The Professional Medical Journal
www.theprofesional.com

ORIGINAL PROF-2437

INTERNALLY DISPLACED PERSONS (IDPS);
ANXIETY AND DEPRESSION

Dr. Wajid Ali Akhunzada[1], Dr. Altaf Qadir[2], Dr. Niaz Maqsood[3], Dr. Ghulam Rasool[4], Dr. Raza Ur Rahman[5]

1. Associate Professor & Head Department of Psychiatry Hayatabad Medical Complex Peshawar Pakistan.
2. Associate Professor of Psychiatry, PGMI/Lahore General Hospital Lahore.
3. Professor of Psychiatry Quid-e-Azam Medical College Bahawalpur.
4. Professor and Head Department of Psychiatry, Bolan Medical College Quetta.
5. Professor of Psychiatry, Dow University of health Sciences, Karachi.

Correspondence Address:
Dr. Wajid Ali Akhunzada
Associate Professor &
Head Department of Psychiatry,
Hayatabad Medical Complex
Peshawar, Pakistan.
wajidpsy@hotmail.com

Article received on:
10/02/2014
Accepted for publication:
03/02/2015
Received after proof reading:
00-00-000

ABSTRACT… Most internally displaced persons (IDPs) live in low-income countries experiencing a war; their psychosocial health has not been well addressed. **Objectives:** To find out the prevalence of anxiety and depression in internally displaced persons (IDPs). **Design:** A randomized cluster sampling, case-controlled study. **Period:** 10th April 2009 to 10th July 2009. **Setting:** This study was conducted at Kacha Ghari camp and Sheikh Yaseen camp for IDPs. **Patients and Method:** A total of 220 cases (those whom were exposed to traumatic experiences) were selected through cluster random sampling. 220-matched controls (those whom were not exposed to traumatic experiences) were selected same day using the same sampling method. Both sexes were included. Socio-demographic information was obtained from IDP- information form. Anxiety and depression was assessed using Hopkins symptoms checklist – 25 (HSCL-25). SPSS version -17 was used for statistical analysis. Chi square test was applied for group comparison to calculate statistical significance. **Results:** More than half of the participants (60 %) in this study were in age group between 18 to 38 years. 55 % of the population were females. Majority of participant were married (86% - 90%) and were uneducated (74% - 90%) belongs to lower socio-economical class. The total Scores and the Depression Scores on Hopkins symptoms checklist – 25 (HSCL-25), were significant high in case group than in control group with the P values of 0.04 and 0.05 respectively. **Discussion:** Trauma and torture leaves a permanent scar on the survivors. It has physical, psychological and social squeals. Hopkins Symptoms Checklist-25 is intended to provide primary care physicians, mental health practitioners and other health care providers with an instrument for detecting anxiety and depression in torture and trauma victims. **Conclusions:** Besides being displaced from their residence exposure to trauma come out to be the important causative factor in creating psychological disturbance among internally displaced persons.

Key words: Internally Displaced Persons (IDPs, Anxiety and Depression.

Article Citation: Akhunzada WA, Qadir A, Maqsood N, Rasool G, Raza ur Rehman. Internally displaced persons (IDPS): Anxiety and depression. Professional Med J 2015;22(3):337-342.

INTRODUCTION

Internally displaced persons (IDP) are people who are forced to flee their homes but unlike refugees, they remain within their country's borders. This migration may result from (or is in order to avoid the effects of) armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters[1], There are currently nearly 20 million IDPs worldwide, roughly twice the total number of refugees[2]. Search of literature show that approximately 70 and 80% of all IDPs are women and children[3]. Most internally displaced persons (IDPs) live in low-income countries experiencing a war; their psychosocial health has not been well addressed[4].

In Pakistan there were more then 400,000 IDPs at the end of 2008. This was due to ongoing conflicts in three regions of Pakistan. Currently one million people have been displaced in Khyber Pukhtoonkhwa (the then NWFP) province of Pakistan due to military operation[5]. The largest displacement in Pakistan occurred in Swat Valley of the Khyber Pukhtoonkhwa. The valley, with a population of 1.5 million people, was seized by pro-Taliban fighters in July 2007[5].

A traumatic event has a capacity to provoke fear, helplessness, or horror in response to the threat of injury or death[6]. The mind's and body's response to feelings (both perceived and real) are fear and intense helplessness. Symptoms may include anxiety, impaired judgment, confusion, detachment and depression. People who are

exposed to such events are at increased risk for PTSD as well as for major depression, panic disorder, generalized anxiety disorder, and substance abuse, as compared with those who have not experienced traumatic events[6]. They may also have somatic symptoms and physical illnesses, particularly hypertension, asthma, and chronic pain syndromes[6].

Trauma and torture leaves a permanent scar on the survivor with physical, psychological and social sequels. The two major psychiatric illnesses associated with trauma and tortures are major depression and post-traumatic stress disorder[7].

Health and psychosocial well-being of IDP is affected in a number of ways. There is an overwhelming loss of perceived power and self-esteem. Over 25% of displaced people, for example, said they no longer felt they were able to play a useful role. Widespread depression and feelings of fatigue and listlessness were common and may have prevented people from taking steps to improve their situation. Almost a quarter of internally displaced people had a high startle capacity and said they were constantly nervous. Most adverse psychosocial responses increased with age and in a population that includes many elderly people this poses serious problems[8].

Presence of mental health problems contribute to difficulties in coping with resettlement in normal life. In torture and trauma survivors there may be a reluctance to discuss trauma related events or symptoms with a health' care practitioner because there are painful feelings which the patients often would rather put behind them. So obtaining accurate knowledge of traumatic event its impact, resulting symptoms and properly classifying them into a diagnostic category is fundamental for providing effective treatment and good therapeutic intervention

PATIENTS AND METHODS

Design

A randomized cluster sampling, case- controlled study.

Place and Duration of Study

This study was conducted at Kacha Ghari camp and Sheikh Yaseen camp for IDPs from 10th April 2009 to 10th July 2009.

Total of 220 cases who have history of exposure to traumatic experiences were selected through cluster random sampling. For comparison 220-matched controls whom have no history of exposure to traumatic experiences were selected same day using the same sampling method. Both sexes were included. Ethical consideration was taken into account and informed consent was taken from participants before including in the study. The IDPs are registered with UNHCR (United Nations High Commission for Refugees) and Interior Ministry, Khyber Pukhtoonkhwa. Using the registration record, systematic random sampling was done. In order to overcome difficulty in reaching the female population, female interviewers were hired. A two stage sampling frame was adopted to obtain 1) a probability sample of households (tents) based on systematic random sampling and 2) a random selection of adult male or female respondents within each household.

To assess anxiety and depression Hopkins symptoms checklist – 25 (HSCL-25) was administered to subjects of both groups. Hopkins Symptoms Checklist-25 is an instrument for detecting anxiety and depression in torture and trauma victims in primary care and psychiatric setting[9]. The HSCL-25 is a symptom inventory which measures symptoms of anxiety and depression. It consists of 25 items: Part I of the HSCL-25 has 10 items for anxiety symptoms; Part II has 15 items for depression symptoms. The scale for each question includes four categories of response ("Not at all," "A little," "Quite a bit," "Extremely," rated 1 to 4, respectively). Two scores are calculated: the total score is the average of all 25 items, while the depression score is the average of the 15 depression items. This checklist has been translated in Urdu and has been used in Pakistani population[8, 10]. This scale has already been used in Afghan population which has similar socio-cultural backgroung[11].

SPSS version -17, was used for statistical analysis. Chi square test was applied for group comparison to calculate statistical significance.

RESULTS

Socio-demographic characteristics of subjects in sample and control groups are similar and given in table I. Majority of subject in study were young having age between 18 to 48 years. Female dominate by 10% in this sample. Majority of participants (90%) in this study were married and were economically poor. Almost three fourth of the participants were uneducated and those who were educated have completed their education up to metric only.

Variable	Sample (%) n=220	Control (%) n=220
Age(in years)		
18 – 28	31.4%	30%
29– 38	27.7%	32.7%
39—48	20.9%	19.1%
49—58	5.5%	8.2%
59 and above	14.5%	10%
Sex		
Females	**55.5 %**	**55.5 %**
Males	44.5 %	44.5 %
Marital status		
Married	**86.4%**	**90%**
Un- Married	**9.1%**	**7.3 %**
Widowed	1.4%	0.9 %
Separated	3.2%	1.8%
Education		
Primary	12.7%	5.54 %
Middle	6.3%	4.54 %
Matric	**5 %**	**3.1%**
Intermediate	0.9%	4.9%
Graduation	0.9%	1.3%
Illiterate	**74%**	**81%**
Occupation		
Govt –Servant	1.8%	2.7%
Private employee	4.09 %	1.8%
Un-employed	**31.8 %**	**33.6 %**
Self- employee	17.2 %	18%
House wife	**38.1%**	**37%**
Student	6.8%	6.3%
Family Size		
Nuclear	29 %	30 %
Large	**60.4 %**	**55%**
Extended	10.45%	15%
Socio-economical status		
very poor	**58.2%**	**58.6%**
poor	**30.9%**	**32.5%**
Middle	10%	9.1%
upper	00	00
Time in Camp		
Less than I week	35.2 %	20.9%
2 to 3 weeks	25%	38.2%
1 month	26%	22.3%
More than 1 month	13%	18.6%

Table-I. Socio-demographic characteristics of subjects in sample and control group.

Table-II shows the average of the total scores and the average of the depression scores. The average of the total scores has the mean of 1.76 with the standard deviation of ± 0.292, and *p value* 0.045 which is statistically significant. The average of depression scores has mean of 1.79, with the standard deviation of ±0.0313, and the *p value* of 0.054, and is statistically significant.

DISCUSSION

This study reveals extremely high levels of psychiatric morbidity amongst the IDP population from Swat. The majority of the subjects in this study were of young age, which is also replicated in international studies[12]. Age is related to both exposures to additional stressors and to more cumulative experiences with coping. Tylor and Frazer [13] found that older rescue workers were less distressed than the young ones in the same disaster. Similarly an inverse relationship was found between age and several symptoms after a Texas tornado by Bolin[14]. After the Buffalo Creek Dam Disaster a mid-age-range victims (25-54 years) were more severely affected than those age 16 to24 or older than 54 years[15].

Along with age gender is also implicated in

Variables	Mean ± SD*	DF	χ2	p- value
Average of Total Scores	1.76± 0.292	1	1.004	0.045
Average of Depression Scores	1.79 ± 0.313	1	1.000	0.054

Table-II. Average of Total Scores and Average of Depression Scores

vulnerability to disaster and stress. In our study 55.5% were females. Several studies have suggested that women are more affected by disaster than men[16,17].

Woman were more likely to be referred to a psychiatrist after exposure to widespread deadly food poisoning in Spain[18].

Other studies have suggested that the genders may respond differently to trauma, with women experiencing more anxiety, depression and somatization[16,19].

And men showing more symptoms of actual physical illness, belligerence and alcohol abuse [16,18,20].

Regarding the marital status of the participants of our study, 86.4% of our study group and 90% of the controlled group were married. This finding may be due to our culture settings[21].

Where early age marriages are very much prevalent. Other studies conducted in our local culture has shown the same findings[21,22].

A large majority, (74%) of our study group were illiterates, were house wives (38.1%) and unemployed (31.8%)[23].

In our study 60.4% belong to the large families were either from very poor or poor social economical class. This may be due to the fact that people belonging to the rich class, those having financial stability did not come to these IDP camps.

They either could afford to rent a house in other safer cities are had some affluent supporting relatives, in other cities. Where they could get accommodation rather than to be in an IDP camp.

In our study the average of total score and the average of the depression score were statistically significant. This reflects that these IDPs (who were exposed to trauma) had clinically recognizable depression and anxiety symptoms along with emotional distress. These patients may not recognize the link between these symptoms and an exposure to the traumatic event. Patient may be unwilling to disclose the event and the presentation of depression, substance abuse[24,25] or other co morbidities. Symptoms that do not meet the full criteria of post traumatic stress disorders appear to be quite common in these victims of conflict and war. Who fled their homes to be in safe places and have become IDPs.

Many people blame themselves for failing to act and ways that could have averted the events or mitigated the circumstances of the event. Although many traumatized persons attempt to avoid distressing emotions related to their experiences, being able to confirm them will promote habituation, so that over time, their thoughts about and emotional responses to the event will become less disstressing[26].

It is very important to examine the interaction between the triggering trauma and the vulnerary ability and protective factors that will help people to cope and make them resilient to the effects of torture and trauma[27].

Obtaining accurate knowledge of traumatic event its impact, resulting symptoms and properly classifying them into a diagnostic category is fundamental for providing effective treatment and good therapeutic intervention.

There is a need to understand the psychological squeals of exposure to traumatic events among persons who had fought in or been the victims of war and violent conflict.

Clinical implications

It has already been documented that human-made/technological disasters may have different and more marked consequences than natural disasters.

The world today is plagued by terrorist attacks and numerous war zones. These are in addition to the natural catastrophes which occur from time to time. This calls for adequate preventive

measures like planning for disaster and attempts to de-escalate man made traumatic situations. The growing threat of terrorism worldwide has heightened our awareness of disasters as a potentially important determinant of population health and suggests a pressing need both to identify key areas of consensus in post-disaster research and to highlight areas that require additional study[28]

Limitations

The study lacked prospective pre-disaster data for measuring change after the bombing. However, pre-disaster data are virtually never available in disaster studies, and identifying uncontaminated but similar comparison groups is fraught with difficulty in disaster research.[29]Advances in research methods may allow future studies to overcome the difficulties encountered in this line of enquiry, enabling them to generate reliable pre-disaster data, comparison data and experimental data to address causal relationships[30].

REFERENCES

1. **Internally displaced person from Wikipedia,** the free encyclopedia http://en.wikipedia.org/wiki/Internally_displaced_person#Definition viewed on 17.11.09

2. **Internally displaced person** - Definition and Overview. worldiQ. http://www.wordiq.com/definition/Internally_displaced_person viewed on 15.11.09

3. **IDMC (April 2006) (PDF).** Geneva: Internal Displacement Monitoring Centre, Norwegian Refugee Council. http://www.interndisplacement.org/.p. 6

4. **Thapa SB, Hauff E.** Psychological distress among displaced persons during an armed conflict in Nepal. Soc Psychiatry Psychiatr Epidemiol (2005) 40: 672–679

5. **Pakistan, Displacement ongoing in a number of regions**. A profile of the internal displacement situation 15 May, 2008. Internal Displacement Monitoring Centre, Norwegian Refugee Council Chemin de Balexert 7-9 1219 Geneva, Switzerland idmc@nrc.ch, www.internal-displacement.org : 6

6. **Yehuda R.** Post-traumatic stress disorder. (Review Article) N Engl J Med, Vol. 346, No. 2; 2002: 108-114.

7. **Halepota A, Wasif S**. Hopkins Symptoms Checklist 25 (HSCL-25) Urdu translation: an instrument for detecting anxiety and depression in torture and trauma victims. J Pak Med Assoc Jul 2001;51(7):255-7.

8. **Carballo M, Smajkic A, Zeric D, Dzidowska M, Gebre-medhin J and Halem JV.** Mental health and coping in a war situation: the case of Bosnia and Herzegovina Journal of Biosocial Science, Volume 36, Issue 04, Jul 2004, pp 463-477 doi: DOI:10.1017/S0021932004006753 (About doi), Published online by Cambridge University Press 23 Jun 2004

9. **Veijola J, Jokelainen J, Läksy K, Kantojärvi L, Kokkonen P, Järvelin MR, Joukamaa M.** The Hopkins Symptom Checklist-25 in screening DSM-III-R axis-I disorders. Nord J Psychiatry. 2003;57(2):119-23.

10. **Wasif SA, Faruqui RA, Naqvi H, Ahmed SA**. Psychological morbidity in a group of journalists after six weeks of a bomb blast in Karachi. JPPS 2007; 4(2): 115.

11. **Cardozo BL, Bilukha OO, Crawford CAG, Shaikh I, Wolfe MI, Gerber ML, Anderson M.** Mental Health, Social Functioning, and Disability in Postwar Afghanistan. JAMA. 2004;292:575-584.

12. **Tucker P, Pfefferbaum B, Nixon SJ, Dickson** W. Predictors of Post Traumatic Stress symptoms in Oklahoma City: Exposure , social support , peri truamtic responses. The Journal of behavioral health services and Research,27:4 November 2000.406-416.

13. **Tylor AJW, Frazer AG:** The stress of post disorder body handling and victim identification work. Journal of human stress.1982.4-12.

14. **Bolin RC;** Long-term Family Recovery from Disaster. Denver, CO, University of Colorado: Press.1982.

15. **Glesser GC, Green BL, Winget C:** Prolonged Psychological Effects of Disaster: A Study of Buffalo Creek. New York: academic Press 1985.

16. **North CS, Nixon SJ, Shariat S et al** : Psychiatric disorders among survivors of Oklahoma City Bombing. Journal of the American Medical Association 1999;282: 755-762.

17. **North CS, Smith EM, Spitznagel EL**: Post Traumatic Stress Disorder in survivors of a mass shooting . American Journal of Psychiatry 1994;151: 82-88.

18. **Lopez-Iba JJJ, Soria J, Canas F et al** Psychopathological aspects of toxic oil syndrome catastrophe. British Journal of Psychiatry 1985; 147: 352-365.

19. **Soloman SD, Smith EM, Robin LN et al**. Social involvement as a mediator of disaster- induced-stress. Journal of applied Social Psychology, 1997; 17: 1092-1112.

20. **Bennet G:** controlled survey of effects on health of local

community disaster. British Medical Journal 1970;3:454-458.

21. **Chaudhri MA, Ahmad M, Jehangir S.** Pattern of somatization in depression. Pak Armed forces Medical journal 1994; 44(1):89-91.

22. **Tabassum R, Macaskill A, Ahmad I**. Attitude towards mental health in urban Pakistani community in the United Kingdom. International journal of social Psychiatry 2000;46:170-175.

23. **Ali W.** Gender and Depression. Journal of College of Physician and Surgeons of Pakistan. Special Issue. Vol.11(4): 260-262.

24. **Mc Pherson D, Anxiety Disorder in : Tylor RD ed**. Family Medicine. Principles and Practice. 6th edition. New York: Springer. 2003.2085-8.

25. **Grinage BD:** Diagnosis of Post traumatic Stress Disorder. A peer review. Journal of American Academy of Family Physician. December 15.2003:1-10

26. **Foa EB, Steketee G, Rothbaum BO**. Behavioral/ cognitive conceptualizations of post-traumatic stress disorder. Behavior Therapy 1989;20:155-76.

27. **McFarlane AC.** The Aetiology of Post-traumatic Stress Disorders. Following a Natural Disaster. British Journal of Psychiatry (1988), 152, 116-121.

28. **Galea S, Vlahov D, Resnick H, et al**. An investigation of the psychological effects of the September 11, 2001, attacks on New York City: developing implementing research in the acute post disaster period. CNS Spectr 2002; 7:585–7.

29. **North,C. S. & Pfefferbaum, B. (2002)** Research on the mental health effects of terrorism. JAMA, 288,633-636.

30. **North CS, Pfefferbaum, B, Narayanan P, Thielman PS et al** . Comparison of post-disaster psychiatric disorders after terrorist bombings in Nairobi and Oklahoma City ,British Journal of Psychiatry (2005) , 1 8 6 , 4 8 7 - 4 9 3

PREVIOUS RELATED STUDY

Shahida Shaikh, Saleem Akhtar Shaikh, Inayat Magsi, VAGINAL DISCHARGE; SYNDROMIC MANAGEMENT AMONG INTERNALLY DISPLACED WOMEN LIVING IN CAMPS AT LARKANA (Original) Prof Med Jour 18(4) 598-603 Oct, Nov, Dec 2011.

AUTHORSHIP AND CONTRIBUTION DECLARATION

Sr. #	Author-s Full Name	Contribution to the paper	Author=s Signature
1	Dr. Wajid Ali Akhunzada	Original researcher, data collection and article writing	Wajid
2	Dr. Altaf Qadir	Literature review	Altaf
3	Dr. Niaz Maqsood	Statistical analysis	Niaz
4	Dr. Ghulam Rasool	Reference citation and formulation	Ghulam Rasool
5	Dr. Raza Ur Rahman	Manuscript writing	Raza