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REVIEW

Forced migration and mental health: prolonged internal displacement, return migration and resilience

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Forced internal displacement has been rising steadily, mainly due to conflict. Many internally displaced people (IDP) experience prolonged displacement. Global research evidence suggests that many of these IDP are at high risk for developing mental disorders, adding weight to the global burden of disease. However, individual and community resilience may act as protective factors. Return migration may be an option for some IDP populations, especially when conflicts end, although return migration may itself be associated with worse mental health. Limited evidence is available on effects of resettlement or return migration following prolonged forced internal displacement on mental health. Also, the role of resilience factors remains to be clarified following situations of prolonged displacement. The public health impact of internal displacement is not clearly understood. Epidemiological and interventional research in IDP mental health needs to look beyond medicalised models and encompass broader social and cultural aspects. The resilience factor should be integrated and explored more in mental health research among IDP and a clearly focused multidisciplinary approach is advocated.

Keywords: Internal displacement, Return migration, Mental health, Resilience, Public health

Forced internal displacement

Facts and definitions

Displacement of people can be of a voluntary or forced nature. Displacement can also be external (e.g. refugees, economic migrants across national borders) or internal (e.g. internally displaced people [IDP], or rural-urban migrants within national borders). Both external and internal displacement is rising across the world, particularly due to conflicts and natural disasters, but also related to socio-economic factors.[1,2] The Internal Displacement Monitoring Centre (IDMC) estimates that currently around 27 million people are internally displaced in the world.[3] Refugees and asylum seekers have also increased in numbers in the past decades; however, forced internal migration or displacement, especially due to conflict, is seen to have more detrimental effects on populations in the health and socio-economic-cultural domains.[4]

Forced external migrants or refugees and asylum seekers are, to a somewhat limited extent, protected by international refugee laws.[2,5] Forced internal migrants or IDP are not protected by these laws as they are displaced within nation boundaries. This may prevent IDP receiving substantial aid and services, increasing vulnerability, even though the reason for displacement and problems encountered are often similar to those experienced by refugees.[4] With this background, the concept of the 'internally displaced person' is critical. There are varying definitions applied to groups of displaced people in the literature.[2] The UN Office for Humanitarian Affairs (OCHA)-led Guiding Principles of Internal Displacement define IDP as 'persons who are forced to flee their habitual residence due to conflict or disaster, and who have not crossed a recognised international state border'.[6]

The definition of 'IDP' has grown from the initial framework proposed in 1992 by the UN to encompass various situations that could cause internal displacement of individuals/populations, including not only conflict or violence but also events such as natural disasters, human rights violations or government-sanctioned development-driven displacement.[4] Although there are currently two main approaches followed by the United Nations High Commissioner for Refugees (UNHCR) and International Committee of Red Cross (ICRC) in managing IDP issues, the 'Guiding Principles on Internal Displacement', first introduced in 1998, acts as the core document.[6] Mooney further considered the debate among humanitarian and academic groups about whether the special status or definition for IDP is warranted (as there are numerous vulnerable groups warranting special attention).[4] However, evidence from global situations of forced internal displacement shows that IDP warrant a special status as a separate group with increased vulnerability and at risk for mental and physical health problems.[2,7]

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Prolonged internal displacement

Displacement, as a process, involves several phases and components broadly categorised as pre-flight, flight and post-flight/re-settlement.[2,8] The pre-flight phase involves the health status and socio-economic status of the displaced person while the flight phase involves the trigger event for displacement, usually with some level of trauma.[2] Extensive international research has been conducted into these phases, especially focusing on the health of those displaced.[9] In most situations investigated, the forced displacement has been due to conflict and mainly involves non-combatant, civilian populations.[10] Many IDP have undergone psychological and physical trauma before and/or during their displacement ordeal. However, some IDP/populations will have had pre-existing vulnerabilities (socio-economic, health-related) that may act as mediating or precursor factors in developing psychopathology subsequent to traumatic displacement.[2,11]

Forced internal displacement may end quickly or last generations, depending on the pre-flight cause.[4] There is no current agreement about the facts defining an end to the status of 'internally displaced person', which is compounded by the lack of legal status embedded within the IDP 'definition'.[12] A prolonged post-flight phase (i.e. a lengthy displacement period) can have detrimental impacts on physical and mental health,[11] and may itself be due to perpetuation of the displacement-precipitating event (e.g. ongoing conflict) due to a lack of a sustainable political solution, of initiative from stakeholders (e.g. government) or of attention/capacity from those responsible for providing solutions to IDP (e.g. governments and international agencies).

The post-flight phase of displacement, if prolonged and accompanied by continuing and/or increased adversity, is likely to become conducive to the development of mental disorders. The 'IDP label' stigma, lack of adequate health care/finances/education, broken social networks, co-morbid physical disorders, pre-existing psychopathology, displacement trauma and disintegrated sense of hope for a future, among many other reasons, can all increase risk of mental disorder. However, little attention has been given to the effects of prolonged displacement on mental health.[13,14]

Mental health impact of forced displacement

Adverse impacts of migration on mental health are well-established and are compounded in these situations by the traumatic events typically precipitating migration, as well as by the social disadvantages which follow.[15] Causation may be complex due to pre-migration health and social environment, varied nature of stressors (e.g. conflict exposure) giving rise to migration, the stress of the migration episode itself, and that arising from the post-migration environment.[11] Even after displacement, IDPs continue to face substantial stressors, such as problems with food, shelter, education, healthcare, finances, employment and discrimination which may become perpetuating factors for mental disorders.[16,17] It is highly likely that the risk of developing mental disorders such as depression, anxiety, post-traumatic stress disorder (PTSD) and psychoses are greater among displaced populations than that of stable populations.[18]

Porter and Haslam explored pre-displacement and post-displacement factors associated with the mental health of refugees and IDP in a meta-analytic review.[11] Using a world-wide sample, they examined potential short and long term factors including type of accommodation during displacement, post-displacement economic opportunities, cultural access, conflict status, age and gender differences, pre-displacement urban-rural residence and other socio-economic characteristics. The study found that all these factors were associated with mental health outcomes to a moderate extent, but concluded that development of psychopathology among refugees and IDP was not wholly accounted for by exposure to a traumatic experience such as conflict and related unavoidable post-traumatic sequel, but instead involved a wider interaction of contextual factors.[11]

The authors also raised an important point of debate about modalities of research conducted on mental health of refugees and IDP. The common model is focused on the theory of life events, where psychopathology develops as a result of exposure to acute stressors such as conflict, and many studies conducted on IDP have focused on this model.[8,11] Studies among IDP have mainly focused on PTSD, potentially neglecting other mental disorders.[8] Research has established a dose-response relationship between trauma exposure and PTSD.[1] However, as pointed out by Porter and Haslam, IDP experiences may be based on different contextual and periodic dimensions, which in turn may affect the development of psychopathology beyond post-traumatic reactions.[11] The western model of medicalisation of adverse experiences such as forced displacement has also given rise to the 'trauma model', where vulnerability is given more emphasis than resilience.[19] All these are important in developing a broader and deeper understanding of complex mental health problems faced by IDP.

A study conducted in northern Uganda found that social determinants play an important role in health outcomes among IDP.[20] Traumatic events, overcrowding in displacement and poverty were found to affect the mental health of IDP while political, environmental and socio-cultural determinants were found to have associations with development of psychopathology. In a separate study, Roberts et al. found a strong association of frequency and type of trauma with worse outcomes especially in mental health.[21] A study among conflict-affected IDP in Sri Lanka reported relatively high prevalence rates (compared to national averages) of mental health symptoms and associations with underlying trauma.[22] Betancourt and Khan found evidence that, although children are more vulnerable to developing psychopathology after exposure to forced displacement, they may also fare better on long term outcomes.[23] A study conducted by Kuwert et al., among older survivors of World War II, found that forced displacement was significantly associated with increased anxiety and decreased life satisfaction, even after 60 years.[24] Other studies have found that IDP experience higher numbers of traumatic events over longer time periods than cross-border refugees, therefore increasing their vulnerability.[25]

However, a striking feature of forced and traumatised migratory populations is the fact that many, possibly the majority, do not develop mental disorders, despite the higher than average risk.[15,26] Factors preventing the development of mental disorders among IDP encompassed within 'resilience' as a concept (discussed later in this paper) are likely to be many and varied

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including an individual's pattern of responding to stress (possibly influenced by earlier exposures or quality of key relationships) and the level of social support around the stressful period.[15,27] These factors may not be independent and may co-exist in the pre and post displacement periods; furthermore, they may have an impact on migration, acculturation and alienation processes.[15] Individual resilience and beneficial social networks and environments may have important buffering effects on risk of disorder.[27]

Return migration and mental health

Limited evidence is available on the effects on mental health of resettlement or return migration following forced internal displacement.[1] The two possible outcomes after displacement are either a return to the area of origin or resettlement in a different area (which may be an area to which they migrated in the flight phase itself).[4] Both these outcomes may depend on the choices made by the IDP. The return/resettling may be voluntary or imposed.[28] Studies conducted among conflict-affected populations show that security, livelihood, past conflict impact and availability of services play a role in the return migration process.[28]

Return migration to areas of origin may itself become a complicated and traumatising event, especially after prolonged displacement. Social and cultural links established with the host community may be broken and compromised, over-optimistic expectations in original migrants about returning 'home' may not be met, and generations born in displacement may be adversely affected by moving to an unfamiliar place. Also, trauma experienced during the displacement (flight phase) may be revisited in the minds of IDP when they move back to areas of origin, prompting potential re-traumatisation.[1] Conditions experienced while in displacement may also contribute negatively to the health status of returning IDP, and increase risk of chronic health problems.[29]

Prolonged displacement may be also associated with positive mental health outcomes.[28,29] Studies among refugees resettled in a host country have shown that, in the longer-term, these populations have decreased risk of mental disorders.[14] Resettling in a different country (external displacement) has been shown to be associated with better mental health among women.[30] The feeling of hope, sense of belonging and a chance to rebuild the lost livelihoods may support the adjustment and recovery process, and lead to increased post traumatic growth of the returnees.[31]

Most IDP are located in countries with extremely limited resources and resettling in areas of origin for them may actually mean moving into an area with socio-economic challenges compared to a relatively better area that they were living while in displacement.[29] In contrast to refugees, who may be able to live in a relatively resource-rich, peaceful environment in a host country, IDP may face increased levels of daily stressors and difficult experiences when they return to areas of origin. This may increase their risk of developing mental disorders. As mentioned before, the dearth of research evidence prevents the formulation of a clear picture about return migration impact on mental health of IDP. It remains to be seen what factors may promote adjustment and recovery, and what protective factors may be associated with better mental health outcomes among returned IDP.

Resilience and the mental health impact of displacement

The concept of 'resilience' has been associated with mental health for quite some time, principally seeking to describe positive associations that promote coping and adaptive abilities in the face of adversity among individuals and communities.[7] Researchers have used methodological approaches such as harm-reduction, protection and promotion in conducting resilience related mental health research.[32] Bonano described resilience as the ability to cope with loss and trauma, and as distinct from the recovery process.[33] Resilience has been described in terms of traumatised populations resisting the development of psychopathology in various settings.[32] Although resilience is likely to be important in determining outcomes among traumatised populations such as IDP, playing a key role in associations with mental ill health, the effects of individual and collective (social) resilience have not been fully investigated.[7,33] The resilience concept can be a useful tool to identify and prevent mental disorders and to develop effective interventions among high-risk populations such as IDP. However, Davydov et al., argue that the concept applied in mental health research is limited by non-uniformity and lack of definition.[32]

A study conducted among Congolese adolescents affected by forced displacement showed that despite earlier trauma, mental health outcomes can be improved with a concrete end to displacement and are linked to resilience related attributes such as coping.[1] A qualitative study of coping and resilience among Sudanese refugees found that religion, wider social support and individual qualities such as positive or negative coping response to adverse events and comparison to others had effects on improved recovery after traumatic experiences.[34] Using mixed methods to study the role of resilience in mental health outcomes in a sample of Eritrean mothers, Almedom et al., suggested that prolonged displacement and continued adversity had a negative impact on resilience, especially in women.[7] Furthermore, they presented evidence that social support and collective resilience might aid the recovery process from trauma. On the other hand, Kuwert et al. found that forced displacement was significantly associated with lower resilience later on in an older World War II sample.[24] Both Eritrean and European studies have found evidence that prolonged displacement may precipitate a decrease in resilience among forcefully displaced people.[7,24] However, Melis et al. found that adolescents had increased resilience to psychopathology once the displacement ordeal ended.[1] Increased resilience has been shown in refugee adolescents with a longer duration of living in a host country.[35] The negative effects of duration of displacement on resilience may be linked to development of mental disorders in the long-term aftermath of forced displacement.

Limited evidence is available on resilience in relation to return migration. Although resilience levels have been shown to decrease with longer duration of displacement, resilience may play an important role in re-adaptation during the return migration process. As discussed before, daily stressors encountered by the returning IDP may precipitate the possibility of concurrent

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development of mental illness or exacerbation of already existing disorders. Individual and collective community resilience may act as protective factors in such situations.[31] Again, it stands to be seen how resilience may be associated with returning IDP affected by prolonged forced displacement.

Public health and forced displacement

Internal displacement raises important, albeit complex, public mental health issues.[36] The global burden on public health due to internal displacement and associated social, economic, health and other issues are not clearly understood. Current evidence through epidemiological and other research is inadequate and limited, with their practical relevance, more often than not questioned.[14] Mental health among IDP is highly important and requires specific interventions and management due to the sensitivity and nature of the population.[37] Epidemiological and interventional research in mental health among IDP needs to be broadened from a medicalised model of adversity/trauma-related outcomes to encompass social and cultural aspects (including resilience) that may play key roles in mental health outcomes in these populations.[1,8,19,14]

Substantial policy implications on IDP management can result from interventional and epidemiological studies aimed at understanding and reducing the risk of mental disorders due to forced migration.[8,14] Little is known in the global context about factors which predict the likelihood of forcefully displaced persons taking up return migration; in particular, in a rapidly changing world where the ability to migrate may have substantial social and economic benefits, it is important to establish whether factors exist which may prevent such return migration and the effects on mental health.[18,27] As forced internal displacement usually takes place in resource limited settings, it is important for multidisciplinary public health approaches to be considered when dealing with IDP, prolonged displacement and return migration related mental health issues. Capacity building among health professionals and researchers is equally important to overcome the significant barriers present in working with forcefully and long-term displaced groups or individuals.[14,38]

Conclusion

In this paper, we have explored forced and prolonged internal displacement, return migration, mental health and association with resilience of IDP. Clear evidence has emerged of the lack of adequate information about the impact of prolonged forced displacement on the mental health of the displaced populations. Furthermore, we argue that the resilience factor should be explored more in epidemiological and interventional mental health research among these populations. We advocate a clearly focused multidisciplinary approach on issues faced by global IDP communities with an emphasis on reducing the public health burden on existing fragile infrastructure and resource systems. Return migration of IDP communities should be paid more attention in order to facilitate effective and seamless resettlement process, and reduce re-traumatising the traumatised.

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