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An Assessment of Symptoms Distress among Internally Displaced Persons

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Abstract

Internal displacement is fast becoming a National crisis and many scholars have studied its political and social implications. The extent of symptom distress experienced by internally displaced persons is the focus of the current paper. The humanistic and existential theories capture the most probable explanation for experience of distress among internally displaced persons, since the incident of displacement is a stressful stimulus that may prelude development of rigid and distorted perspectives of the self and may make people to lose touch with their own values and needs. A total of 403 persons comprising of 230 females and 173 males, aged between 26 and 68 years, with a mean age of 37 and standard deviation of 9 participated in the study, which elicited the incidence of symptom distress among internally displaced persons. 203 of them (103 females and 100 males) were internally displaced persons, while 200 (100 females and 100 males) were normal residents. It was however hypothesized that a) There will be a correlation between internal displacement and symptom distress among internally displaced persons; b) There will be a significant difference between internally displaced persons and normal residents on the manifestation of each of the domains of symptom distress. The Symptom Distress Checklist was the main instrument for the study, which purposively chose participants from two cities of Awka and Onitsha. The inclusion criterion for IDPs was being literate, and having been living and working in the North for a minimum of 10years before the incident of displacement. T-test statistic was used to compare the IDPs and normal residents on symptom distress, while Multiple Regression Analysis was used to analyze the correlation between symptom distress and internal displacement. Results strongly suggest that IDPs suffer more distress than normal residents, while a strong correlation exists between symptom distress and internal displacement. It was therefore recommended that strong psychological support should be provided for them to avoid severe breakdown.

***Keywords**:* Internally Displaced Persons, Symptoms distress

Introduction

In Nigeria, internal displacement is a common consequence of inter-communal and political violence, flooding and forced evictions (IDMC, 2013). This implies that internal displacement of persons could be triggered by natural disasters or human-induced conflict which leads to violent clashes. Irrespective of the cause of displacement, the phenomenon always leaves negative socioeconomic marks on people affected. Internal displacement arise from violent clashes are victims of various kind of injustices or violence confrontations, perpetrated against them by their own government, or agents of communal clashes, riots, terrorism, natural disasters, religious conflicts, among others (Hamzat, 2013).A serious source of concern however lies with internal displacement of persons arising from human-induced violent clashes and conflicts in recent times.

The Internal Displacement Monitoring Center (IDMC) accounted that in 1982 only, 1.2 million people were IDPs in 11 countries; however, by 1995, there were 20 to 25 million in more than 40 countries, almost twice as many as refugees. At the end of 2008, there were 26 million people worldwide who had been internally displaced by conflict, general violence or violations of human rights. This figure rose to 27.1 million at the end of 2009 and 27.5 million at the end of 2010 (1DMC, 2009, 2010). The estimated figure at the end of 2012 was 28.8million indicating that additional 6.5 million people were newly displaced, nearly twice as many as the 3.5million during 2011 (IDMC, 2013).

However, the misery of displaced persons has in recent years become a formidable problem of global significance and implications (Ladan, 2001). In Nigeria, the causal factors of internally displacement of persons has been linked to many unfortunate developments over unfounded arguments on religious beliefs, under-development, poverty, unequal distribution of wealth, ethnic tensions, unemployment, political and economic subjugation of minorities, absence of democratic procedures, intolerance, and many other factors.

It worthy of note that the incidence of displacement exposes the displaced persons to emotional problems and other distresses (some of which can be clinically significant), which are characterized by memory of fearful events and nightmare, loss of livelihoods, frustrations, abuses, and threats of assaults (Durosaro & Ajiboye, 2011). Hence, this paper seeks to assess symptom distress among internally displaced persons.

Internal Displacement of Persons in Nigeria

Under the international law, internally displaced persons are persons or groups of persons who have been forced or obligated to flee or to have cause to leave their homes or place of habitual residence in particular, due to or in order to stave off the effect of armed conflict, violations of human rights, situations of generalized violence, natural or manmade disasters, to another place considered relatively safe either within their own national borders (Ladan, 2006).

Although internally displaced persons are often defined as those uprooted by conflict, human rights violations and natural or human-made disasters, Robinson (2003) expanded the scope to also include those displaced by development projects. Most times, the focus of sympathetic attention and international aid centre round those displaced by disaster rather than victims of development. In 2008, Centre on Housing Rights and Evictions and the Social and Economic Right Action Centre suggested that over 2 million people were forcibly evicted from their homes between 2000 and 2007 in cities such as Abuja, Port Harcourt and Lagos following government urban maintenance and or renewal programs (CHRESERAC, 2008).

In situations of armed conflict, IDPs, like any other person benefits from international humanitarian law and the legal protection of international human rights law. However, while they continue to benefit from all of the international human rights instruments and legal protection available to other persons, they are excluded from the specialized protection of international refugee law because they have not crossed an international border. Ibanez and Moya (2007) opined that the fact that they are displaced from their homes exposes them to a situation of vulnerability to poverty and human right abuses.

The full scope of displacement in Nigeria is unknown as there is limited capacity of the state to collect data and the complex nature of displacement patterns. IDMC (2013) observed that no comprehensive survey on internal displacement has been conducted and there are no mechanisms to monitor durable solutions. The available estimates only include people who have sought shelter at temporary IDP camps; whereas, most IDPs had reportedly preferred to seek shelter with relatives, rather than living in camps. The head of National Commission for Refugees, Migrants and Internally Displaced, Hajiya Hadiza Kangiwa estimated at the sensitization rally to commemorate 2013 World Refugees' Day that Nigeria currently has 4.4 million internally displaced people (NAN, 2013).

The cause of IDPs in Nigeria can be traced to many events and situations all across the nation. While some of the conflicts appear to be caused by religious or ethnic differences, gains from politics, social and economic nature are generally behind the violence in the country with increasing level of poverty, low levels of education and a host of youth population with feeling of alienation (Oduwole & Fadeyi, 2013). Nigeria has had cause to contend with the issues of internally displaced persons who were affected by disasters in different parts of the country. However, the number of the displaced induced by disasters far outweighed those from natural circumstances such as floods, landslides, ocean surges, fire, (Manzo, 2011).

Olagunju (2006) traced the numerous violent communal conflicts in Nigeria to mid-1960s when the Western Nigeria witnessed violent ethnic conflicts when the duo of Obafemi Awolowo and Ladoke Akintola, parted ways based on political differences. The event gave birth to a series of crises and clashes which led to a state of emergency being declared in the Region. The Northern Nigeria started witnessing crisis when Ahmadu Bello -an undisputedly most powerful politician in Nigeria in the early to mid-sixties, and leader of the ruling Northern Peoples' Congress in control of the Federal Government with headquarter in Lagos - was assassinated in the coup d'état of January 15, 1966.The failed coup d'état led by Kaduna Nzeogwu, a person of Ibo ethnic origin which is mostly located in Eastern Nigeria led to the civil war of 1967-1970, basically between the Ibo and the Hausa but with other ethnic groups in the federation fighting on the side of the Federal government, which was headed at that time by a Northerner - Yakubu Gowon. After the civil war, there was relative peace in the country until the 1990s.

Since Nigeria's return to civilian rule in 1999, records have it that thousands of people have been killed in recurring inter-communal conflicts and politically motivated violence that have also led to consistently large waves of internal displacement (IDMC, 2013). According to Bamidele (2012), the widely held view by experts is that the politicization of religion and ethnicity in Nigeria has been responsible for the formation of groups such as the Oduduwa Peoples' Congress (OPC), Egbesu, the Movement for the Actualization of the Sovereign State of Biafra (MASSOB), Arewa Peoples' Congress (APC), the Bakassi Boys, Igbo Youth Congress (IYC), Igbo Peoples' Congress (IPC), Niger Delta Volunteer Force (NDVF), Niger Delta Resistant Movement (NDRM),Movement for the Survival of the Izon Nationality of the Niger Delta (MOSIEND), the Nigerian or YobeTaliban, Movement for the Emancipation of the Niger Delta (MEND), Jama'at Ahlus al-Sunnah Liddawati Wal-Jihad or better known as *Boko Haram.*

The activities of these groups as at one time or the other contributed to increasing number of internally displaced persons in Nigeria. Notable among these groups is *Boko Haram* which has its base in North-Eastern Nigeria. IDMC (2013) reported that increased violence by the radical Islamistgroup *Boko Haram*, inter-communal violence between Muslims and Christians and clashes between farmers and pastoralists led to burgeoning human displacement. Although, Nigerian government is yet to compile reliable figures of the displaced, not less 63,000 people were documented as newly displaced by violence.

Terrorism, whether domestic or transnational has a devastating effects. For instance, Oriakhi and Osemwengie, (2012)observed that attacks from Islamic sect - *Boko Haram*- menace in Nigeria has led to loss of

many lives, destruction of properties worth billions of Naira, severe damaged to infrastructure, loss of investment and income to mention but a few.

Symptom Distress

Symptom distress on the other hand refers to those symptoms that cause mental, emotional and physical pain (Susan, 2005). This differs from psychopathology in that it connotes a wider variety of disorders, ranging from those that cause mild distress to those that severely impair a person's ability to function (Cohen, & Kleinman, 2009).

In their work titled Symptom Distress Checklist, Derogatis, Lipman and Covi (1977) view symptom distress as those symptoms associated with distress among psychiatric outpatients and with the experience of anguish arising from the problems of living among people in the general population. They also refer to it as a measure of several manifestations of distress/symptoms in 10 primary categories or domains, which include: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Phobic Anxiety, Hostility, Paranoid Ideation, Psychoticism, and Neuroticism.

Somatization, the first domain in the Symptom Distress is defined by (Lipowsk, 1988) as the propensity of a patient to experience and report physical/somatic symptoms that have no pathophysiological explanation, to misattribute them to disease and to seek medical attention for them. According to Derogatis, Lipman and Covi (1977), somatization is characterized by bodily pains, discomfort, and dysfunction, thus somatizing patients are not feigning symptoms, and somatization is distinct from factitious disorder and malingering. In addition, misattribution of symptoms to somatic disease may result in, or arise out of, the belief that disease is present; hence there is an ample opportunity for misattribution (Egan & Beston, 1987). As such, neuropsychological testing has shown that somatization is associated with information-processing deficits (Rief & Nanke, 1999).

Alexithymia meaning "being without word to describe emotions" has been described as an important factor in somatization (Sifness, 1996) and it is proposed that in the absence of the ability to describe emotions, individuals respond to stressful life situations in a maladaptive way and one of these, is to express emotional distress as physical symptoms. Alexithymic individuals focus on facts, details, and external events and tend to have a limited fantasy life. Additionally, factor including education and cultural sub-culture (e.g. macho males) also play a part in somatization and intelligence is negatively associated with the number of functional somatic symptoms reported (Kingma, 2009).

Obsessive-Compulsive, the second domain in the Symptom Distress, is a type of anxiety disorder in which people suffer from recurrent, unwanted thoughts or ideas (obsessions); engage in repetitive, irrational behaviours or mental acts (compulsion) or both (National Institute of Mental Health 2006). Obsessive-Compulsive disorder is said to be accompanied with irresistible thoughts, impulses, and actions (Derogans et al., 1977) and current research opined that among people with Obsessive-Compulsive disorder, carrying out compulsive behavior tends to ease feelings of anxiety while repressing compulsive behavior causes stress.

According to the National Institute of Mental Health, Obsessive-Compulsive disorder affects about 2.3% of the United States population age 18 to 54 years (i.e., approximately 3.3 million Americans). An additional 1 million children and adolescents have the disorder. The condition typically begins during early childhood or adolescence and affects men and women equally (National Institute of Mental Health, 2006). In addition, up to two-thirds of people with Obsessive-Compulsive disorder suffer from additional psychiatric conditions. These conditions, including depression, eating disorders, personality disorder, attention deficit disorder, and other anxiety disorders (e.g., social phobia and separation anxiety disorder) can make it difficult for physicians to diagnose and treat Obsessive-Compulsive disorder due to overlapping symptoms. Of these additional conditions, major depressive disorder appears to be the most common, affecting up to 55% of Obsessive-Compulsive disorder patients. Bipolar disorder affects as many as 30% of Obsessive-Compulsive disorder patients, while social phobia impacts 23% (Cosoff, 1998).

A clinical diagnosis of the disorder requires that the behaviors be extreme enough to interfere with everyday activities (take more than one hour per day) or significantly interfere with a person's relationships, health, social functioning, or occupational functioning. For example, up to 70% of people report problems with family relationships, and more than half report interference with social and work relationships (Koran, 2000; Hollander, 1997; Koran, 1996; Calvocoressi 1995). As a result, most people with Obsessive-Compulsive disorder struggle to rid themselves of obsessive thoughts and stop compulsive behaviors.

Interpersonal sensitivity (IPS), the third domain in the Symptom Distress, is a term describing the ability to sense, perceive accurately, and respond appropriately to one's personal, interpersonal, and social environment (Bernieri, 2001). The information used to achieve interpersonal sensitivity includes verbal and nonverbal cues exposed through expressive behavior. Nonverbal cues include any detectable signal that has meaning but is not explicitly stated. For example, facial expressions, body language, and vocal intonations are considered nonverbal cues. As a multifaceted construct, interpersonal sensitivity consists of a variety of skills, capabilities, and incentives that vary across individuals and contexts. Moreover, it is likely that multiple situational variables, including cognitive resources, emotional states, and motivation level influence how well an individual can detect nonverbal

cues. Hence, interpersonal Sensitivity or interpersonal accuracy is the ability to assess another's states and traits correctly (Hall & Bernieri, 2001).

In their work, Hall, Andrzejewski and Yopchick (2009) distinguished between attentional accuracy, which is paying attention to the social interaction partner's cues (i.e., remembering others' verbal, nonverbal, and appearance cues); and inferential accuracy, which is the correct interpretation of perceived cues. This distinction corresponds to detection and utilization in the realistic accuracy model of personality. Attentional accuracy has been operationalized by accurate recall of others' verbal messages or of others' nonverbal cues and of others' appearance (SchmidMast & Hall, 2006). Research on inferential accuracy has shown that people are able to correctly infer other people's emotions (Ickes 2003; Matsumoto, 2000), motives and thoughts (Ickes, 2003); others' personality traits (Murphy, Hall& Colvin, 2003); and the type of interpersonal relationship in which two or more persons are involved (SchmidMast & Hall, 2004). As in the realistic accuracy model of personality, the attentional part of interpersonal sensitivity is a precursor to being able to draw accurate inferences. Thus, the concept of interpersonal sensitivity is defined as being attuned to and correctly inferring another person's states and traits (Bernieri, 1994).

Depression, the fourth domain in the Symptom Distress, is defined as a disturbance in mood, thought, and body, characterized by varying degrees of sadness, disappointment, loneliness, hopelessness, self-doubt, and guilt. According to Derogans et al., (1977), depression is a mood disorder characterized by loss of vital energy, interest, and motivation. This implies that the concept of depression includes a wide range of symptoms including normal feelings of depressed mood that affects almost everyone from time to time, to more severe depressive states that meet diagnostic criteria for a depressive disorder.

Furthermore, depression shows high rate of relapse and chronicity as reported in several studies (Paykel, 1992). Specifically, research indicates that about 50% of those who experienced one depressive episode will be depressed again within one year and about 70% within two years. Thus, depression is a complex disorder with a multi-factorial genesis. It is well established in the study conducted by Research Agenda for Psychosocial and Behavioural Factors in Women's Health (1996) that depression is approximately twice as common in women as in men and that it affects people of all ages. Hence, depression has been called the most significant mental health risk for women, especially young women of child bearing and childrearing age. Moreover, genetics, adverse events in childhood, as well as other stressful events later in life are well documented risk factors for depression (Kendler, Karkowski & Prescott, 1999).

Anxiety, the fifth domain in the Symptom Distress, is defined as an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure. This is also marked with restlessness, nervousness, and tension (Derogatis et., al 1977). Feelings of anxiety affect almost everybody from time to time and may be regarded as a normal part of human life. To consider anxiety as an illness, distress and impaired function should also be present.

As is true for depression, anxiety disorders are more common in females and risk factors for developing the disorder are similar to those of depression. Also, anxiety disorders are strongly associated with depressive illness (Kessler, 1995), and research suggests that an anxiety disorder may precede and increase the risk for developing depression (Bittner, 2004).

Hostility, the sixth domain in Symptom Distress, is defined by Matthews (1984) as a multidimensional construct that is thought to have cognitive, affective, and behavioral components. By extension, the cognitive component is defined as negative beliefs about and attitudes toward others, including cynicism and mistrust. The affective component typically labeled as anger refers to an unpleasant emotion ranging from irritation to rage and can be assessed with regard to frequency, intensity, and target. The behavioral component is thought to result from the attitudinal and affective component and is an action intending to harm others, either verbally or physically (Matthews, Jamison & Cottington, 1982). In addition, scholars such as Derogans, Lipma and Covi (1997) viewed hostility as a feeling of anger, hatred, repression and unfriendliness.

In psychological terms, Kelly in his model defined hostility as the willful refusal to accept evidence that one's perceptions of the world are in some way out of alignment with current objective reality. Thus instead of realigning one's feelings and thoughts with objective reality, the hostile person attempts to force or coerce the world to fit their view, even if this is a forlorn hope, and even if it entails emotional expenditure and/or harm to self or others. In this sense, hostility is a form of psychological extortion - an attempt to force reality to produce the desired feedback, even by acting out in bullying by individuals and groups in various social contexts, in order that preconceptions become ever more widely validated. In this sense, hostility is an alternative response to cognitive dissonance.

However, hostility is often confused with anger, and although closely related, they are not identical concepts. Hostility is often defined as a personality characteristic of having a rather stable attitude of ill will and negative evaluation of people and events. Anger, on the other hand, is often described as an emotion evoked when a person is blocked in the attainment of a goal or in the fulfillment of a need (Mendes de Leon & Meesters, 1991). Therefore, hostility is seen as a multifaceted phenomenon that includes cognitive, affective, and behavioral manifestations (Siegman, 1994).

Phobic anxiety the seventh domain in the Symptom Distress is defined as intense, irrational fear of specific objects or situations that cannot be voluntarily controlled or reasoned away and that lead to avoidance of phobic situation (Marks, 1989). This is also said to be associated with irrational fear and avoidance of objects, places, and

situations (Derogans et al., 1977). Therefore, phobias often appear peculiarly dissociated from the intentional verbal-cognitive control that typically is held to characterize normal psychological functioning.

To capture this aspect of phobia, psychoanalysts have interpreted them as unconscious way of coping with anxiety. By investigating the unconsciously originated anxiety in a symbolically related external object, which can be avoided, it is assumed that the ego can be saved from manifest anxiety. An alternative contemporary perspective anchors irrational fears in early, automatic information-processing mechanisms that are inaccessible to intentional control. For example (Ohman & Soares, 1993) has proposed that preattentive, automatic analysis of some types of emotional relevant stimuli is sufficient to activate components of a phobic reaction such as autonomic responses. These preattentive stimuli analysis mechanisms are unconscious both in the sense that they work outside of the focus of attention and that they are inaccessible to introspection and verbal report. This implies that important components of phobic responses are set in motion before the phobic stimulus is represented in awareness as the subject consciously identifies what he or she is reacting to. Therefore, conscious perception of the phobic stimulus occurs against a background of rising physiological activation that is likely to feed back to the stimulus appraisal process, further enhancing the fear. Thus, phobia may appear to be involuntary and irrational because the fear response is initiated before conscious, intentionally controlled processes come into play.

Paranoid ideation, the eighth domain in the Symptom Distress, is defined by Colby (1981) as persecutory delusions and false beliefs whose propositional content clusters around ideas of being harassed, threatened, and harmed, subjugated, persecuted, accused, mistreated wrong, tormented, disparaged, vilified and so on, by malevolent others, specific individuals or groups. In their work (Derogatis et., al 1977) asserted that paranoid ideation is associated with suspiciousness, distrustfulness and blaming others. In addition, Morey (1991), proposed that paranoid ideation is characterized by intense, irrational mistrust and suspicion, resentment, hypervigilance, persecutory delusion as well as hostility. Freeman and Garety, (2004) added that this anxiety leads towards a sense of resentment for others.

However, persons with paranoid ideation and/or persecutory delusions due to their distinct cognitions and beliefs are reported to have numerous distinct information processing style characterized by less information seeking before making judgments (Garety, Hemsley, & Wessely, 1991); selective attention to threats and jumping to conclusion; better memory for threatening words (Bentall, kaney& Bowen-Jones, 1995); self-consciousness (Fenigstein & Vanable, 1992) and else, and thus are subjected to frequent research.

Psychoticism, the ninth domain in Symptom Distress, is defined by (Derogatis et al., 1977) as a personality dimension that is associated with hallucination, delusions, and externally manipulated thoughts. This also refers to a personality pattern typified by aggressiveness and interpersonal hostility.

According to Eysenck (1985), psychoticism can be conceived as a set of correlated behaviour variables indictive of predisposition to psychotic breakdown, demonstrable as a continuous variable in the normal population and independent of Extraversion and Neuroticism. However, in the Eysenckian personality scheme (Eysenck & Eysenck, 1985), psychoticism constitutes the third personality dimension, orthogonal to extraversion and neuroticism. It is conceptualized as a continuum of liability to psychosis (principally schizophrenia and bipolar affective disorder) with "psychopathy" (i.e., antisocial behavior) defined as "a halfway stage towards psychosis". Thus, schizophrenics, bipolars, and psychopaths are viewed by as being different only in degree, rather than qualitatively, from normals, with the single personality dimension of psychoticism differentiating normals from psychopaths (intermediate in psychoticism) and from schizophrenics and bipolars (extreme in psychoticism). Self-report questionnaire scales have been developed (Eysenck, &Eysenck, 1985), including a children's version that attempt to measure psychoticism. High scorers on the Psychoticism (P) scale are conceptualized as "cold, impersonal, lacking in sympathy, unfriendly, untrustful, odd, unemotional, unhelpful, antisocial, lacking in insight, strange, with paranoid ideas that people were against him".

Neuroticism, the tenth domain in the Symptom Distress, derives from the word ‘neurosis’ introduced by the Scottish physician William Cullen in 1769 to refer to disorders of sense and motion caused by a general affection of the nervous system. This is consistent with the view that individual differences in neuroticism represent differences in mental noise “operationalized as reaction time standard deviations” (Robinson & Tamir, 2005). This is also viewed by (Derogatis, et. al. 1977), as a state characterized by poor sleep and appetite, and feeling of unwellness.

In Eysenck’s (1990) PEN model, neuroticism has been related to activation thresholds in the sympathetic nervous system or brain regions that govern fight-or-flight responses when confronted with danger. This perspective has received ample support from research on individual differences in the responsiveness of the avoidance (vs. approach) system. In their view, Costa and McCrae (1992), referred to neuroticism as a general tendency to experience negative affects. Another conceptualization regards neuroticism as a general negative emotionality (Tellegen, 1985). According to this notion, high-neurotics individuals have a higher likelihood than emotionally stable individuals to experience feelings of anxiety and depression and people high in neuroticism are prone to have irrational ideas, be less able to control their impulses, and to cope more poorly than others with stress (p. 14).

Theoretical Perspectives of Symptom Distress

One of the first theories that ever emerged on symptom distress is Psychoanalytical Theory of Freud (1923). According to this the theory, human personality is broken into three significant components: the id, ego and

superego. According to Freud, the id is the source of sexual energy that is built and motivated by the pleasure principle. The ego is the structure that helps the id to express itself. It emerges in order to realistically meet the wishes and demands of the id in accordance with the outside world. It operates on reality principle. The superego on its own, exercises moral judgment and social rules by keeping the ego and id in check.

However, psychoanalytic theory focuses on unconscious conflict that cause anxiety in the individual and result in maladaptive behaviour. These conflicts arise when the libidinal impulses of the id clash with the constraints on behaviour imposed by the superego. The ways people handle their conflicts are defined by the types of defense mechanisms they employ. When behaviour becomes ruled by defense mechanisms and when the defense mechanisms themselves are maladaptive, then it can result in abnormal behaviour.

Freud proposed that as human beings grow, they pass through a series of universal psychosexual stages. In each stage, sexual derives are focused on the stimulation of certain body areas and particular psychological issues can arouse anxiety and other symptom distress. The stages are oral, anal, phallic, latency and genital stages (Susan, 2004).

Another is Cognitive Theory by Abramson, (1989). This theory posits that symptom distress can be determined by one's thoughts or beliefs. Cognitive theorists suggest that people' attribution of events, their perceptions of control and self-efficacy, and their global belief or assumptions influence the behaviours and emotions they have in reaction to situation. Therefore, it makes sense to suggest that the symptom distress such as anxiety, somatic symptom, and depression being developed by victims of violence may be as a result of their thinking pattern and beliefs about their conditions.

Humanistic and existential theories focus on what might be called "the person" behind the cognitions and the behaviours. These theories are based on the assumptions that human being has an innate capacity for goodness and for living a full life. Rogers (1951) developed the most widely known version of humanistic theory. He believed that without undue pressure from others, individuals naturally move towards personal growth, self-acceptance and self-actualization, which is the fulfillment of their potential for love, creativity and meaning. Under the stress of pressure from society and family, however, people can develop rigid and distorted perspectives of the self and can lose touch with their own values and needs. This can lead to psychopathology or loss of touch with reality.

Maslow (1954), another key figure in the development of the humanistic perspective, argued that human being have a hierarchy of needs and self-actualization can occur only after lower – order needs are satisfied. The most basic needs are physiological needs, followed by safety needs, social needs, esteem needs and at the highest level of the hierarchy is the need to fulfill one's own personal values and to reach self-actualization. Maslow said that "people who are at this highest level of the hierarchy no longer strive in the ordinary sense but rather develop." They attempt to grow to perfection and to develop more and fully in their own style. Psychopathology and general disease can result from a person's inability to fulfill lower – order needs and reach a point of growth instead of striving.

Statement of the Problem

Internal displacement is fast becoming a National crisis. In recent years, the plight of displaced persons has become a challenging problem of global significance and implications (Ladan, 2001). The total number of displaced persons is currently estimated around fifty million worldwide, with the majority of these people in Africa and Asia. In Nigeria, the full scope of displacement is unknown (Egwu, 2011) as there is limited capacity of the state to collect data and the complex nature of displacement patterns. IDMC (2013) observed that no comprehensive survey on internal displacement has been conducted and there are no mechanisms to monitor durable solutions. The available estimates only include people who have sought shelter at temporary IDP camps; whereas, most IDPs had reportedly preferred to seek shelter with relatives, rather than living in camps.

The head of National Commission for Refugees, Migrants and Internally Displaced - Hajiya Hadiza Kangiwa estimated at the sensitization rally to commemorate 2013 World Refugees' Day that Nigeria currently has 4.4 million internally displaced people (NAN, 2013), thereby, making the rate of internal displacement a general concern.

This notwithstanding, it is worrisome however to note that despite the growing research on internal displacement, little or few empirical researches have tried to assess this incident in relation to symptom distress (which are likely to be suffered by the internally displaced person) and also to compare these symptoms among internally displaced and normal resident persons, so as to ascertain whether differences exist in the manifestation of these symptoms across this population. Hence, this paper seeks to assess symptom distress among internally displaced persons and to compare internally displaced persons and normal residents on symptom distress. Also, it wishes to provide answer to the following questions:

1. Will there be a correlation between internal displacement and symptom distress among internally displaced persons?
2. Will there be a significant difference between internally displaced persons and normal residents on the manifestations of each of the domains of symptom distress?

Purpose of the Study

The present study is on 'Assessment of Symptom Distress among Internally Displaced Persons in Awka and Onitsha.'

Specifically, the objectives of the study are to find out:

1. Whether there will be a correlation between internal displacement and symptom distress among internally displaced person.
2. Whether there will be a significant difference between internally displaced persons and normal residents on the manifestations of each of the domains of symptom distress.

Hypotheses

a) There will be a correlation between internal displacement and symptom distress among internally displaced persons.
b) There will be a significant difference between internally displaced persons and normal residents on the manifestation of each of the domains of symptom distress.

Method

Participants

A total of 403 persons comprising of 230 females and 173 males, aged between 26 and 68 years, with a mean age of 37 and standard deviation of 9 participated in the study, which elicited the incidence of symptom distress among internally displaced persons. 203 of them (103 females and 100 males) were internally displaced persons, while 200 (100 females and 100 males) were normal residents. The internally displaced persons were sampled using purposive sampling techniques. This is a sampling technique that enables the researcher to choose the sample based on who is appropriate for the study. The normal residents were sampled using simple random sampling techniques. This on the other hand is a sampling technique that gives every member of the population equal chance of participating in the study.

Instrument

One instrument was used in the study: the Symptom Distress Checklist 90 (SCL-90), designed by Derogans, Lipman and Covi (1977). Internal displacement was entered a demographic, alongside other demographic variables which included marital status, gender, number of years lived in the North and age.

Symptom Distress Checklist (SCL-90) Scale

This is 90-item scale designed by Derogatis, Lipman and Covi (1977), to assess 10 primary categories of symptoms associated with distress among psychiatric outpatients and with the experience of anguish arising from the problems of living among people in the general population. It comprised of A-Somatization, B-Obsessive Compulsive, C-Interpersonal Sensitivity, D-Depression, E-Anxiety, F-Hostility, G-Phobic Anxiety, H-Paranoid Ideation, I - Psychoticism and J-Neuroticism. In this scale, sections A-J are scored separately, after which the values of the numbers shaded in each item of each section is added together to obtain the score for the section. The overall values for 10 sections are further added up, to obtain the overall SCL-90 score. The scoring was done on 5-point simple response format of 0-Not At All, 1-A Little Bit, 2-Moderately, 3-Quite a Bit, 4-Extremely.

Validity and Reliability

Erinoso (1996) reported significant coefficients of concurrent validity between Retirement Stress Inventory, Omoluabi (1996) and SCL-90 Scales which ranged from .26 for Scale F (Hostility) to .47 for Scale J (Neuroticism). Derogatis et al. (1977) reported alpha coefficients which ranged from .77 for Psychoticism to .90 for depression. The one week interval test-retest reliability coefficients ranged from .78 for Hostility to .90 for Phobic Anxiety. Furthermore, to ascertain the internal consistency of the scale in Nigeria (Eastern Nigeria specifically) Anazonwu, Obi-Nwosu and Ifedigbo (2013) subjected the symptoms distress checklist (SCL-90) to a study with 150 students of the Department of Psychology, Nnamdi Azikiwe University Awka, and the following scores were obtained, showing the Cronbach Alpha Reliability Coefficients for (SCL-90): Somatization = .88, Obsessive Compulsive = .85, Interpersonal Sensitivity = .76, Depression = .83, Anxiety = .88, Hostility = .65, Phobic Anxiety = .85, Paranoid Ideation = .77, Psychoticism = .83, and Neuroticism = .77.

Result

The table I above showed a significant difference between internally displaced persons and normal residents on interpersonal sensitivity and paranoid ideation (t=.95, $p<.05$=.00) and (t=.95, $p<.05$=.00). On the other hand, the table showed no significant difference between internally displaced persons and normal residents on other symptom distress. This somewhat confirmed the hypothesis which stated that 'There would be a significant difference between internally displaced persons and normal residents on the manifestation of each of the domains of symptom distress.'

Table I: Showing summary of Independent t-test analysis on the differences between internally displaced persons (IDP) and normal residents (NR) on symptom distress

Variable	F	Sig	t	df
Somatization				
IDP*NR	3.03	.80	1.213	396.72
Obsessive Compulsive				
IDP*NR	1.49	.22	.541	399.91
Interpersonal Sensitivity				
IDP*NR	.98	.00	.95	400.88
Depression				
IDP*NR	.95	.33	1.11	394.29
Anxiety				
IDP*NR	3.01	.08	.80	399.16
Hostility				
IDP*NR	.11	.74	.24	400.97
Phobic Anxiety				
IDP*NR	.23	.63	.76	400.46
Paranoid Ideation				
IDP*NR	.98	.00	-.520	400.86
Psychoticism				
IDP*NR	1.30	.26	-.03	400.682
Neuroticism				
IDP*NR	.742	.39	-.60	390.20

Table II:Showing summary of Multiple Regression analysis on the correlation between internal displacement and symptom distress

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.543	.110		14.039	.000
	Somatization	-.007	.004	-.102	-1.617	.107
	Obsessive Compulsive Behaviour	.006	.006	.086	1.049	.295
	Interpersonal Sensitivity	-.003	.005	-.044	-.545	.586
	Depression	-.002	.003	-.054	-.714	.476
	Anxiety	-.002	.004	-.028	-.356	.722
	Hostility	.005	.007	.059	.729	.466
	Phobic Anxiety	-.008	.007	-.085	-1.139	.255
	Paranoid Ideation	.006	.008	.044	.719	.473
	Psychoticism	.001	.006	.007	.098	.922
	Neuroticism	.006	.007	.058	.879	.380

a. Dependent Variable: Displaced Persons

The table above showed positive relationship between internal displacement and obsessive compulsive behaviour (t=1.05, p<.05=.30); Hostility (t=.73, p<.05=.47); Paranoid Ideation (t=.72, p<.05=.47); Psychoticism (t=.97, p<.05=.92) and Neuroticism (t=.88, p<.05=.38), and a negative relationship between internal displacement and somatization (t=-1.62, p<.05=.12); Interpersonal sensitivity (t=-.55, p<.05=.57); Depression (t=-.71, p<.05=.48); Anxiety (t=-.36, p<.05=.72) and Phobic Anxiety (t=.-1.14, p<.05=.26). This confirmed the hypothesis which stated that 'There would be a correlation between internal displacement and symptom distress among internally displaced persons.'

Discussion and Conclusion

Discussion

The study focused on the assessment of symptom distress (somatization, interpersonal sensitivity, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, paranoid ideation, psychoticism, and neuroticism) among internally displaced persons.

The results obtained showed that hypothesis I, which stated that 'There would be a correlation between internal displacement and symptom distress among internally displaced persons,' was accepted. This finding aligns with the observation of Durosaro and Ajiboye (2011) and Mazo (2011), that the incidence of displacement exposes the displaced persons to emotional problems and other distresses which are characterized by memory of fearful events and nightmare (some of which can be clinically significant), loss of livelihoods, frustrations, abuses, threats

of assaults etc.. Hence, persuasive that internal displacement exerts consequential negative influence on the people affected.

It is plausible however to say that these findings very strongly suggest that five of these symptoms: a) obsessive compulsive, b) hostility, paranoid ideation, psychoticism and neuroticism are positive correlating factors with internal displacement, while the remaining five symptoms: a) somatization, b) interpersonal sensitivity, c) depression, d) anxiety and e) phobic anxiety are negative correlating factors with internal displacement. The reason for this can be overly linked to the fact that experience of displacement leaves socio-economic marks on the affected persons, which has the capacity to trigger hostile behaviour, intense mistrust, resentment, hyper-vigilance, aggressive and poor coping strategies as observed among affected people.

Again, hypothesis II, which stated that 'There would be a significant difference between internally displaced persons and normal residents on the manifestation of each of the domains of symptom distress,' was somewhat accepted. This is because the result showed significant differences between internally displaced persons and normal residents on symptom distress of paranoid ideation and interpersonal sensitivity. The finding can be explained in terms of social distance since some of the internally displaced persons stayed away doing business and working for as many as 10 (ten) to 20 (twenty) years, and almost disconnected from their relations, before the incident of displacement, which forced them to come back to their people and original region. Thus, resulting in difficulty reintegrating into the existing socio-economic environment. It is sensible however to assert that the loss of trust as a result of this difficulty may have triggered difficulty to socialize with others, which in turn hampers their income, resulting in the manifestation of these symptoms and the observed differences.

On the other hand, they seemed not to differ on some of the symptom distress because they have cultural affiliation. And even though they have economic differences and had separated from them for some while, they still understand their language and culture, which made co-existence very possible, without much distress. Again, having same cultural affiliation makes them to share some values.

This study has increased the awareness of the challenges faced by the internally displaced persons, especially mental challenges. It is persuasive therefore that calculated efforts by relatives, local and state governments be made to address the issue of social distance and reintegration of internally displaced persons to avoid complete psychological breakdown, which if it happens, will take a toll on the socioeconomic wellbeing of the populace. Communities, local and state governments are therefore advised to build structures (such as school, markets) and incorporate policies that will accommodate the entire displaced persons without further delay.

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