seeing dead bodies (96.3%), witnessing abduction and forced recruitment (84.9%). Other participants reported having experienced harassment by armed personnel and majority of the participants 249 (76.6%) reported to have experienced beatings and torture by armed personnel. These findings are in line with prior reports from Amnesty International (2003), which noted high levels of torture among the civilians living in war tone areas that is geared towards instilling a high level of fear and pain. In agreement with prior studies of Basoglu (2000) and Campbell (2007) results of this study also provide further support that torture among the civilians in war and demobilized communities continue to be in form of imprisonment of none violent opponents, the application of death penalties, forced taxes and forced recruitments or abduction.

A finding of this study was that the prevalence of war related traumatic events for the current study were far higher than most studies conducted from

similar setting of war and post war. A study of Burnett and Peel (2001) reported proportions of the refugees after exposure to atrocities of war related traumatic events from different countries to vary from 5% to 30%. In the same way, the study of Cardozo, Vergara, Agani, & Gotway (2000) among the Kosovar Albanian refugees revealed that approximately 67% of these refugees had been deprived of water and food, 67% reported being close to a combat situation and 62% reported being close to death.

Reported percentages of war and related atrocities among the Congolese refugees under this study varied between 9.9% to 96.9% with more than half of the sample falling within the range of 60% to 96.9% (see Tables 4 & 5). Much as the current findings on the prevalence of traumatic events endured by the refugees continue to be higher than results indicated by prior studies, the traumatic events are similar in nature. In a survey of individuals presented to a Dutch clinic specializing in the treatment of traumatized refugees (Kleijn, Hovens, and Rodenburg, 2009), the authors found that the most commonly reported traumatic event was forced isolation (e.g., imprisonment, separation from others). The types of events reported varied differently for example 37% reported incidents of torture, 37% reported being close to death, and 35% indicated having witnessed death of a friend or family member to combat related situation. This high level of the prevalence of war related traumatic events in the current study could have been as a result of prolonged war in Congo and the presence of different armed groups that have ravaged the country with in the last 20 years.

Additionally, since our sample was of the recent group that fled to Nakivale as a result of M23 rebels, one could argue that their experiences were perhaps fresh from different active armed groups. In summary, basing on these statistical variations, one can therefore conclude that there is high prevalence of war related traumatic events among the Congolese refugees.

Participants were asked about their experiences concerning family violence. The majority of the participants in this study (81.8%) indicated having ever experienced or witnessed most of the events such as having been shouted at by a family member, witnessing physical assault by a family member or experiencing physical assault by a family member. More than half of the refugees witnessed someone being humiliated by a family member or assault with a weapon by a family member and the least experienced event was sexual assault by a family member (16.6%). This is in agreement with previous studies that have well documented the prevalence of high rates of family violence among the refugee camps (UNHCR, 2006). Our study revealed that there was an escalation of family violence within the last month, more than a quarter of the refugees (36.3%) reported to have witnessed physical assault by a family member and 67 (20.6%) participants reported to have been shouted at by a family member. The possible explanation for these findings could be the re-integration of former perpetrators of violence to civilian refugees within the Refugee settlements and hence higher rates of PTSD symptomatology. The findings of this study regarding family related trauma within the last month are in agreement with findings of Cardozo, Vergara, Agani & Gotway (2000) who observed continuous trauma among the refugees even after escaping from war torn zones. The current results reveal that in addition to the often life-threatening events experienced by refugees shortly prior to flight, they continued to experience recurring trauma, losses and challenges during the exile period as well as conflicts with in their families.

Furthermore, results of this study revealed that the Congolese refugees in question had ever been exposed to community violence in their lives but also with in the last month. On average, participants had been exposed to at least 6 community related traumatic events. This is in agreement with findings of Porter & Haslam (2001) who found that having left their homes, refugees were often forced to confront isolation, hostility, violence and racism from community members in their new resettlement locations.

From the present data, it is clearly indicated that some refugees reported to have been fighting in combat and possibly they were the reason for others being in a refugee crisis situation. They had perpetrated violence and the feeling of being

in the same refugee camp with other refugees was traumatizing and scary for both groups of the refugees.

There is a massive body of literature on how the Hutu led genocide was among the world's bloodiest and yet the same tribes must now live together in the same refugee settlement (Buckley & Susanne, 2009; Cruvellier, 2010; UN, 2010; Verpoorten, 2005). In addition, Nakivale Refugee Settlement hosts' refugees from various countries like Rwanda, Somalia, Burundi, Ethiopia and Congo. These factors could be the reasons for the continued refugee cultural clashes in the refugee settlement thus escalating into community violence which could also be linked to the observed family violence. The findings of this study are in line with prior findings on family violence in these settings (UNHCR, 2006).

This stress of living in a hostile environment both within the camp and the surrounding areas presents additional stress on the refugees' mental health. The current data provides evidence that our Congolese sample silently experiences community violence within the settlement camps that goes unnoticed by the authorities, yet the camp is supposedly assumed to offer relief.

In Nakivale Refugee Settlement, "new refugees" go through difficulties in acquiring land for their subsistent cultivation of food. The bureaucracy involved is tiring, sometimes with unsympathetic staff that hurl insults to them, thus obtaining little food and taking a long time before they are recognized as registered refugees (Papadopoulos, 2002). In Kajurungunsi, the newly created village occupied by only Congolese refugees who arrived after 2012, it is common for the refugees to physically fight over land with Ugandans who are commonly referred to as "nationals" by the refugees. This violence has left some refugees injured with knives as narrated by one of the respondents.

Similarly, some of the staff members from the refugees' Office of the Prime Minister are not patient with the refugees. One of the participants clearly reported (when answering an open ended question that demanded the description of the most traumatizing event experienced) to have been beaten and humiliated before his family and the whole refugee community by an Officer from the Office of the Prime minister. Another refugee participant reported having been deprived of his money by the officers at the border of DRC and Uganda. These examples pointedly show that refugees continue to experience violence even after they have fled from their countries of origin.

Number of Violent related Traumatic Event Types and PTSD Symptom Severity

The second objective of this study was to establish whether the increasing number and types of traumatic events were associated with PTSD symptom severity among our sample of the Congolese refugees in Nakivale Refugee Settlement. It was hypothised that exposure to increasing numbers of traumatic events would be associated with increasing PTSD symptom severity. Results of this study indicated that increased numbers of traumatic events and types was associated with increased PTSD symptom severity. This was consistent with prior research (e.g., Neuner et al., 2004; Kolassa et al., 2007; Elbert et al., 2009; Hecker et al., 2013), thus confirming the "building block effect". This indicates that repeated exposure to increasing numbers and different types of traumatic events cumulatively one after another increased the risk of developing PTSD symptom severity. These traumatic events were problematic as they seemed to be associated with increased frequency to which individual refugees developed mental health problems. It is therefore the finding in this study that the increasing numbers of traumatic event and types was a significant predictor of PTSD symptom severity. As previously reported by Neuner et al. (2004), our sample reported high PTSD symptom rates of between 50-65% .

The association between exposure to the number and different types of traumatic events and PTSD symptomatology which were observed in our study concurs with other studies that have observed a similar relationship between exposure to severe traumatic event types and the prevalence of PTSD symptoms among the refugees in Nakivale (de Jog, Komproe & Van Ommeren, 2003; Onyut et al., 2009; Priebe et al, 2010; Annan, Brier & Aryemo, 2009; Ertl et al., 2011). In line with other related studies, the current results indicate that exposure to violence is significantly related to symptoms

of post-traumatic stress disorder (Calhon et al., 2002; Kilpatrick et al., 2004) with links particularly well documented for sexual abuse, witnessing a stranger being assaulted and being directly victimized.

Conclusion and recommendations

The prevalence of war-related, community and family traumatic events was high among the Congolese refugees in Nakivale Refugee Settlement both for lifetime and within the last four weeks prior to the interview. The possible juxtaposition of war-related violence to development of family violence and subsequent community violence among the refugees could not be missed and demanded closer future research scrutiny and our findings therefore provide a basis for this further research. Secondly, it is possible to argue, from our results, that PTSD symptom severity increased with the number of traumatic event types which were endured by our sample of Congolese refugees who are currently living in Nakivale refugee settlement.

Congolese refugees have experienced a number of violent related traumatic events and they continue to experience the same in form of community and family violence and this has resulted in increased symptoms of PTSD. Thus on the whole, the findings in this study suggest an association between exposure to the number of potentially traumatic event types and PTSD symptom severity. This adds further support to the phenomena that repeated exposure to different types of traumatic events cumulatively heightens the risk of trauma related mental illness among war affected populations.

There are, however, some limitations in our study. First, being a cross sectional study design did not allow for the establishment of causality. Therefore the reported associations need to be interpreted with caution. Longitudinal and prospective studies are needed to shed light on the causal relations. Secondly, in conflict and demobilized communities, refugees don't only endure a number of unpleasant events, but also have few chances of escaping the development of trauma related mental disorders such as PTSD and depression.

We conclude by recommending that any medical interventions for the refugees need to take the findings of this study and their implications in consideration. We also argue for and emphasize on the recorgnition of the ethnic divides amongst the refugees when being resettled to avoid and prevent any continued violent clashes along these lines when in re-settlement. Our results also continue to highlight the need for better provision of psychological services among refugee populations as well as their protection against violent traumatic related events in their locations of resettlement.

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Coordinating Psycho-Social Interventions For The Internally Displaced Persons (IDPs) Following Insurgency In North Eastern Nigeria.

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Abstract:

The terror campaign of the dreaded "Boko Haram" sect in Northern Nigeria has resulted in abductions and deaths in tens of thousands, displacement of millions which includes men, women, children and the elderly and an enormous economic debacle. Exposure to "Boko Haram" adversity led to Psycho-traumatic events resulting in psychiatric and physical morbidities, and social difficulties among people in the region. Various uncoordinated and non-evidence based psycho-social interventions (which may not conform to the traditional and cultural values of the Internally Displaced Peoples, IDPs) are being provided to the IDPs by various governmental and non-governmental organizations (NGOs), with no available data on the number of groups involved in the interventions, contents of the psycho-social interventions, mapping of localities where such interventions are taking place and poor documentation of activities. All this makes monitoring very difficult and evaluation practically impossible. This paper presents a discussion of the need for coordination of the interventions in order to streamline the activities of all the groups involved in psychosocial intervention, ensure equitable distribution of available resources and avoid duplication of activities. Coordination will also ensure replication of activities in other communities while developing a locally adoptable framework for psychosocial intervention thus building a national response framework/module.

Keywords: *Psychosocial, Intervention, Boko Haram, Insurgency, North Eastern Nigeria, Abduction. Internally displaced persons (IDPs), Coordination.*

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INTRODUCTION

Since July 2009, an Islamist fundamentalist insurgence sect, the Boko Haram has intensified its insurgent activities and campaign of terror in North Eastern Nigeria. In May 2013 the President declared a state of emergency in the core states of Borno, Yobe and Adamawa as a measure to curb the unleash of terror by the sect. However, the emergency measures woefully failed in cushioning the adverse effect of insurgency but rather strengthened the resolve of "Boko Haram" to maim the lives of Nigerians by carrying out well-planned bombings, drive-by shootings, kidnappings and other indiscriminate violent attacks on the populace. In 2014, the United Nations High Commissioner for Refugees (UNHCR) announced that due to the insurgency, over 43,000 Nigerians had fled to neighbouring Cameroon and over 100,000 to Niger's Diffa region. The vast majority of these displaced fleeing people were women and children. However, over 650,000 people remained as Internally Displaced Peoples (IDPs) in Northern Nigeria [2,4]. Presently there are over 2 million IDPs and over 7000 women and girls under captivity of the "Boko Haram" although some of them have been rescued [7].

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Background

Hickey (1984) described Northern Nigeria as a region with a predominantly Muslim population, having a well-documented history of militant religiosity dating far back to the highly successful holy war (jihad) fought by Sheik Uthman dan Fodio (1754–1817) in the early 19th century [8]. This led to the establishment of the Uthman dan

Fodio Islamic state (Sultanate) which covered the entire Northern Nigeria with the exception of Kanem Borno (present North East region) which resisted the incursion of Uthman dan Fodio and rejected his style of Islam. Uthman dan Fodio set up a well-organized administrative structure within his sultanate, with the Emirs reporting to the Sultan , himself, in Sokoto. With the coming of European colonialists, this entire region was overrun by the British (including the Kanem Borno) and remained known as Northern British protectorate until 1914 when the Northern and Southern British protectorates were merged into a single State which they called the Colony and Protectorate of Nigeria [22]. The British governed Northern Nigeria by indirect rule through Emirs and other established pre-colonial authorities of Uthman Dan Fodio. They, thus, preserved the administrative structures of the Sultan, as well as the cultural and religious independence of the Northern Nigerians. However, parts of Northern Nigeria, especially the Northeast Kanem-Borno was suspicious of western education early on although it was later fully integrated into the British colonial school curriculum. Nevertheless, this suspicion remained upto today and bears the roots of Boko Haram. The Council of Foreign Relations (2015) reported that an insurgent group named "Jama'atu Ahlis Sunna Lidda'awati Wal-Jihad" (meaning "western education is a sin" in Hausa Language) was created by an Islamic cleric Mohammed Yusuf in Maiduguri, Borno state. It became popularly known as "Boko Haram", and proclaimed western education as a sin [12,3]. The group became quite prominent in Maiduguri the capital of Borno state (North Eastern Nigeria) and rejected western lifestyle, education and the scientific concepts of Evolution and the Big Bang Theory in preference to Koranic Sharia worldview interpretations. Murray (2011) described the main activity of Boko Haram between year 2002 and 2005 as societal withdrawal and establishment of camps and schools in remote regions of Borno and neighboring Yobe states to teach these concepts to the populace[14]. These activities became noticeable by Nigerian authorities and efforts to control the group was made which led to frequent confrontations and resulted into the group's changing into a resurgent Islamic urban fundamentalist movement preaching against consumption of alcohol and other (western) practices considered non-Islamic.

Resurgence to Insurgency

Vanguard (2009) highlighted that between 2005 and 2009, there was mass resignation Boko Haram members in Maiduguri from government jobs while renouncing their university education and certificates. Mosques and centers were built exclusively for thes Boko Haram members and there was open defiance of government rules such as wearing of protective helmets while riding on motor bikes. Several Boko Haram members were involved in several clashes with the police and thus making the leader of the sect more prominent [22].

In July of 2009, a major clash between members of the Boko Haram sect and Nigerian security forces in Maiduguri and some states of Northern Nigeria led to over 800 deaths in an assault meant to suppress the sect and capture its leader. The death of the captured leader, Mohammed Yusuf by the security forces was videotaped and the sect accused the security forces of it being an extra-judicial killing [9].

This was followed by a virtual non-existence of the sect's activities for a while until it changed tactics. All of a sudden the sect changed from religious resurgence to insurgency, which included prison breaks (over 700 prisoners were released in Bauchi), assassination of traditional, religious and opinion leaders and the unleashing of mayhem to the community [27]. There were all out indiscriminate attacks on what the sect considered un-Islamic symbols and activities including Churches (and other Christian worship centers), beer drinking joints, football viewing centers, recreational centers, teachers of formal schools, churches and other educational symbols [9]. There were suicide bombings on police headquarters and United Nations offices in Abuja which marked the beginning of suicide missions in Nigeria. There was an increase in attacks of churches, non-conforming mosques, and markets in major Northern Nigeria states capitals, especially Kano, Damaturu and Maiduguri. All this was in an effort to set Nigerians against each other, polarise the country, cripple the economic activities of the North and force the Christians (and other non-Muslims) to vacate the

North. The mayhem left massive civilian casualties (over 10,000 deaths) as a result of terrorism and the counter-terrorism missions with massive displacement of peoples especially in North Eastern Nigeria.

The fate of the internally displaced persons (IDPs) and refugees was pathetic as they often went without food, water, medication or shelter for days. Northern Nigeria was left on its own, a situation which was considered bizarre in today's world where scores of international humanitarian organizations operate round the clock in humanitarian crisis situations to care for IDPs/refugees [2,6,13,15,20,25]. This was so until the attack on school-girls in Chibok town.

Abduction of School Girls and Capturing of Chibok Town

Vanguard (2014) reported that "Boko Haram" became of interest to the international media and community when over 300 girls were attacked and kidnapped from a local government secondary school in Chibok town while writing final year examinations. Chibok is a small town in the south of Borno state in North Eastern Nigeria. The coordinated attack involved about 200 heavily armed Boko Haram militants at night. Fifty-three of the girls escaped while 276 remained in captivity. The inability of the Nigerian government to rescue the girls became clear despite promise of help from US, Britain, France and Israel. There were reports of some of the girls having been raped, killed, sold into slavery, and married off to militants or being forcefully converted to Islam. This major incident prompted an international outcry with calls for support for the helplessly devastated Chibok town, hence the hash-tag "#bring back our girls". Later Boko Haram released a video of the girls in captivity, which momentarily raised the hopes of some parents who were able to recognize their daughters [2,26].

The attack on Chibok town did not happen as a surprise. For quite some time, residents had been warned of an impending attack and it came after Boko Haram had overran the towns of Gombi and Hong in nearby Adamawa state. By late 2014 to early 2015 Boko Haram controlled over 22 LGAs in three states of North Eastern Nigeria (Borno, Adamawa and Yobe). Over 2 million people had been displaced from their homes and were scattered all over Nigeria and the neighbouring countries of Niger, Cameroon and Chad. David (2014) reported few months after the abduction that the dreaded sect captured Chibok town after engaging the outnumbered military and under-armed vigilantes and killing the parents of the abducted girls and other residents of the town [4].The population of the IDPs included men, women, children and the elderly peoples [3].

Psycho-social Impact and Interventions

Since the middle of 2015, the military capability of "Boko Haram" have been gradually and progressively decimated [21], to the extent that today their command structure has been completely weakened and they have lost all the territories under their control to the Nigerian Military.

However, they have resorted to guerrilla attacks of soft targets using under-age children as suicide bomb carriers. Boko Haram is currently described as one of the most horrendous and brutal terrorist organizations in the world. Literature is abound showing that psycho-traumatic events result in psychiatric morbidities among people exposed to traumatic violence it in conflict zones in and outside Africa [18]. Roberts et al (2008) documented African IDPs in Uganda who severe developed Post Traumatic Stress Disorders (PTSD) following exposure to war-related psycho-trauma [19]. In Nigeria PTSD and depression has been shown to occur among IDPs in post conflict in Jos [16] and Kaduna [21,22]. Many IDPs also suffer physical traumas which can also cause psychological traumas e.g. landmine injuries. Governments in Africa, Nigeria inclusive, always try to resettle internally displaced peoples and address their psycho-social needs. Also, numerous organizations (NGOs, FBOs, CBOs, CSOs etc) and international development partners have also shown interest in providing mental health and psychosocial support to the IDPs. However, these interventions are often diverse, uncoordinated, non-evidence based and not based on the needs of the IDPs (Mollica R et al). Moreover, many of the interventions may not conform to the traditional, cultural or religious values of the communities they purport to serve with unfortunate consequences. In

insurgency-torn North Eastern Nigeria, there is no documentation of the activities of the intervention organizations, their numbers, the contents of services provided or the mapping of areas where such psychosocial interventions are taking place. This paper attempts to give the rationale of the need for coordination of the interventions in order to streamline the activities of all the groups involved in psychosocial interventions. Such an effort should ensure equitable distribution of the available resources and avoid duplication of activities.

Need for Coordination of Psycho-social Intervention

Currently, in Nigeria, there is no data on the psychosocial interventions operating in North Eastern Nigeria, a region badly affected by the Boko Haram insurgency. The need for coordination of the mental health and psychosocial interventions becomes necessary in the face of the unavailability of data on the number of groups involved in interventions, contents of psycho-social interventions and mapping of localities where such interventions are taking place. The existing poor documentation makes monitoring difficult, and evaluation practically impossible. Coordination will bring about streamlining of the activities of all the groups involved in psycho-social intervention, ensure equitable distribution of available resources and avoid duplication of activities.

Furthermore, it will ensure replication of activities in other communities while developing a locally adoptable framework for psycho-social intervention. Where this is properly implemented, it will become a template for a National response module which could be emulated by other (African) countries affected by conflict.

CONCLUSION AND RECOMMENDATIONS

The terror reign of Boko Haram in North Eastern Nigeria has resulted into human rights abuses, traumatic experiences, livelihood crises, population displacements and a refugee debacle. All these and other atrocities inevitably lead to a complex humanitarian emergency with devastating psychiatric problems such as PTSD, depression and suicides as well as psychological distress and other social problems. A lack of proper documentation of intervention services makes monitoring difficult, coordination impractical and evaluation impossible. Coordination and streamlining of the activities of the involved psycho-social intervention groups ensures equitable distribution of available resources and avoids duplication of activities. There is an urgent need to document and coordinate the provision of psycho-social interventions by governmental and non-governmental organizations to the IDPs in conflict areas of North Eastern Nigeria, and to ensure cultural acceptability of interventions, their proper mapping, efficiency and sustainability.

In Nigeria there should be a jointly sponsored stakeholders forum including National Emergency Management Agency (NEMA), Presidential Initiative for the North-East (PINE), Association of Psychiatrists in Nigeria (APN), Federal and State governments, and other NGOs specialized in trauma relief to team up in coordinating the psycho-social interventions provided to the IDPs in the North Eastern Nigerian region affected by the Boko Haram insurgency.

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The Role of Imams In Providing Psycho-Social Support To Traumatised Muslim Refugees And Immigrants In Vancouver, Canada

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ABSTRACT

Introduction:

A number of immigrants and refugees often face psycho-traumatic events in both their countries of origin and in re-settlement. Studies have documented on the role of religious leaders in providing mental health and psychosocial support services to their members by major religious groups alongside the mainstream mental health services. However, there is a dearth of research in understanding the role Imams play among immigrant Muslim communities in North America. The few studies undertaken revealed that imams play a significant role in addressing the mental health needs of their congregants and this role increased dramatically in post September 11th 2001.

Objectives: *This study attempted to explore immigrant Vancouver Muslims mental health needs from imams' perspectives.*

Methods: *Using qualitative methodology, the study utilized ethnographic in-depth one-one-interviews with imams across mosques in Vancouver, Canada. Using standardized study guides the imams were asked about their roles in addressing the psychosocial needs of their Muslim population who were mostly refugees and immigrants. The obtained tape-recorded data were transcribed, thematically analyzed, summarized and conclusions made.*

Results: *The study revealed that Imams were considered the primary psychosocial service providers for the immigrant and refugee Muslim populations in their communities. The services mainly covered family therapy, conflict resolution and adjustment to Canadian culture as well as managing mental health problems. The imams also reported a significant and enduring negative impact of war on the refugees and how these past war-related traumas were the leading causes of family dysfunction, domestic violence and youth delinquencies.*

Conclusion: *This study highlighted the need for more culturally appropriate psychosocial support services for refugees and new Muslim immigrants in the Vancouver area, Canada. It also calls for stronger collaboration between health care service agencies and culturally-specific faith-based organizations in the refugee and immigrant communities in order to address their specific needs.*

Key Words: *Canada, Imam, Muslim, Refugee, Immigrant, Mental Health, Psychosocial.*

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Introduction

The role of religious leaders in providing essential mental health services especially in Christianity and Judaism has been well documented. Research shows that religious men and women often provide some form of mental health care to their followers. However, only a few studies have been conducted within the Muslim communities in North America in understanding the role imams play in this regard as pertaining to the Muslim refugee and immigrant populations (Koenig, 1998, Ali, Milstein & Marzuk, 2005). The few studies conducted reveal that imams often play a significant role in addressing the mental health needs of their congregants and this particular role increased dramatically after the events of September 11th 2001. This was a time when Muslims across North America and other

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Western countries suddenly became the targets of public and media backlash, state security harassment and discrimination at all levels (Milstein & Marzuk, 2005). This exploratory study attempts to explore the mental health needs of Metro Vancouver Muslims, in Canada, basing on imams' perspectives. It is important to address some of the mental health care needs of such a population from a transcultural psychiatric framework. This study also served as a baseline assessment of mental health needs of Muslims in Metro Vancouver. Several scholars have in the past questioned the practice of universalizing Western psychiatry, and called for the need to "democratize" psychiatry and appreciate and acknowledge the various cultural expressions of distress and ways of healing (Kleinman, 1995, Summerfield, 2008).

BACKGROUND

Review of the Muslim religious literature

Islam is a way of life and the Islamic law (Sharia) guides Muslims in many aspects of their lives. These laws consist of four main sources that are ordered in a hierarchy: (i) the Qur'an which is believed by Muslims as the word of God and revealed to Prophet Muhammad; (ii) the Hadiths which are the sayings and deeds of the Prophet Muhammad; (iii) the Qiya or analogy and (iv) the Ijma or consensus (Pasha &Pridmore, 2004).

The Qur'an states that: "We reveal from the Qur'an that which is healing and a mercy for the believers", (Qur'an, 17:82) and the prophet was quoted saying "Allah does not just send any disease alone but he also sends down a cure for it" (Al-Saheeehyn as quoted by Ameen, 2005). There are numerous verses in the Qur'an and Hadith that talk about health and wellness including mental health and the use of Qur'anic and prophetic healings by the prophet and his followers are detailed in the scriptures (Ameen, 2005).

The Qur'anic scriptures explain some of the causes of mental illness as spirit possession (Jinn), witchcraft (Sihr) and evil eye, and that treatment constitutes of recantation (ruqya) and recitation of verses of the Qur'an either by the individual, family members or imams and other religious healers (Dein, Alexander & Napier, 2008, Ahmed & Amer, 2012). This spiritual causality narrative has profound effect on the understanding of illness and help seeking behaviors of the Muslim persons with such theological beliefs. Indeed in many Muslim-based cultures, these beliefs have become the most important attributes to mental illness even in contemporary times (Al-Issa, 2000).

Help seeking behavior

Current studies among Muslims across the world including in Western countries reveal that the majority of Muslims identified both bio-psychosocial and spiritual causes for mental illness and that a significant number will first seek faith healing before seeking a biomedical doctor while others may concurrently seek both. (Rozario, 2009, Eneborg, 2012). In the Western world, studies on Muslim mental health issues and practices were barely available prior to the events of September, 11, 2001. This scarcity of literature was attributed to the lack of interest by Western researchers, inaccessibility of Western journals to researchers from Muslim nations, language and writing-style barriers. It is also true that the majority of Muslim clinicians and researchers are Western trained and therefore face conceptual and methodological dilemmas in working among Muslims from a Western approach with distinctively different cultural conceptualizations and explanatory models of disease and illness (Amer, 2009). The few available studies pointed out that the majority of Muslim respondents did believe in spiritual causality (jinns, witchcraft or Sihr and the evil eye), and that the locally available faith healings tended to be utilized mostly by the Muslim faithful (Abu-Ras, Geith, & Cournos, 2008, Dein, Alexander, & Napier 2008, Ahmed, & Amer, 2012). In a recent New York study where the majority (70%) of the Muslim respondents had some college education, a staggering 84% still endorsed spirit possession as the cause of mental illness and they felt that their primary support for a mental problem would be a religious healer (Abu-Ras, Geith & Cournos, 2008). In Britain, Muslims tended to under-utilize the mainstream mental health system. Indeed reports abound of thriving spiritual healing services among the Muslim populations to an extent that they even advertise their services in the local community newspapers. It is understood that some of these healers ask for exorbitant fees

but people still pay for it, choosing to bypass the free National Health Services (Mullick, Khalifa, Nahar& Walker, 2012,Dein, Alexander & Napier, 2008).

These studies in the United States and Great Britain have highlighted the vital role that Muslim Imams play in the mental health of Muslims and roles played by the institution of the mosque for refugees and immigrant Muslim communities. They stressed the need for a concerted effort by mainstream mental health providers to collaborate with the local imam spiritual leaders to bridge the gap and to improve services to the Muslim minority in their midst (Abu-Ras, Geith, &Cournos, 2008). Furthermore, imams increasingly encountered individuals with complex social and psychological problems yet most imams lacked the educational and professional training necessary to effectively deal with such issues. In some instances, imams were themselves new immigrants with poor language proficiency and knowledge of available community resources. This further handicapped their effectiveness in rendering essential mental health services to their congregants (Abu-Ras, Geith, & Cournos, 2008).

Muslim Refugee and Immigrant Services in Canada

In Canada (and USA), it has been noted that immigrants, and especially from the Islamic faith are less likely to seek mental health services due to language and cultural difficulties, lack of awareness of existing health services and institutionalized racism. For most immigrant communities, mental illness was largely attributed to metaphysical causation thus preferring to seek help outside of the mainstream biomedical health care system. Understanding Canadian Muslims' mental health issues is critical in addressing the barriers mentioned above. It is probable that Muslims now constitute the majority of refugees who are resettled in Canada, and they bring with them higher rates of post-war related traumas and experiences of extreme poverty (Hansson, Lurrie, &Mckenzie, 2008, Hossain, Ross-Sheriff &Tirmazi, 2010).

The Muslim population in British Columbia (BC), Canada, has increased dramatically in the last 20 years from a mere 10,000 in the 1980s to about 200,000 at the moment. There is a real possibility that BC Muslims are experiencing increased levels of psychosocial stress and copying difficulties just like their American counterparts, but little is known about such outcomes (BCMA, 2012).

The study set out to investigate some of the psychosocial challenges that immigrant Muslims in Metro Vancouver face, as inferred from the perspective of their imams who provide them with the psychosocial support they need. It is hoped that this will broaden our understanding of the needs of the muslim community and to come up with recommendations on how to collaborate with their community in mitigating those challenges.

METHODS

This study was exploratory in nature and informed by a social constructivism paradigm where multiple realities are espoused, accepted and realized through the lived and shared experiences of the researcher and study participants (Newman, 2006). That is why one-on-one in-depth ethnographic interviews rather than survey questionnaires were utilized as the method of research choice. This methodology was preferred because it gives both parties enough time and space to reflect and explore deeply the questions of interest (Newman, 2006, Hoonaard, 2012). Interviews were also preferred to survey questionnaires since using pre-determined questions and answer options could have limited respondents' contributions in an understudied area. It also allows researchers to gain more insights that may have been overlooked or underestimated. Participant observation was also employed in this study where the researcher attended and participated in a prayer session at one of the mosques and joined the congregants for the special Eid prayer on the 15th October, 2013.

The sample was purposefully selected from Metro Vancouver's nine main mosques. The author is an active member of the community and sits on the Muslim Advisory Committee (MAC) of the Ministry of Children and Family Development (MCFD) of

British Columbia and gives mental health talks at local mosques. This direct interaction with the community on mental health, substance abuse and family issues provided valuable insight into the challenges facing the community but also enabled understanding of how collectively they support each other. The study sample consisted of interviewing 5 imams purposively selected from the 9 main mosques in Metro Vancouver. Semi-structured study guides were used and the interviews were conducted in English and tape recorded with full consent and confidentiality assured. The obtained tape-recorded data were transcribed, thematically analyzed, summarized and conclusions made.

RESULTS

The interviews with the imams revealed and supported what the literature said about the important role imams play as providers of psychosocial support to their congregants (Rozario, 2009, Eneborg, 2012). Most importantly, all the respondents endorsed the fact that individuals and families resettled as refugees and immigrants from conflict countries struggled most with family dysfunctions and youth delinquency as the main psychosocial and mental health issues. In fact the mental health issues and couple/family counseling appeared to be a core function of the imams in Metro Vancouver as per the study findings. The emergent themes from this study were: (i) Marital problems (ii) Psychosocial problems (iii) Mental illness problems, (iv) Negative attitudes, stereotyping and stigma (v) Explanatory model of mental illness and help seeking.

Marital and Family Problems:

Imam I stated:

> "*Also, my role is to deal with issues related to marriage, as you mentioned marriage conflict between husband and wife. It happens very often, so we prefer that issues no to go to courts or to police, so we try to intervene and to give them advices and consultations. Basically, I have to play the role of marriage counsellor*",

The role of imams as couple therapists or counselors was so important that some of them would train and obtain licenses as marriage officers fully licensed and recognized by the government of British Columbia. This imam mentioned that family conflicts were a significant problem within the immigrant Muslim community and that imams were playing an important role in mitigating this problem. He further claimed that imams utilized culturally acceptable unique styles to solve family conflicts through faith-based resolution processes and adjudications, to which most couples related spiritually and culturally. He elaborated that the imams were saving the government both substantial financial and human resources by resolving these conflicts amicably at the community level to preserve families. This spared the time and efforts of the police and justice departments, Ministry of Children Family Development (MCFD), foster care and related departments where some of the children in these troubled families could have ended up.

Psychosocial Problems:

Imam II stressed the myriad of psychosocial and family issues that came to his attention all the time. Imam II shared thus:

> "……. *marital issues, spousal abuse, cultural conflicts, issues with police, families in court, child custody happens a lot. Divorce rate is very high, also unstable parents and children relations. Conflict between kids and parents' cultural divide, financial difficulties also adds because I was dealing with a lot of spouses issues and a lot of abuses, a lot of adolescence problems, a lot of kids, social issues, and it was too much it was a lot….*"

Due to lack of culturally appropriate services Imam II was obliged to do further studies in counseling psychology in order to fill the void. He, therefore, decided to enroll in a Masters of Psychology degree course to obtain the skills to help in these psychosocial problems.

Both of these examples show how imams were slowly waking up to the challenges and equipping themselves with specialized trainings in order to effectively deal with the community's psychosocial, marital and family needs and act as frontline social service providers.

Society's negative attitudes, stereotyping and stigma:

In addition, two of the interviewed Imams talked about how September 11 had strongly and negatively distabilised the stability of Muslims mental health, especially increasing the risk of developing mental health problems of depression and anxiety. They also mentioned the powerful role of the media in presenting Muslims as terrorists and

how this contributed to further stigmatize and stereotype Muslims.

Imam IV stated:

> *"So after September 11 … so every Muslim is a suspect. So every Muslim woman who is wearing hijab is a suspect. Every Muslim who has a beard or goes to the mosque is a suspect so that really put the Muslims in a tremendous pressure where they are not so comfortable with themselves, about their identity and how and when to pray."*

He also mentioned how many Muslims changed their names to avoid the stereotype such as changing their names form "Mohammed" to "Moe", reflecting the impact of the potential widespread stereotype.

Mental health problems/illness:

Regarding mental health problems including overt mental illness, the imams endorsed that most of those dealing with such challenges initially resorted to faith healing while some concurrently utilized the mainstream health care system as well as the institution of the mosque. Of interest were the strong belief attached to the power of God (Allah). Imams III said:

> *"We have many people who have mental illness issues in the community, so we sit with them, we examine these issues from a religious perspective, and, many times, we help them through, you know, through supplication, through prayers, because our religion teaches us to connect us to Allah. We know that whatever happens, happens due to the will of God; so He's the one who causes all of these things and He's the one who heals mental issues, mental problems, and many other problems, so we try to motivate these people to be patient and to connect themselves to Allah; and many times it helps them a lot."*

Imam IV endorsed similar religious understanding and said:

> *"Among Muslims, there is acceptance of 'Qadr' (the will of God) and so we generally accept illness and other misfortunes……so if someone is depressed it's seen as the Qadar of Allah".*

All the imams endorsed the importance of the 'will of Allah, Qadar' and said that all illness comes from Allah and that the best way was to pray, attend the mosque and participate in ruqya (supplications) in order to deal with illness and other social maladies. This demonstrated that the imams and the institutions of the mosques were the preferred destinations of care for psychosocial and mental health needs for the Muslim population around the world and indeed in Metro Vancouver's Muslim immigrant communities.

Explanatory model of mental illness: Similarly another reason why the immigrant Muslim people chose spiritual healing over biomedical medicine was their explanatory understanding of the causality of mental illness which they associated with spirit possession, sihr (witchcraft) and the evil eye. Such views are congruent with Muslim cultures across the world as endorsed by the Qur'an teachings and demonstrated in previous studies (Ahmed & Amer, 2012).

Imam V stated thus:

> *"…… because they feel Islam can treat these illnesses very well as they strongly believe in the supplications from the Quran and from the teachings of the Prophet. In the Islamic literature, that we believe in, there is a treatment for mental illness because you need to connect these people spiritually to the Creator and when you connect them to the Creator, their confidence level will be stronger, and they feel good about themselves, and when they feel good about themselves, they feel the supreme power which is the power of God is with them and it will help them to overcome this weakness that they feel, their internal weakness, and absolutely that we experience many times, these kinds of methodologies successfully working and helping many people to get better".*

It is this strong belief in God that endears the Muslim faithful to heavily rely on their imam spiritual healers for their psychosocial needs. In fact it is reported in England that Muslims bypass the free National Health Services (NHS) and sometimes pay exorbitant fees to faith healers for health needs and specifically mental health needs (Dein, Alexander & Napier, 2008). Similar stories came out of this study as well, where very ill individuals did not even attempt to visit their General Practitioners or psychiatrists and only did so after the advice of the imam. Even then, they quickly dropped out of the biomedical treatments to exclusively rely on spiritual treatments.

One imam was called to treat a very sick female patient that never consulted her family physician or psychiatrist for her condition. He explained thus:

> *"then I went with my friend to that family after we broke our fast we went to the home and the wife was possessed by Jinn, so we went in their living room, she was completely gone, she was frightened from a long time ago, and we started reading Quran on the lady, and we continue reading for about two*

hours. No, she never went to hospital, no"

Imam II further endorsed this by stating that in his mosque, they basically had to set aside specific days of the week for spiritual healing where a large number of people would come to seek healing. He said:

> "…… the *mosque had specific days for ruqyas, the number of patients were so many with entire room filled. It's the people perception, they feel cured when Quran is read upon them, situation when people react to Quran, speaking different language, vomit, this is evidence of sihr and jinn*".

DISCUSSION

This qualitative study, using in depth interviews with the imams revealed five major themes in Metro Vancouver's immigrant Muslim communities where culturally appropriate imams were the main sources of help giving. The emergent themes as per the study findings were: (i) Marital and family problems (ii) Psychosocial problems (iii) Mental illness problems, (iv) Negative attitudes, stereotyping and stigma (v) Explanatory model of mental illness and help seeking.

In summary the study showed the significance of understanding diverse explanatory models of health and wellness especially mental illness among the immigrant Muslim ethnic minorities in order to provide culturally appropriate services. It also highlighted the importance of closely collaborating with cultural brokers, alternative and faith leaders in addressing issues of mental health service provision, psychosocial support and addressing inequities. The need to enhance the capacity of culturally appropriate community agents so that they can effectively address and mitigate various psychosocial needs of their respective immigrant communities could not be understated as individuals and families from such communities had strong faiths in their cultural institutions and heavily relied on them for their psychosocial needs.

In addition, the imams were considered the primary resource of guidance for the immigrant Muslim communities and had high levels of trust and expectations thrust on their shoulders. It was thus crucial that imams possess the right knowledge and tools to sufficiently and effectively assist those who sought help from them and to as well direct or refer them to the proper channels if the problems were above their expertise. Tools like knowledge in counseling, awareness of available resources, language proficiency, and active communication with health care services and the police went beyond the circle of the immigrant Muslims associations and institutions and constituted the foundation of understanding to meet the immigrant Muslims community psychosocial needs. Finally as a recommendation and as Kleinman (1995) stated in his authoritative book "Rethinking Psychiatry" there is a need for scholars and health practitioners within the Canadian society and elsewhere in the Western world to rethink of the role of religious and other ethno-cultural institutions in the context of health and other essential human services in addressing inequities and other barriers to essential services and use such institutions as one of the ways to address such inequities.

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Long Term Impact Of Disasters' Trauma On The Psychosocial Adjustment Of Children In Gujarat, India

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ABSTRACT

Background:

Disasters are associated with long-term adversities and secondary stress. The process of psychological recovery and rehabilitation is particularly arduous for children.

Aim: *The main aim of this study was to assess how children who were exposed to two differential traumatic events (natural vs man-made disasters) in Gujarat, India, fared psychologically.*

Method: *Differences between children's psychological adjustment post trauma was explored by studying earthquake and riots victims as differential trauma groups. Six hundred seventy eight (678) children from ages 8-15 filled out the Strengths and Difficulties Questionnaire (SDQ) to assess psychological adjustment post trauma. Differences between trauma (n=329) and no trauma groups; earthquake, EQ, (n=159) vs. riots, R, (n=170) groups were studied using ANOVA. Descriptives were calculated and tabulated for trauma/no trauma and EQ/R groups across SDQ measures.*

Results: *Significant differences were found between the trauma/ no trauma as well as between the two trauma groups (Earthquake vs Riots) on the SDQ subscales and total difficulty score (TDS).*

Conclusions: *Exposure to trauma and violence in particular negatively affected the long term psychological well-being of the children. However children from the man-made disaster (riots) had higher stress scores compared to those from the natural disaster (earthquake). This has clinical implications for the management of the mental health fallouts of man-made traumatic disasters (wars, riots etc) vis-à-vis natural disasters and calls on society to do all that is possible to prevent/eliminate man-made trauma.*

Key words: Trauma, Riots, Earthquake, disaster, adversities, stress, natural, man-made.

Declaration of interest: No conflict of interest

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INTRODUCTION

Disasters impact at many levels. One of these is the burgeoning psychological cost of living through material, social and personal losses, injuries and rebuilding these resources from scratch. When speaking of disasters, we are talking of events which disturb and disorganize the social and interpersonal fabric of individuals and society. Disasters are frequently associated with acute and long-term adversities as well as secondary stresses (1). It is a common understanding today amongst the behavioural sciences that the short-and long term consequences of this extreme stress in the disaster-affected communities can be comparable to organized violence (or vice-a-versa). Different trauma sources (agents) may have predictable, although wide-ranging, psychological implications for individuals and vulnerable groups such as children.

In this research, the two traumatic variables under scrutiny were: a human-induced disaster (riots) and a natural disaster (earthquake).The study compared two groups of children affected by the separate incidents (earthquake and local riots), both of which occurred in the state of Gujarat in India. The earthquake which occurred in 2001 in the state of Gujarat followed by riots in 2002 between Hindus and Muslims formed the basis of this research.

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BACKGROUND

The Traumatic Events in Gujarat

The paper compares two traumatic events that took place in the north western province of Gujarat, India: the 2001 earthquake and the 2002 riots. The 2001 Gujarat earthquake was the second largest recorded in India, the largest being in 1737, and it was the worst natural disaster in India in more than 50 years (2).

However, since 2001, India has experienced several large scale natural disasters including Indian Ocean Tsunami and Kashmir earthquake in 2004 & 2005 respectively. The seismic waves spread out in a 700-kilometer circumference from the epicenter, and within this area the devastation was immense. There were more than 20,000 deaths and 167,000 people injured. Four districts of Gujarat lay in ruins and altogether, 21 districts were affected. It is estimated that around 300,000 families and at least 3 million children aged 14 and under were affected. Around 600,000 people were left homeless.

Nearly a year after the earthquake, in 2002, communal violence broke out in Ahmedabad, the capital city of Gujarat and in other places. These riots were due to the anger felt by the Hindus over the gruesome burning of Hindu activists who were travelling in the train to Godhra another city in Gujarat state. The riots which started in the early morning of 27th February 2002 continued for next four months. The carnage that followed surpassed all previous instances of communal riots in Gujarat (1969, 1985, 1989 or 1992) both in terms of loss of lives, as well as the barbarism involved. Over 2000 Muslims and 254 Hindus were killed; and 200,000 Muslims and about 10,000 Hindus were displaced. It is reported that property worth 5 million rupees was destroyed. International Human Rights Watch Report (3) noted that over 1000 cases of rapes and mutilations of women and children were recorded by the Human Rights Commission (3).

Literature Review

Scientific literature points out that the prevalence of post-traumatic stress disorder, PTSD, as documented in studies after natural disasters is generally lower than that documented after man-made disasters (4). In contrast to man-made disasters, it is more difficult in natural disasters to explicitly identify groups of persons who can be considered as being directly affected victims or not (5). Research points out that correlates of post-traumatic stress after natural disasters are comparable to those of after man-made disasters. These include: guilt (6), psychiatric morbidity (7-9), difficulties in concentration (10) and coping strategies (11-12). Children have been clearly shown to be more prone to PTSD than adults (13). Furthermore, older children seem to be more prone to psychological disturbances due to the ensuing stress as they are able to comprehend the meaning of the event better than the younger children (13-14).

Research has also identified children as a high-risk group for post-traumatic stress disorder and there is now evidence that a developmental model of trauma can better inform disaster mental health research and treatment of affected children and adolescents post-event (15). Post traumatic stress symptoms have been documented among children after natural disasters in a number of studies.

After the Armenian earthquake of 1988, 95% of children from a severely exposed city compared 26% from a mildly exposed city had severe levels of post traumatic stress symptoms 1.5 years after the incident (16). A research study of young adults and adolescents over 15 years evaluated the impact of the 1999 Turkey earthquake after one year of its occurrence (17). It was found that those living closer to the epicentre of the earthquake were far more affected by depression and PTSD compared to those far way from the epicentre. In another study assessing general psychological functioning in adolescent victims in the Colombia earthquake using MMPI-A, the results showed no clinically significant elevations suggesting that the disaster had not resulted in diagnosable psychopathology (18). However in comparison to a group of controls, the earthquake-affected adolescents showed significant elevations on certain clinical sub-scales notably of Depression (D), Psychasthenia (Pt) and Schizophrenia (Sc) indicating some mild affection. These studies indicate that it is the perceived threat rather

than the disaster agent itself as being the more important factor in the children's post-disaster psychopathology (19-20). Mercuri & Angelique (13) argued that witnessing scenes of destruction and or/ life-threatening situations elicited more stressful reactions than the type of disaster experienced.

There were certain reactions commonly associated with children post-disasters, such as worry about safety of self and others, separation anxiety, worry about repeat attacks, hypervigilance, heightened startle response, decline in school performance, changes in eating & sleeping patterns, somatic complaints irritability, temper tantrums and depression. Post-traumatic play and regressive behaviour were also commonly seen in children as a way of dealing with the trauma (19, 21-22).

This study focuses on the child survivors of the two events (Earthquake as a natural disaster and Riots as a man-made disaster) by looking at the differential long term psychological stress and socio-emotional impact of these disasters on the children.

METHODS

Participants

Three groups of children of age ranging between 8-15 years (mean age being 11) were randomly selected from various schools from different locations in Gujarat state. For the earthquake affected area, participants were selected from Khengarpur, Lodhai, & Bhuj as these areas were amongst the worst affected earthquake sites with Lodhai being very close to the epicenter itself. The riots affected children were recruited from four different schools in the old and new city of Ahmedabad where maximum instances of rioting and deaths were reported. The non-exposed control group participants were recruited from four different schools in Ahmedabad city, suburban Ahmedabad, Bhuj and Khavda. The first two schools were to be a matching control group for the riots children since riots were mainly in the city. Two schools from Bhuj and Khavda were chosen to provide a matching control for the rural sample of earthquake exposed children.

The total subject pool consisted of 678 children (ages 8-15yrs, mean 11) with 329 (48.5%)

TABLE 1: Demographic Characteristics of the Trauma Exposed & Non-exposed Children

Variable	Trauma Exposed Groups		Total Trauma	(No Trauma) Control Group	χ^2, τ_b Tests	
	Earthquake	Riots			EQ vs R	Trauma vs no-trauma
	N	**N**	**N%**	**N% (N)**		
Gender					**NS**	**NS**
Male	79	85	9.5 (164)	50.1 (174)		
Female	81	87	50.5 (173)	49.9 (167)		
Age					**NS**	**0.06***
8-<10	15	16	9.4 (31)	4.6 (16)		
10 -<12	47	39	25.7 (85)	8.2 (98)		
12-<14	63	68	39.6 (131)	35.4 (123)		
14-16	35	49	25.4 (84)	31.7 (110)		
Religion (N %)					**NS**	**0.47****
Hindu	86.3	21.5	52.9	93.9		
Muslim	13.8	78.5	47.1	6.1		
SES/Poverty (N %)					**0.26****	**NS**
P[1]	30.1	44.3	36.3	5		
NP[1]	18.1	7.5	12.5	16.2		

N= 678, NS means non significant; $p < 0.05$, ** $p < 0.01$ P[1]= poverty group NP[1] = no poverty group

children having been exposed to trauma (both earthquake & riots). The number of children in the control group was 349 and represented 51.5% of the total sample. The proportion of earthquake and riots affected children in the trauma exposed group was as follows: 159 (23.5%) children were affected by earthquake or lived near the worst affected areas and 170 (25.1%) belonged to the riots affected category. Boys and girls were more or less equally distributed across the groups (see table 2).

Table 2: Descriptives For (Psychosocial Adjustment), SDQ; TDS And Sub-Scales For Trauma And No Trauma Groups

	Trauma		No Trauma		EQ*		R*	
SDQ scale	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Emotional	**4.07****	2.37	**3.28****	2.03	**3.22****	2.14	**4.71****	2.37
Conduct pr	2.26	1.85	2.13	1.70	**1.69****	1.50	**2.70****	1.99
Hyperactivity	3.55	1.70	3.63	1.59	3.13	1.60	3.86	1.74
Peer re	2.40	1.64	2.35	1.73	2.24	1.67	2.51	1.61
Prosocial	**8.09***	1.97	**8.51***	1.61	8.28	1.79	2.93	2.10
Total Difficulties	**12.28***	4.99	**11.39***	4.67	**10.29****	4.32	**13.78****	4.99

EQ* earthquake R* riots TDS- total difficulties score on SDQ
Mean values with asterisks show SDQ scales where significant differences were found b/w groups on ANOVAs ; where *p < 0.05, ** p < 0.01

Measures

The Strengths and Difficulties Questionnaire (SDQ) is a short behavioral screening questionnaire consisting of 25 items. The SDQ version that was used was filled out by children themselves. They rated the presence of certain behaviors on a 3-point Likert scale (0- not true, 1- somewhat true, and 2- certainly true). The time period was the last 6 months. The 25 items were divided between the following 5 scales: emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behavior. The first 4 scales were also added together to generate a total difficulties score.

The total difficulty score (TDS) is a measure of overall child mental health problems that has been shown to have good psychometric properties in studies from around the world (22-26). Cases were allocated to a reference range, a borderline range or a clinical range of the scoring distributions based on a normative sample. Cutoffs were set at the 90th percentile for the clinical problems and at the 80th percentile for the borderline problems.

Data Collection

The SDQ-Gujarati version was translated following a rigorous translation-back-translation procedure and establishment of semantic equivalence. It was circulated to the children after consent for participation was taken from parents or guardians and children's assent obtained in written format. Children younger than 11 were administered the parent version filled by their parents and the self report versions were given to those 11-15 years old. Assessing psychosocial adjustment and mental health of Gujarati children was done using the new version of the translated Gujarati SDQ. The data was collected over a 2.5 year period, where three rounds of field work were carried out between 2006-2007 for 2.5 months, 2007 for 4 months and 2007-08 for 2 months.

Data Analysis

All of the statistical analyses were performed using SPSS 16 for Windows (SPSS Inc, Chicago, IL). Descriptives were calculated and tabulated for trauma/no trauma and Earthquake, EQ/Riots, R groups across the SDQ measures: the total SDQ score (TDS) and the subscales scores. Comparisons between and across the groups was done using ANOVA.

RESULTS

Table 1 below summarizes the demographic characteristics as percentages for Gender and Age as well as the SDQ scores across the two research groups, EQ & R; also for Trauma group (combined) and Control group (no-trauma). Results from X2 and τb statistics for demographic characteristics are also summarized. In addition to this, t-tests were carried out to find mean differences between the trauma and no trauma groups on the SDQ TDS and subscales. The table summarizes differences between Trauma /No trauma and EQ/R groups with their corresponding means and F values for Age, Gender, Religion and Poverty groups

Table 2 below provides descriptives (mean and SD) for the trauma and no trauma exposed groups' performance on SDQ. The mean TDS scores of trauma and no-trauma groups are 12.28 and 11.39 respectively and 10.29 and 13.78 for earthquake and riots groups respectively. The values are also given for the four subscales for trauma/no trauma and earthquake/riots.

Gender

Trauma/No-trauma: No significant differences were found for gender, suggesting that the gender of children was not significantly associated with the status of trauma since X^2 (1, N = 678) = 0.024,

Table 3: Children (n,%) of the trauma exposed sample scored in the clinically significant mental health problems range across age and gender on SDQ TDS and subscales

SDQ subscale	Age group (years)				Gender	
	8-10	10-12	12-14	14-16	M	F
	(n,%)	(n,%)	(n,%)	(n,%)	(n,%)	n (%)
Emotional Symptoms	6 (17.7)	12(35.3)	11(32.3)	5(14.7)	12(35.3)	22 (64.7)
Conduct Problems	4(17.4)	8(34.8)	7(30.4)	4(17.4)	13(56.5)	10(43.5)
Hyperactivity	3(25)	5(41.7)	3(25)	1(8.3)	10(83.3)	2 (16.7)
Peer Relationships	0	2(22.2)	1(11.1)	0	6(66.7)	3(33.3)
Prosocial Behavior	2(14.3)	4(28.6)	7(50)	1(7.1)	8(61.5)	6(46.1)
SDQ Total	4(25)	5(31.2)	4(25)	3(18.8)	9(56.2)	7(43.8)

$p > .05$. Because of absence of any association, Kendall's tau was also insignificant here.

EQ/R: Association between gender of children and nature of disaster (Earthquake/Riot) was found to be highly insignificant $X^2\ (1, N = 332) = 0.00, p > 0.1.$

Age

Trauma/No trauma: Chi-square result suggests that children's age was significantly associated with the status of trauma as indicated by values of X^2 (3, N = 678) = 9.075, $p < .05$. Since there was a significant association between age and trauma status, τ_b was used to ascertain the strength of this relationship. This statistic was used since ages are given in rank order (four age intervals across two trauma groups). τ_b = -0.061, p < 0.10 suggests a significant negative association between age-group and status of trauma indicating that children of higher age group were less traumatized than younger ones.

EQ/R: Tau-b results showed that the association of age-group of children was not significant with nature of disaster (Earthquake/Riot) i.e., value of τ_b = 0.07, p > 0.05 showed a non-significant relationship between the two variables.

Religion

Trauma/No trauma: The relationship between religion (Hindu vs Muslim) of the children and status of trauma was significant since X^2 (1, N = 678) = 148.2, $p < .01$. Because of such a significant association, Kendall's tau b was further examined which, as expected, came out significant (τ_b = 0.47, p < 0.01).

EQ/R: The relationship between the children's religion (Hindu vs Muslim) and nature of disaster

showed that this was significantly associated $X^2(1, N = 332) = 139.37, p < .01.$

Socioeconomic status, SES, (Poverty/No poverty categorization):

Trauma/No Trauma: The results were $X^2(1, 678) = 3.00$, $p > 0.05$, (τ_b=0.07, p>0.05), showing that they were both not significant. The percentage of children that were under poverty/no poverty sub groups did not differ on basis of whether they were exposed to trauma or not.

EQ/R: The results were $X^2(1, 332) = 22.95$, $p < 0.01$, and (τ_b=0.263, p<0.01) showing that they were both significant. The results suggest a significant (associative) difference between the children that were under the poverty sub group vs no poverty subgroup on basis of whether they were affected by the earthquake or riots.

Testing variations between groups on SDQ scores:

One-way ANOVAs were calculated in order to look at variances between the trauma/no trauma & earthquake/riots groups on SDQ measure.

Trauma/No trauma differences on SDQ

One-way ANOVA with trauma and no trauma as the independent variable and self-reported SDQ as dependent variables showed clear differences between means for two SDQ subscales and in the Total Difficulties Score, which was, F(1, 544)=4.49, p<0.05.

Significant differences were also found between the two groups on SDQ subscales for Emotional, F (1, 544) =17.25, p<.001) and Prosocial, F (1,544) =7.58, p<0.05. The mean values for the trauma group (4.07) was higher than the no-trauma group (3.28) whereas for the Prosocial scale, the mean values of the trauma group (8.09) was less than that of the no-trauma group (8.51).

Earthquake/Riots differences on SDQ (abbreviated as EQ/R difference)

One-way ANOVA on the two trauma groups, Earthquake and Riots, as independent variables and self reported SDQ measure as dependent variable showed significant differences on the Total Difficulties Score, TDS with F(1,211)=28.9, p<.001. The mean TDS values were clearly much higher for the Riots group (13.79) in comparison to the Earthquake group (10.29).

On the Emotional, Conduct and Hyperactivity subscales too there were significant differences seen. Emotional scores, F (1, 211) =22.67, p<.001; for the Conduct and Hyperactivity scores F values were: F (1,211) =16.65, p<.001 and F (1,211) =9.94, p<0.05 respectively. The Prosocial mean scores were lower in the Riots group (7.93) in contrast to the Earthquake group (8.28). With the Emotional scores the mean value was 3.22 for the Earthquake group but slightly higher at 4.71 for the Riots group. The mean values for the Conduct score was 1.69 for the Earthquake group and 2.70 for the Riots group.

Table 3 below gives percentages of children who scored abnormally high SDQ scores (TDS and sub-scales) across gender and age categorizations. Children aged10-<12 were in the highest numbers (about 31%) in terms of receiving abnormal scores (high needs and difficulties) on SDQ TDS. Most, (56%) of those who received abnormally high scores were girls. The older children, age group 14-16 years, were in lowest numbers (18.8%) amongst those who appeared to be in the clinically significant distress score category.

Discussion

The findings of this study showed that there were significant differences in the difficulties experienced by the trauma-exposed children on TDS score in comparison to children who were not exposed to trauma. Table 2 summarizes the mean and SD values on SDQ subscales and TDS across the two groups. Children in the trauma vs non-trauma group seemed to show significant differences on Emotional and Prosocial scores as their mean scores showed that they experienced greater emotional difficulties. These difficulties might impact their ability towards more Prosocial behavior at home or school or with friends (since the mean score of 8.09 indicated low need in comparison to the no trauma group). Prosocial subscale on SDQ is meant to measure children's resilience or strengths in an overall appraisal of their psychosocial adjustment.

The higher score on Prosocial subscale indicated one's higher strength in seeking social support and working through difficulties. Results show the trauma group's ability for Prosocial behavior to appear to have deteriorated. No gender differences were seen between the two groups on this item but nearly 56% of trauma group children whose scores fell into the clinically significant category (abnormal range) were girls. Significant results were found between age and trauma exposure status, a significant negative association was seen between age-group and exposure to traumatic events suggesting that the children of higher age group appeared less traumatized.

Children from age-group 10-<12 were in the highest numbers (31% of the total) in terms of experiencing clinically significant distress or difficulties in adjustment. The relationship between children's religion and exposure to trauma was found to be a significant one. It could be that a child's religious affiliation mediated the exposure to violence. This hypothesis needs to be tested further with a larger and more homogenous sample. Being poor/not poor, however, did not seem to be associated with higher SDQ or TDS scores after one's exposure to trauma.

In terms of how different the two trauma groups were from each other, the results showed certain characteristics in which the earthquake and riots affected children could be differentiated. First of all the scores on SDQ point to significant differences between the two on the Total Difficulties Score, TDS. The mean TDS values were higher for the riots in comparison to the earthquake group pointing to difficulties that the riots affected group might still be experiencing nearly 5 years after the incidence of riots.

Differences are also seen in the Prosocial behavior where children who were affected by riots showed lower scores than the Earthquake affected children. Prosocial behavior is linked to trust, perception of support both social and familial, and to reciprocity and it is not difficult to imagine how exposure to religiously instigated violence might make these children less able to trust and behave proactively in their environment. Other studies on aggression, complex developmental trauma, borderline personality disorder and attachment disorders indicate similar patterns where prosocial behavior and conduct difficulties are also negatively correlated (27).

The children exposed to riots also reported more conduct and emotional difficulties in comparison to the earthquake affected children. Both events, despite being different in origins, presented unique sets of relational deprivation that are yet to be fully researched and understood. There is evidence that man-made violence presents greater vulnerabilities for children and families (14-15, 28).

As stated above, the variations in current psychosocial functioning affirm the very differences in the nature of the two events under study here (natural disaster vs man-made disaster). No gender or age differences were found between the two groups. Religion was found significant between the two groups. Religion is a significant component of one event under study which is riots and perhaps indicated how the two events (one man-made and the other natural) have different characteristics. In the earthquake sites which were chosen for this study the population was mainly Hindu whereas in the city area where riots took place there was a significant representation of Muslims. In fact, this also showed the unique socio-demographic topology of Gujarat. Poverty/ no poverty status was found not to be significant between the two trauma group, although there is need for further systematic studies with larger sample sizes, to elucidate the links, if any, between trauma and poverty.

Finally, it was humbling and important to note that the trauma exposed children continued to display significant mental health and adjustment difficulties several years after the events had occurred.

Conclusion

This study showed that those children who were exposed to both traumas did experience significant psychological difficulties particularly challenges in the emotional and prosocial domains. Furthermore, it showed that the exposure to man-made traumatic disaster (violent riots) had more complex and long-lasting mental health

consequences in comparison to exposure to a natural traumatic disaster (earthquake). Nevertheless, the children's emotional well being got disturbed in the aftermath of both natural and man-made disasters. Conduct related problems were particularly heightened due to the children's exposure to, especially, man-made trauma (riots). These findings give further evidence of the heinous nature of man-made trauma in causing long-term negative psychological problems in affected victims, especially children. This has clinical implications for the management of the mental sequels of man-made traumatic disasters (wars, riots etc) vis-à-vis natural disasters and calls on society to do all that is possible to prevent/eliminate man-made trauma from society. Further studies that systematically look at different sources of trauma and address post-disaster adversities and their management are seriously needed especially among children.

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Psychosocial Outcomes Among Children Following Defilement And The Caregivers Responses To The Children's Trauma: A Qualitative Study From Nairobi Suburbs, Kenya.

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Abstract
Defilement is traumatic and often associated with psychosocial problems in children, parental distress and significant social strain on family relationships and well-being. This study aimed at examining psychosocial outcomes in defiled children and their caregivers' perceptions of the children's trauma after defilement. The study was carried out between June 2015 and July 2016 at Kenyatta National Hospital and Nairobi Women's Hospital. It adopted a qualitative descriptive design using interviews to obtain information from six purposely selected caregivers comprising of four mothers, one father and one grandmother. All the perpetrators were adult males and two of the defiled children were male and 5 were female. Two of the children were siblings; a brother and his sister. Five of the perpetrators were known to the children and one of these was the child's biological father. The defiled children had negative outcomes in terms of poor academic performance, low self esteem, depression and poor social relationships. In addition one of the children contracted HIV/AIDS, two became pregnant, one was used to traffic drugs, and another had mental retardation. The caregivers felt significant psychosocial distress. There is therefore, need to routinely screen for psychological, social and physical outcomes of children exposed to defilement trauma and to always consider caregiver distress when treating these children.

Key words: *Defilement, children outcomes, caregivers' distress, children, Kenya.*
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INTRODUCTION

Defilement is a debilitating experience for the victimized children with negative psychological, social, educational and physical health outcomes that are not only detrimental to the affected child but also their families and society at large (Reza et al., 2009; Madu et al., 2010; Collin-vezina et al., 2013; WHO, 2014).

Various studies have reported the estimated prevalence of defilement and sexual abuse to range between 7-36% among females and 5-10% among males (Pereda et al., 2009; Callender & Dartnall, 2010; Sumner et al., 2015). Hillis et al., (2016) reported that between one to two billion children were exposed to violence worldwide during the year 2013 to 2014 and this violence took the form of physical, emotional or sexual violence. In Kenya, the reported prevalence of defilement among young female children was exceptionally high at 55%, (Child-line, 2008).

Indeed, defilement was the leading form of sexual violence against children in terms of reported cases at the Gender Based Violence Recovery Centres (GBVRCs) of the Mental Health Departments of Kenyatta National Hospital (KNH), and Nairobi Women's Hospital (NWH). According to the "CRADLE" Foundation report 2009, approximately 79 % of girls in Kenya aged between 13 and 15 years had been defiled. Whereas these figures might be an over estimate, fairly high rates were also reported by The National Survey on Violence Against Children report (2010) which reported that 32% of adult females and 18% of adult males had experienced sexual violence during their childhood (National Survey on violence against children, Kenya, 2010).

Both the Kenya Sexual Offences Act (2006) Section 8 and Children's Act (2001) Section 15 state that defilement is an umbrella term describing criminal and civil offences in which an adult engages in sexual activity with a minor or exploits a minor for purposes of (the adult's) sexual gratification.

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The Sexual Offences Act (2006) further states that a child is anyone below the age of 18 years and that a child cannot consent to sexual activity with adults.

The Convention on the Rights of the Child compels parties to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of violence including defilement and sexual abuse (United Nations, 1989). The recently set UN Sustainable Development Goals set an agenda for global human development endeavours from 2015-2030 in which they acknowledged defilement as a fundamental obstacle to the health of the children and society as a whole. Their "Target 16.2" aims to end abuse and exploitation of children, and Target 5.2 aims to eliminate all forms of violence against women and girls, including sexual exploitation" (United Nations General Assembly, 2015).

Psychosocial outcomes related to defilement of children demonstrate its negative impact on children with deleterious and far reaching negative consequences on their physical and mental health (Jewkes et al., 2010; Walsh et al., 2010; Kisanga et al., 2013; Jaffee & Christian, 2014); and that the economic burden of defilement in any society is substantial (Corso & Fertig, 2010; Fang et al., 2012; Florence et al., 2013; Raghavan et al., 2014). In addition to these effects on children, Dunju and Lutz (2016) reported that the children's parents/ caregivers developed symptoms of distress in response to their children's exposure to sexually traumatic events. Similarly Alisic et al., (2016) in their study also found that parents/ caregivers experienced secondary trauma as a result of their children being exposed to sexually traumatic events. In their narratives, the parents/caregivers used words with negative emotions and anxiety to describe their children's trauma experiences which, in turn negatively impacted their children (Fivush et al, 2007). Morris et al., (2012) found an association between the parental/caregiver response to trauma in the children to development of Post-traumatic Stress Disorder (PTSD) and depression in the children.

A positive (supportive) family and social environment after children experience of defilement was associated with reduced risks for negative psychological outcomes (Kinnally et al., 2009). They hypothesized that negative appraisals of trauma in children by the caregivers and dysfunctional strategies in handling the children gave negative psychological outcomes (Ehlers et al., 2003). This study aimed to investigate psychosocial and physical outcomes among children following defilement and the parental/caregiver responses.

METHODOLOGY

The study employed a qualitative descriptive design using study guides to conduct interviews to obtain information from six purposely selected caregivers comprising of four mothers, one father and one grandmother. All the perpetrators were adult males and two of the defiled children were male and 5 were female. The study took place at Kenyatta National Hospital (KNH) and Nairobi Women's Hospital (NWH) for a period of one year from June 2015 July 2016. The two hospitals were chosen because they were both conveniently located in Nairobi and were centres of excellence in looking after children and women.

Those who were recruited into the study were caregivers of defiled children with their defiled children. The participants had to have been registered at the KNH and NWH Gender-Based Violence Recovery Centres (GBVR). Contacts of the parents/caregivers of the defiled children were obtained from the files one month after the defilement incidence.

The children had been put on standard treatments provided at the GBVR centres in both hospitals. Participants whose clinical status after examination was found to be in need of emergency treatment were attended to with liaison to the clinicians at the two GBVR centres.

The study included those who were able to understand English or Kiswahili or use of an interpreter for those who did not understand either language. The parents/caregivers of defiled children gave informed consent to participate in the study and the children gave assent. The participants were consecutively recruited. A caregiver of a defiled boy or girl was selected from the age groups of 7-10 years, 10-14 years

and 14-17 years to a total of 6 participating caregivers. Purposive sampling method was used to invite the caregiver's for the narratives. An interview guide was used to establish, from the caregivers, how the incidence of defilement had affected the child, the family, and relations of the child with the family, peers and neighbourhood including schooling.

The occurrence of symptoms of post-traumatic stress disorder, depression, low self-esteem and school performance was inquired into by conversation. The researcher audio-recorded the interview and also recorded the caregiver's distress, giving ample time to respond to the questions and allowing the caregivers to process difficult emotions. It was important to hear the caregivers' voices and concerns on their children's defilement incidence as well as look at children's deteriorating progress over time from the caregivers' perspective.

Qualitative narratives with the caregivers enabled the researchers to collect richer data, greater density of information, more vivid description and clarity of meaning that cannot generally be acquired through quantitative measures. The process employed good communication and rapport-building skills, using a non-judgmental attitude and observing verbal and non-verbal cues during interview. Timely questions were asked with a view to exploring emerging issues, guide the respondents through the interview process and ensure that he/she and the study participants adapted to the situation as soon as possible to reduce tension during interview. Observation was employed particularly in the early stages to help guide the study, ensure quality and to provide first- hand experience to the researcher.

The study was approved by Ethics and Research Committee (ERC) of the Kenyatta National Hospital of the University of Nairobi (approval number P577/09/2014). Funding for the study was obtained from the National Institute of Mental Health (NIMH) through project R34 which also provided the researcher with oversight and resources around child mental health and qualitative research. The details of ethical considerations was laid down in the letter of consent namely; consent explanation, confidentiality, personal and general risks and benefits, and the right not to participate or to withdraw anytime was explained to the participants by the researcher. Once informed consent was obtained the qualitative narratives were conducted using interview guides.

The researcher transcribed the audio data providing the ideal opportunity to commence the process of analysis, as the files needed to be frequently replayed during the transcription process. Data was entered into N-vivo 12 software and the themes united for analysis. The researcher adapted an iterative approach to ascertain similarities and differences in the form of excerpts and expressions. The researcher triangulated the information with her mentors/supervisors who included a psychiatrist, psychologist and social worker all of whom had keen interests in gender-based violence, trauma and child mental health.

RESULTS

I. Characteristics of caretakers, defiled children and the defilers

Study guided interviews were held with 6 caretakers who consisted of five parents (mothers) and a male guardian and the defiled children were seven. They were all registered at the Gender Based Recovery Centres at KNU and NWH and they all participated in the informant interviews.

Of the six caretakers of the defiled children five (83%) reported that the child was defiled by a person known to the victim and this was most commonly neighbours or persons entrusted to care for the children including a father and pastor. All the perpetrators were adult males and they defiled both male (2) and female (5) children. One of the defiled children had mental retardation. One parent reported that two of her children – a boy and girl – had been defiled yet they did not disclose even after repeated defilement as did a boy who was repeatedly defiled by a neighbour who also used the child for trafficking drugs. The child victims of repeated defilement by the same perpetrator did not report the defilement because of threats issued by perpetrators.

The study comprised of caregivers of 5 girls and 2 boys from the following age groups of 7-10 years, 11-14 years and 15-17 years making a total of 7 defiled children and 6 caretaker narratives. Table I below shows the characteristics of the defiled children and their perpetrators.

Table I: Characteristics of the Defiled Children

Case	Perpetrator	Age (years)	Sex	Caretaker	Class
K-3	Father	8	Girl	Mother	2
K-6	Pastor	8	Boy	Mother	2
K-2	Neighbour	13	Girl	Guardian	5
K-4	Neighbour	14	Girl	Mother	8
K-5	Neighbour	14	Boy	Mother	4
K-1	Unknown	15	Girl	Grandmother	8
K-7	Pastor	14	Girl	Mother	5

II. Qualitative narratives of caretakers regarding the defiled children and perpetrators.

Defilement incidence K-1: Girl age 15 years

The defiled girl was 15 years old and in class eight and an only child. She lived with her mother and stepfather for a while before coming to live with her grandmother. She currently lives with her grandmother who was given custody of the child through the chief of the area where they lived. They used to disagree with the stepfather and used to have many challenges and that's why she came to live with her grandmother. She was progressing well in school and was happy about life before the defilement incidence. She says the defilement incidence has brought about shame with the other children and that's why she runs away from home. The perpetrator was unknown to the child. Her grandmother was 46 years and a businesswoman operating a shop outside the plot where they lived. The grandmother was not married and had four children including the mother of her granddaughter.

***D*efilement incidence K-2: Girl age 13 years**

This girl was 13 years with mental disability (mental retardation). She was defiled by a person known to her. She is the first born among three siblings, her sister is 10 years and the brother is 7 years while the last born is six months. She was in class 5 and used to go to school before being taken to Kirigiti Rehabilitation Centre by the police due to running away from home and wandering on the streets at night. She did not have the behaviour of running away from home before the defilement incidence. The caretaker was a single mother who was 40 years and unemployed.

Defilement incidence K-3: Girl age 8 years

This girl was 8 years. She was the first born girl in a family of three children. Her brother was 10 years and her younger sister was 6 years. They lived as a family consisting of the mother, father and her siblings before the defilement incidence. On examination by the doctors her hymen had been broken an indication that this could not have ben her first defilement incidence. She looked sad during the interview though the mother reported that she was always in jovial mood and played with the other children and her siblings. She is in class 2 and she was defiled by her biological father. She says the defilement has made her neighbours to ask her many questions which made her sad. They have however moved from that estate to another home where the neighbours are not aware of the incidence. She also changed schools because fellow children teased her after they knew about the defilement incidence. Her father separated with the mother due to the defilement incidence, currently the father is in jail and he was 37 years. Her mother was 35 years and used to work in a cleaning company before the incidence of defilement, she lost her job because of the many off duty permissions she had to request to attend to her daughter needs.

Defilement incidence K- 4: Girl age 14 years

The girl was 14 years old and was in class 8. She was defiled by a neighbour who was unknown to her. She enjoyed life and was doing well in school and preparing to do her exams. She had come home from school with her friends who had visited her. After the defilement incidence, she became pregnant and the circumstances forced her to drop out of school. As a result she attempted sucide. The mother was a single parent aged 42 years old and unemployed.

Defilement incidence K- 5: Boy age 14 years

The boy was 10 years in class 4 and was defiled by a person unknown to him but who lived in their neighbourhood. His parents had separated but his father leaved close by. The child is able to visit the father during school holidays. The boy looked withdrawn and sad though he says he enjoys life. He is in school and the performance is average. The boy is an only child to a 45 year old woman who gets her income from selling vegetables.

Defilement incidence K-6: Boy age 8 years and K-7: Girl aged 14 years

This is a case of an 8 year old boy and his sister who is 14 years old. The boy looks happy but the girl looks sad. The two are siblings and were defiled by their local church pastor together with other children. The boy is in school but the girl was affected by the defilement incidence since she became pregnant and was not able to continue with school. The mother was a single parent aged 39 years old and was engaged in doing small businesses.

III. Impact of defilement on children according to the caregivers narratives

Academic performance

Poor performance emerged as a major impact of defilement on academic progress of the children all of whom were of school going age. This manifested through deteriorating school grades, repetition of academic years, absenteeism and even dropouts. Parents/ caretakers mostly reported below average performance in school examinations. Often a child who had been defiled would attempt the examinations but after being absent from school for a prolonged period following the defilement, he/she would be unable to attain the points required to proceed to a higher class within the formal educational system. As a result some mothers opted to enrol their affected children in vocational training institutions or drop out of formal school due to poor performance or change schools. One respondent reported thus:

> *"My daughter was in class 8, she has since not been able to go to school but she went to do the (national) exam and got 197 (out of a possible 500) marks in the Kenya Certificate Primary Examination. My son, who was also defiled, is still in school but his performance was also affected by the defilement. I have taken my daughter for catering course. The defilement has affected her school performance. I would have taken her to form 1 (secondary school)."* [Informant K- 6]

Poor performance in school work was often reported by parents who would take action to resolve the problem. The remedial actions included making school visits to discuss the poor performance and in a specific case the parent and teachers organized remedial out-of-hours lessons to help the child keep up with the academic requirements while adjusting to the impact of defilement on her now poor academic performance. Both parents and teachers were convinced that deterioration in performance was linked to defilement compared to the child's performance prior to the defilement. The parent reported thus:

> *"My daughter's educational performance has gone down since the defilement incident… She is nowadays among the last in her class. Before the incident she was better but now she has dropped. I have gone to her school and talked to the teacher and we have agreed to have her go for after-hours tuition (remedial teaching) to see if this will help her" [Informant K- 1]*

Depression

The responses of the informants showed a clear impact of defilement on the emotional wellbeing of the affected children developing depression. Caretakers often reported signs and symptoms of depression in their children and mentioned that these signs and symptoms pointed to depression in children that followed defilement. The caretakers often gave reports of persistent anxiety, fears, feelings of hopelessness and depressive symptoms like anger, irritability, sleep changes and loss of interest in daily activities in the affected children. The children also had difficulties functioning and enjoying life the way they did before the incident. The caretaker thus reported:

> *"She (my grandchild) was admitted to the hospital for two weeks, she had trouble falling asleep… she has problems concentrating in school, she is easily angered, and has lost the closeness I used to have with her … she runs away from home for hours without knowing where she is going… she has lost interest in school. The problems started after her defilement.*

She even attempted suicide" [Informant K-5]

"The drugs (PEP and EP) which my daughter was given did not help her since she contracted HIV and also became pregnant … when she (defiled child) learnt she was HIV positive she was very devastated. She has not been able to go to school, she is sad all the time, she eats poorly, she has lost weight and she just feels tired all the time. She keeps on having nightmares and she has lost hope in life. She attempted suicide once but I have talked to her. " [Informant K-4]

The symptoms of depression were aggravated in victims who apart from suffering defilement either contracted Sexually Transmitted Diseases (STDs) or conceived. There were cases in which defiled children contracted HIV and also conceived despite receiving post exposure prophylaxis (PEP) and emergency contraception (EC). A participating mother reported a previous suicide attempt in a child who contracted an STD, and also conceived following defilement, dropped out of school and manifested signs of depression. She said:

"The drugs (PEP and EC) which my daughter was given did not help her since she contracted HIV and became pregnant". She also told me the same thing happened to her brother as they both had contracted HIV infection".

"My daughter could not believe she was pregnant. She got pregnant with the pastor…one day my daughter told me she would rather take rat poison to kill herself. She then told me that the pastor used to pray for them (her and other children), but in the process they were defiled and… I took my daughter to hospital and it was confirmed she was pregnant. My daughter could not believe she was pregnant. My daughter also told me the same thing used to happen to her brother… (Both) were treated since they had contracted an infection… My daughter was emotionally disturbed by the defilement incident. She has attempted suicide once. She feels like crying most of the time…" [Informant K-6]

Self-esteem

The informant reported that the information regarding defilement incidents in most cases became known within the neighbourhoods and even in the schools the victims attended. The caregivers reported that schools attended by children were close to their residences. There were reports of stigma both at school and at home and this often led to low self-esteem among the defiled children. Caregivers reported cases where adults within neighbourhoods questioned victims about their sexual violence incidents to obtain information only to be taunted by these same colleagues hence negatively impacting on their self-esteem. One informant reported thus:

"The child was admitted to hospital for two weeks and she was having nightmares and had difficulties falling asleep… my child had a problem staying in our plot (residential area) since other children could tease her as they knew about the defilement incident. This affected her self-esteem badly. Women (neighbours) used to call her and ask her to tell them what happened that night." [Informant K-1]

Social relationships

Defilement came with significant strain on social relationships and family wellbeing. The most drastic changes in family and social relations were reported when the perpetrator was a family member. Such cases ended up in marital breakup, loss of financial stability especially when the perpetrator happened to be the main provider for the family, and also impacted on the relationships between the defiled child and other family members who commonly reported strained relations with victims related to his/her adjustment to the defilement experience. A caretaker reported thus:

"The defilement of my child has made me lose my job since I have been borrowing permission every now and then either to go to court or to attend to my daughter's issues…. My children were in private school and I have been forced to take them to public school. The defilement has caused breakup of my marriage since my husband was the one supporting us….I shifted and went to another house and started struggling by myself." [Informant K-2]

DISCUSSION

This study found significant deleterious effects on the affected children physically, psychologically, academically and socially. Physical effects of defilement included pregnancy and STDs. The study findings are similar to other studies including a study by Seka et al (2012) which reported that girls suffered more negatively found that in most cases, compared to boys, girls suffered more negatively from sexual abuse as most defiled girls turned out to be HIV positive or got pregnant. In another study Mwangi et al (2013) found that

0.54% boys and 0.84% of girls were HIV positive as a result of defilement and 1.6% became pregnant. In the same study 0.4% boys and 1.2% girls got Sexually Transmitted Diseases as a result of experiencing defilement.

Seka (2012) in her study noted that psychological distress is another problem that defiled children experienced a lot which undermined their self-esteem. This study had similar findings and the problem was worsened by the stigma. Oftentimes families had to relocate to avoid the post-defilement stigma. In our study, one respondent said: "My child had a problem staying in the plot (residential area) since other children could tease her and they knew about the defilement incident and this affected her self-esteem.....so we moved".

Mwangi (2013) also noted that defiled children experienced severe psychological and behavioural problems including running away from home, use of drugs and dropping out of school. In her study 67% had psychological problems. Similar findings were found in this study which prompted one respondent to state: "She (defiled child) runs away from home for hours without knowing where she is going". Such behavioural problems were associated with significant depression and even suicide attempts. This study found that defiled adolescents attempted suicide which is comparable to Kar et al., (2007) who found that defiled children and adolescents could develop PTSD with high rates of depression associated with suicide ideations and attempts as the caretaker lamented: "My daughter was emotionally disturbed by the defilement incident. She has attempted suicide once. She feels like crying most of the time".

Educationally, Mwangi (2013) in her study noted that defilement robbed children of their childhood which negatively impacted on their education. Maniglio (2009) reported a similar finding that defilement was associated with decline in academic performance as well as learning difficulties. Similarly in this study the defiled children reported a drop in their academic performance. In Kenya, Omondi (2014) demonstrated that 80% of the reported defilement cases among Kenyan children experienced detrimental effects on their education which was summed up by one respondent as:

> *"My daughter's educational performance has gone down since the defilement incident… She is now among the last in her class. Before the incident she was better but now she has dropped. I have gone to school and talked to the teachers and we have agreed to have her go for extra coaching (remedial teaching) to see if this will help her".*

Unfortunately, redress after defilement is very poorly attended to. In Kenya, Omondi (2014) & Ndungu et al., (2014) found that the victims of defilement who sought justice were confronted with a legal system that ignored and denied them justice and at times it even seemed to condone violence against the defiled child victims while protecting the perpetrators. Lastly, this study found that children with mental disability were vulnerable to being defiled as one of the defiled children had mental retardation. This compares to a study by Smith & Harrell (2013) who found that a child with a mental disability had a higher risk of experiencing sexual abuse than the child without.

In conclusion, therefore, children who are victims of defilement were found to have significant negative outcomes in terms of poor academic performance, low self esteem, depression and poor social relationships. In addition some got life threatening outcomes to the defilement trauma, such as contracting HIV/AIDS, becoming pregnant, or the use of drugs and alcohol or developing serious mental disorder and suicide attempts. Many defiled children perform poorly in school and their caregivers developed significant psychosocial distress. There is therefore, need to routinely screen for psychological, social and physical outcomes of children exposed to defilement trauma and to always consider caregiver distress when treating them.

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World Association Of Cultural Psychiatry (WACP) Position Statement On The World Migration Crisis

Puerto Vallarta, Jalisco, México, October 29th., 2015 to November 2nd., 2015.

Preamble

The 4th World Congress of Cultural Psychiatry had as its central topic: ***Global Challenges and Cultural Psychiatry: Natural Disasters, Conflict, Insecurity, Migration and Spirituality****.*
The congress took due note of the intensification of violent conflicts and turmoil in different parts of the world, causing widespread destruction and increasing displaced people, immigrants and refugees. This situation has recently reached dramatic levels that make a World Migration Crisis (WMC) with mass movements of people that generate great mental health risks. This led to the elaboration of this Declaration which was approved by the WACP's Board on November 2nd, 2015.The aim of the Declaration is to identify common and distinctive factors of the WMC, and formulate a 'Call for Action' in need of urgent implementation.

The United Nations High Commissioner for Refugees (UNHCR) estimated that 59.5 million people were forcibly displaced worldwide in 2014.This figure includes Refugees, Asylum Seekers, Internally Displaced People (IDP) and Stateless People. They often end up inextremely marginal living conditions which seriously compromise their physical and mental health.

AJTS 2016 (5(1): 48-49

Middle East-Europe migration waves

Today, almost one of every four refugees is Syrian, and in 2014, 51 % of refugees were **children.** The country hosting the largest number of refugees is**Turkey,** reaching nearly 2 million. Lebanon, Jordan and Turkey, currently shelter 3.6 million. Continued fighting in Syria has brought the number of Internally Displaced Peoples (IDPs) up to **7.6 million. As well,** Iraq witnessed massive new internal displacements as a result of the war and invasion by the Islamic State in Iraq & Syria ('ISIS').

Furthermore, **1.66 million** people submitted applications for asylum in 2014, the highest level ever recorded. The **Russian Federation, Germany and Sweden** became the largest European recipients of individual applications, in that order. According to the UNHCR, more than 380,000 migrants and refugees have landed on Europe's southern shores so far this year, up from 216,000 arrivals in the whole of 2014. According to the International Organization for Migration, 2,988 people died in the Mediterranean in 2015 while trying to cross to Europe. Squalid conditions in makeshift refugee camps have contributed to bring Europe's current migrant/refugee crisis into the global spotlight.

Latin America-North America migrant fluxes

Throughout a period close to one century, migration from Latin American countries to the United States and Canada has been a persistent and only lightly analyzed social phenomenon. Economic and socio-political factors, such as unemployment, public budget deficits, government instability, social disorganization, family needs, civil wars or administrative corruption, have been the main reasons behind an increase of the so-called "Hispanic undocumented migration". Most people are working in low-paying areas and remain marginalized and discriminated against. There are 54 million Hispanics living in the U.S. which makes up 17 % of the total population, the largest ethnic minority in the country. Furthermore, about 98% of 364,768 apprehensions in 2012 occurred along the Southwest U.S-Mexican border. In addition to the high economic costs, dramatic

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reports of violence and systematic discrimination are frequent experiences of these immigrants throughout the journey.

Asia and the Pacific Region

The Asian region is home to 7.7 million people, more than half of whom are refugees, 1.9 million IDPs, and 1.4 million are stateless persons. The majority of the refugees originate from Afghanistan and Myanmar. Up to 96 % of Afghan refugees live in Iran and Pakistan. For several decades now, people from different ethnic groups in Myanmar have been fleeing and, currently, an estimated 500,000 refugees are in zones of neighbouring countries such as Karen and Karenni in Thailand, Chinese in Malaysia, Rohingyas in Bangladesh and in large urban centers. There are over 400,000 IDPs in Myanmar, more than half of the population of the Kachin and Rakhine states. 63% of the 3.5 million refugees live outside camps, mainly in urban environments where they are basically unprotected.

Africa

Massive new displacements caused by conflict, violence and human rights abuses are likely to continue to affect African countries. The projected numbers of people of concern are expected to decrease slightly, from 15.1 million in 2014 to 14.9 million this year (2016). The scale of the displacement caused by the upheaval inside the Central African Republic is of about 611,000, in South Sudan1.5 million in 2013, and 200,000 in 2014, with equal numbers in Burundi and 85,000 in Yemen. Renewed fighting in the Democratic Republic of Congo has broughtup to **2.8 million of** IDPs. Also, a significant proportion of Mali's population, 267,000 people, and it remains displaced internally and externally. The Boko Haram insurgency in the federal states of Adamawa, Borneo and Kobe in north-eastern Nigeria has displaced more than 650,000 to flee their homes within the country, and an estimated 70,000 to take refuge across the borders with Cameroon, Chad and Niger.

World Association Of Cultural Psychiatry (WACP) Call For Action

- We call on all European governmentsto respect, uphold and administer the U.N. Refugee Convention (1951) with fairness and promptness.
- We extend this call to the U.S. Government to adopt and reinforce policies more practically, flexible and human, regarding the management of Hispanic and other immigrants now and in the future.
- We call on all Governments of countries in the receiving end of immigrants to act with promptness and fairness and respect for human dignity in the assessment, screening and decision processes related to the legal status of migrants.
- We call for all basic health care to be provided to migrants, with a clear emphasis on the immediacy of medicals as well as emotional and psychological measures.
- We call for respect to and protection of individual, cultural, religious and spiritual dignity, valuable features revered by most people, after the long haul of the migration journey and its traumatic sequelae.

The WACP will actively work towards the organization of international meetings on the subject of the WMC and its different expressions. The aim is to bring together government officials, politicians, advocates, media, communities, health and mental health professionals, social and professional organizations and researchers, engaging them in the formulation of concrete and coordinated actions. The collaboration of other organizations with strong political and international impact should be actively pursued for the materialization of all these objectives.

Addendum

In Africa, we, as Mental Health Workers, call upon the various Ministries of Health and all health care agencies to prioritize refugee and immigrant mental health in their service delivery.

Guidelines to Authors

General instructions:

Submit original and two copies of the manuscript to: Editorial Secretariat , African Journal of Traumatic Stress, Department of Psychiatry, School of Medicine, College of Health Sciences, Makerere University P.O. Box 7072 Kampala, Uganda Email: ajts@gmail.com. The AJTS has no charges for papers accepted for publication. Papers published in the Journal should be evidence based and should have relevance to trauma. They can be research papers, reports, reviews, personal stories short communications or news worthy briefs. Manuscripts should be typewritten on white A4 paper using font size 12, double spaced and should not be more than 15 pages excluding references, tables, graphs, pictures or charts with wide margins (2 cm) and line numbered where possible.

Title: Should be brief and reflect the main theme of the paper. It should be less or equal to 15 words.

Authors: Names should appear below the title and below which the address should be typed.

Abstract: An Abstract in English should, if possible, be accompanied by French translation and Vice Versa. It should include key words, arranged alphabetically with one the first letter of the first key word capitalized. Key words should be separated by commas. Abstracts should be limited to a maximum of 250 words and should contain salient features of the study, briefly indicating Title, Introduction, Objectives/aim, Methods, Results and main Conclusions. Single solid lines should separate the by-line material from the Abstract and the Abstract from the main text.

Text: should appear in the following order: Title (maximum 20 words), Authors and their adresses, Abstract, Introduction, Methods/Methodology, Results/ findings, Discussion, Conclusion, Recomendation and policy implication where applicable, Acknowledgement(s) and twenty or less reference listings should follow Vancouver or Boston styles. Main section headings should be bold, centred and of uppercase letters. Do not underline the title or section headings. Subsections should also be bolded and when included only the first letter of the subsection should be capitalized. Use SI units of measurement and undeline all Latin words and scientific names. Use numerals before standard units of measurements e.g. 3g, 9 days, 36 hr: otherwise use words for numbers one to nine and numerals for large numbers. Non standard abbreviations should be avoided and where used, they should be explained at their first mention.

Introduction: Provide a survey of literature, Aims/ objectives and clearly justify the need for the study.

Methods/Methodology: This should be informative enough to enable readers to interprete the results obtained. Particular attention should be paid to the design, analysis and statistics. References for the methods used should be included.

Results: Should be concise. Avoid reproducing information already in tables.

Discussion: This section may be combined with results but generally should be separate. It should indicate clearly the significance and implications of the results obtained. Inferences and opinions should be distinguished from facts and should not duplicate results except to introduce or clarify points. Reference should be made to published literature.

Acknowledgements: Financial contributors, pre-paper reviews etc deserve acknowledgement.

References: Only articles or books published or are in press may be cited. Where need be, copies of the publishers' letter of acceptance should accompany all such citations. The references should be arranged sequentially by numbers (Vancouver style) or alphabetically (Boston style).

Authors should be referrred to in the text by name and year eg: (H.S Wako and M. Mukasa, 2001). Role of higher education in the Third World. Curent Sciences 81(8)868

If there are more than 3 authors quote only 3 and put et al and leave out the rest. Within the text, references should be given as; Lin and Liu (2000) and if many citations cite as Okello (1981), Otim (1993).

For books list as: Smiths G. (1987). Changes in composition of pathogen populations caused by resistance to fungicides. In Population of plant pathogens, their dynamics and genetics. Cook M.S and Cohen, C.E (Eds), pp 227-237. Blackwell Scientific Publications, Oxford.

Personal communication may be cited only in the text, giving names, date and institution or organization of source of information.

For websites: Kariuki

T. (1997). Report on the Joint JSPRS Commission III/IV Workshop '3D Reconstruction and Modelin gof Topographic Objects, Stuttgart, Germany. http://www.radig.informatic.tu-muenchen.de/ISPRS/WG-114-1V2-Report.html (accessed 28 March 2005).

Tables and figures: Tables and figures should be self explanatory, without reference to the text or other tables and figures. Captions should be brief but adequately describe contents. The word Table should be in Upper case letters and should be numbered with arabic numerals. Figure captions should be typed on a separate sheet of paper. In the text spell out the word Table but abbreviate Figure to Fig. Capitalize the first letter of table column and row headings. Footnotes are designated with supersript lowercase letters.

Graphs should be boxed and cordinates and abscissions marked with index lines. Pictures and illutrastraions may be in black and white or colour and of a size that allows reduction of up to 50%.

Paper revision: An author receiving editorial recommendations for revision should submit the revised manuscript within 4 weeks otherwise longer intervals will be treated as new manuscripts.

Gully page proofs will normally be sent to the author for correction if time permits.

For style and format, authors are advised to consult the most recent issue of African Journal of Traumatic Stress.

McGill University
Division of Child Psychiatry

Infant Mental Health Day

TRAUMA AND DISPLACEMENT: THE CHALLENGES OF INTERVENTION WITH YOUNG REFUGEE CHILDREN AND THEIR FAMILIES

Friday, November 11th, 2016

Institute of Community and Family Psychiatry, Jewish General Hospital

AMPHITHEATRE: 4333 Cote Sainte-Catherine Road, Montreal, Quebec, H3T 1E4

The 24th McGill Infant Mental Health Day will address the current challenges of working with young displaced and refugee children and their families. Our invited guests are in the forefront of international research and clinical practice in this field. Participants will have an opportunity to benefit from their knowledge and expertise. This conference is of interest to physicians, nurses, social workers, educators/ psycho-educators, occupational and speech therapists, psychologists and psychiatrists working with infants and very young children.

INVITED SPEAKERS:

Marie-Rose Moro, MD, PhD, Professor of Child and Adolescent Psychiatry, Paris Descartes University
Cécile Rousseau, MD, McGill Professor of Psychiatry, Scientific Director of SHERPA, CIUSS du Centre-Ouest de L'Ile de Montréal, CLSC Parc Extension.
Ghayda Hassan, PhD., Researcher and clinician, Response Team and Intercultural Research, CIUSS du Centre-Ouest de L'Ile de Montréal, CLSC Parc Extension.

PROGRAM

8:00 a.m. Registration
8:45 a.m. Opening Remarks: Donna Casa-Martin, BSc. Ed, Psychotherapist, Chair

Moderator: Ashley Wazana, MD

9:00 a.m. Marie-Rose Moro, MD, PhD
Refugee infants and families: transcultural perspectives
10:00 a.m. *Question Period*
10:15 a.m. *Coffee Break*
10:45 a.m. Ghayda Hassan, PhD
"My name is not Refugee": caring for children from Syria
11:45 a.m. *Question Period*
12:00 p.m. *Lunch*

Moderator: Ashley Wazana, MD

1:15 p.m. Marie-Rose Moro, MD, PhD
Clinical interventions: Lessons from the field
2:00 p.m. *Question Period*
2:15 p.m. Cécile Rousseau, MD
Intrusion and protection: holding the refugee mother- infant dyad
3:00 p.m. *Question Period*
3:15 p.m. Panel Discussion and *Question Period*
Marie-Rose Moro, MD, PhD
Cécile Rousseau, MD
Ghayda Hassan, PhD
4:00 p.m. Closing Remarks: Donna Casa-Martin, BSc, Ed, Psychotherapist, Chair

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Presentations will be in French and English with Simultaneous Translation

This event is an accredited group learning activity of the Royal College of Physicians and Surgeons of Canada and of l'Ordre des psychologues du Québec. AQSMN members are entitled to a reduction of $10.00.

LEARNING OBJECTIVES:

1. Participants will learn about clinical issues, affecting young refugee children and their families
2. Participants will learn about clinical interventions with this population
3. Participants will be sensitized to transcultural dimensions of adaptation and treatment

McGill Infant Mental Health Group:

J. Canfield, MD (MCH/MUHC) D. Casa-Martin, BSc. Ed (Private Practice) S. Dongier, MD (DH)
J. Ferdinand, MD, (Batshaw/MCH) J. Grunberg, MED (Private Practice) M. Larose, MD (MCH/ MUHC)
J. Loomer, MSW (DH) K. Minde, MD (MUHC) A. Wazana, MD (JGH)
G. Valles , Administration, (MCH/MUHC)

Register by e-mail at psychiat.division@muhc.mcgill.ca and submit the coupon below along with your payment. Registration will be accepted upon receipt of payment. This is a non-refundable event. Please note that lunch is not provided. Registration is limited to 150 participants. Please send this registration coupon along with a cheque of **$80.00** payable to: **McGill University, Division of Child Psychiatry**, and mail to **Giovanna Valles, Child Psychiatry, Glen Site, 1001, boulevard Décarie, Montréal, QC H4A 3J1,** Tel.: 514-412-4400 (22470) - Fax: 514-843-1517 E-mail: psychiat.division@muhc.mcgill.ca

Peter C. Alderman

4th SYMPOSIUM OF MAKERERE-COLUMBIA(MUCU) &
THE SOCIETY OF ADOLESCENT HEALTH IN UGANDA(SAHU)
TO BE HELD ON THE 29-30 MARCH 2017,HOTEL AFRICANA KAMPALA, UGANDA

CALL FOR ABSTRACTS

THEME:

KEEPING OUR ADOLESCENTS HEALTHY THROUGH PREVENTIVE CARE

SUB THEMES:

Prevention of Diseases among adolescents

Interaction between Oral Health and Adolescent Health

Adolescent Responsive Programing

Abstracts of no more than 300 words with Title, contact email,background,methods,results and conclusion OR Title, contact email, Summary of Program, Program Activities, Lessons learned should be sent to:

conferenceSAHU2017@gmail.com

IMPORTANT DEADLINES and INFORMATION:

29th January 2017(abstract submission ends)16th February 2017(accepted abstracts and scholarships announced)ONLY 10 local and 3 international scholarships available; participants will be required to register on site and the fee is 50,000ugx($15)

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