INFLUENCE OF PSYCHOSOCIAL FACTORS ON DEVELOPMENT OF MENTAL DISORDERS AMONG REFUGEES: A CASE OF HAGADERA CAMP IN DADAAB, GARISSA COUNTY

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DECLARATION

This research is my original work and has not been presented for a degree at any other university.

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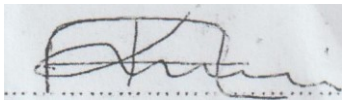
Signed  Date.....29/10/2022.

DEDICATION

I dedicate my work to my family members, friends and colleagues who have a task of supporting the people they interact with as a way of preventing or curtailing mental disorders within the community.

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I am grateful to Allah for His grace that's has been sufficient throughout my academic journey. Also, I owe gratitude to Kenya Methodist University (KEMU) for being supportive to me. The institution provided the necessary facilities while my lecturers and supervisors accorded me immeasurable support during my study period. I cannot forget to thank my family, all my friends and colleagues for their candid support without which, my academic life would have been unbearable.

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ABSTRACT

When compared to the normal population, refugees are more prone to psychosocial distresses which lead to the development of mental disorders. The current study sought to examine the influence of psychosocial factors on the development of mental disorders among refugees in Hagadera Refugee Camp in Dadaab Complex, Kenya. The study's objectives were; to examine the influence of collective ties on development of mental disorders; to determine the influence of acculturation on development of mental disorders; and to evaluate the influence of family separation on development of mental disorders among refugees living in Hagadera refugee camp in Dadaab Complex. Guided by Attachment Theory and Cognitive Theory. Using simple random sampling method, the study recruited 200 refugees visiting Hagadera Mental Clinic. Males accounted for 54% and females 47%.The study adopted descriptive research design to collect and analyze quantitative data which was collected using self-administered questionnaires. The study used descriptive statistics including standard deviation, mean, percentage, and frequency to analyze data and presentation was done by use of tables. The findings indicated presence of different mental disorders among participants where prevalence of mood disorders was (40.5%), anxiety disorders (39%), PTSD (8%), schizo-affective disorders (4.5%), narcolepsy (3.5%), psychosis (1.5%), somatic complaints (1.5%), stress (1%), and affective disorder (0.5%). Other findings were that participants reported low levels of acculturation as indicated by a mean score of 2.90 (lowest score 1.92, highest score 3.45) and a standard deviation of 0.937. Participants also scored low on collective ties with a means score of 3.54 (lowest score 2.49, highest score 3.97) and a standard deviation of 0.624. The findings also indicated that family separation was pronounced with a mean score of 3.16 (highest score 4.02, lowest score 2.68) and a standard deviation of 1.2000. Inferential statistics showed that the regression model was statistically significant in predicting that collective ties, acculturation and family separation contributed in the development of mental disorders among refugees (Sig. value of 0.000). Regression analysis indicated a strong and a significant relationship between collective ties and development of mental disorders (coefficient value=.217, p-value=.021), between acculturation and development of mental disorders (coefficient value = .118, p-value = .012), and between family separation and development of mental disorder (coefficient value = .417, p-value = .001). The study findings indicated that one consequence of experiencing compromised detached collective ties, family separation, and inability to acculturate accurately among refugees, is the development of mental disorders. This understanding fortifies the relevance of feasible and acceptable psychological intervention aimed at addressing issues emanating from strained collective ties, process of acculturation, and familial separation among refugees community.

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ABBREVIATIONS AND ACRONYMS

WHO	World Health Organization
PTSD	Post-Traumatic Stress Disorder
DALY's	Disability Adjusted Life-Years
UASC	Unaccompanied asylum-seeking children and adolescents
UNHCR	United Nation High Commissioner for refugees

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CHAPTER ONE

1.1 Background to the study

The refugee problem affects most of the world's regions and many people have been compelled to flee their homes for internal and external reasons. It is important to note that refugees differ from economic migrants and immigrants in various ways. Refugees are those who fear persecution for their religion, ethnicity, social group affiliation, or political stance. In response, refugees get uprooted against their choice from the nations where they were born or the regions where they resided to relocate in the quest for peace and security (United Nations, 2008, p.4). According to Stone, (2018), 20 people get relocated every minute in the modern world. Also, one in 113 persons are displaced, refugees, or asylum seekers. According to the report, 65.6 million people are displaced globally and 40.8 million are domestically displaced.

Internationally, that is within one's country of origin, 22.5 million are displaced. Half of the refugees are from Afghanistan, Syria, and South Sudan, according to the report by Stone, (2018). The United Nations Department of Economics and Social Affairs [UNDESA], (2018) found that there were 363,000 first-time asylum seekers in the U.S. in 2015 and 335,000 in 2016. Among these asylum seekers, Syrian, Iraqi, Afghan, and Pakistani dominated.

The United Nations High Commissioner for Refugees [UNHCR], (2014) data indicates that by the end of the year 2013, 43 million people were displaced. Nearly 14.3 million were in Africa, with 400,000 in North Africa and 13 million in sub-Saharan Africa. 7.7 million were internally displaced and 3.4 million were refugees. South Sudanese (115,000), Somalis (1.1 million), Sudanese (650,000), Congolese (500,000), 116,000 being Western Sahara, and 308,000 being Eritreans, were the most notable refugees as of 31 December 2013. (UNHCR, 2014).

Recent years have seen a rise in African refugees. As of June 2019, there were 74.8 million forcibly displaced people globally (UNHCR, 2018). According to data from UNHCR, (2019), by end of 2018 UNHCR was concerned with about 26.4 million African refugees. This is 35% of the 74.8 million global refugees. The population comprised refugees, stateless, asylum seekers, returnees, and IDPs (UNHCR, June 2019). This indicates a surge in refugees in Africa and beyond. Kenya accommodates 530,000 refugees, consisting of 434,000

Ethiopia, 220,000 Ugandans, 230,000 from South Sudan, Chad with 430,000, and 230,000 Egyptians (UNHCR, 2014).

Kenya is Africa's leading refugee host. Kenya hosted 476,695 refugees in May 2019. 54.5% of refugees and asylum seekers in Kenya were Somali, 24.4% South Sudanese, 8.8% Congolese, and 5.9% Ethiopian. 44% dwell in Daadab, 40% in Kakuma, and 16% in cities (UNHCR, 2019). Hagadera, Dagahaley, and Ifo are Daadab's three refugee camps. Daadab welcomed 211,701 asylum seekers and refugees as of May 2019, according to UNHCR data (UNHCR, 2019). According to August 2018 UNHCR figures, the Hagadera camp hosted 74,000 refugees (UNHCR, 2018). Forced emigrants have trouble finding safe housing. UNCHR statistics from 2018 indicated that 2,600 migrants and refugees died across the Mediterranean. Most were heading to Italy from Libya. Refugees who've suffered loss are more prone to develop despair, anxiety, PTSD, and somatization (Fanzel et al., 2005).

Before, during, and after a move, refugees encounter different issues. During the transfer, migrants lose their culture, religion, social support, and sense of identity. In addition, refugees require assimilating into the new host culture. Refugee populations are more likely to endure psychological anguish due to these vulnerabilities (Bhurgra & Becker, 2005). Keller et al. (2013) studied treatment-seeking urban refugees where 45.7% were diagnosed with PTSD 81.1% reported with anxiety, and 84.5 experienced with symptoms of depression (Keller et al., 2013). Even though not all evacuees develop mental illness, many are affected by their experiences. For instance, less than 5% of 63 Sudanese migrants in Australia satisfied PTSD criteria, although 25% reported clinical mental discomfort (Schweitzer et al, 2013). Mental illness and sadness impact all refugees' adaptability and growth when migrating.

When people facing adversity in life relocate from their home area to a place of safety, they do so in large groups that appears organized. Refugees progress on their journey with great energy in the shelter of the crowd irrespective of their age, gender, social status, or even nationality. On finding safety, individual refugees may realize that their values, behaviors, and that of the host population may vary significantly. As such, individual and collective behavior becomes unpredictable. Refugees encounter a wide range of various stressors of everyday that differ significantly from the primary dangers and stressors that motivated them to relocate from their home country. As such, the refugee population is more vulnerable to the development of mental disorders (Berry & Sam, 2007).

Nevertheless, the literature points to some significant coping mechanisms based on group identity and processing (Alfadhli & Drury, 2016). The study by Cohen and Wills, (2005) indicated that social support is associate with the well-being of stressed persons. Similar findings indicated that the presence of social networks improved mental health (Berry & Sam, 2007; Dalgard, 2005) among the normal population and refugees (Williams, 2003). Therefore, collective ties such as supportive groupings among refugees play a significant role in preventing and addressing mental disorders as indicated by Alfadhli and Drury, (2016) in their study.

Refugee populations comprise survivors of persecution and various violent events such as war and torture, experiences that predispose them to the possibilities of developing mental disorders. In addition, refugees may have no preferences over the source of help that they dearly need at the time of relocation. As such, people running away from adversity find refuge from any country willing to host them. The inability to make a choice of the nation to host a people running from their home country make refugees interact with people of cultures that differ from their primary way of life. Each people have a unique culture, history, ideas, problem-solving methods, and ways of communicating. Consequently, when people moved away from their environmental, spiritual, social and economic surroundings, people often become unsettled (Bhui et al., 2012).

The desire to move on with life makes people hosted in a different culture seek to adjust their ways of life. Some get assimilated in that they abandon their native culture and put all their effort towards learning and embracing the host culture. Assimilated refugees adopt the customs, language, and values of the host culture while losing their own. Other displaced people prefer to keep their cultural values and norms and avoid interacting with the host culture. Such refugees get marginalized because they keep their conventional lifestyle and fail to accept the host community's culture. This is often connected with weak verbal ability. Other displaced people develop negative sentiments towards their culture and the dominant culture, ending up being ostracized. Another possibility of adjustment among refugees is through integration. Such people keep components of their culture and endeavor to learn the host culture's norms, beliefs, and practices and ends up getting fully acculturated. Acculturation is the process of maintaining cultural identity while assimilating into a new community (Fazel & Stein, 2011). The study by Bhui et al. (2012) indicated that this form of integration of cultures is related to lower incidences of mental health concerns among teenagers of different ethnic backgrounds. The other three approaches; assimilation,

marginalization, and being ostracized are associated with low mental health and the development of mental disorders (Hollander et al., 2011).

Resettlement is a durable option in which refugees get immediate and long-term safety. However, the process of resettlement remains stressful with various challenges including family members' separation. While it's an expectation that family member, including extended members, remains united, disaster often breaks such bonds (Dwivedi, 2000). Separating family members sever important communication characterized by deep, meaningful, and caring exchanges that keep members intact in good and bad times. When people run from adversities, they face danger on their journey from their country of origin to a place of resettlement. Some of the dangers include children getting separated from their parents, either accidentally or as a safety measure. Sometimes, children are given to people smugglers who facilitate their escape from their home country. The study by Ayott and Wiliamson, (2001) indicated that the most vulnerable group of refugees was unaccompanied children (separated from both parents) and those with no legal parents. Resettled refugees living apart from their family members get distressed as they question the welfare of their members living apart when they are not in a position to support them finically or emotionally (Dwivedi, 2000). Such worries steal the psychological wellness of such refugees making them more vulnerable to the development of mental disorders. Data indicates that refugees in Hagdera Refugee Camp present with various mental disorders as shown in table 1.1

Table 1.1

Mental Health Department Monthly Reports For The Year 2018

Diseases reported	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Epilepsy/Seizures	232	198	267	239	204	381	241	269	218	198	309	185
Alcohol or other substance use	4	3	0	0	0	1	1	0	0	2	3	0
Mental Retardation	19	35	12	26	8	10	9	10	8	13	18	15
Psychotic disorder	205	176	254	199	215	242	213	263	197	199	219	149
Severe emotional disorder	14	5	19	14	9	8	7	6	8	7	13	2
other psychosocial complaint	2	34	64	6	1	25	7	63	11	41	130	37
somatic complaint	155	111	96	121	119	134	133	91	127	97	25	70
Total	631	562	712	605	556	801	611	702	569	557	717	458

Source IRC [2018]

From the Table, it is evident that there are high numbers of refugees who have mental disorders. This implies that there are some factors that influence the prevalence of various mental disorders. This study, therefore, seeks to assess psycho-social factors that influence the development of mental disorders or lack of it in Hagadera refugee camp.

1.2 Statement of the Problem

Many studies suggest that refugees have a great hazard of mental problems (Norredam et al., 2009). This is because they experience many challenges before, during, and after relocation to safety. According to the United Nations, (2008) refugees have been tortured or traumatized

and Pin-cocked, (2013) reported that 5–10% of refugees in the US had been shocked with electricity, raped, beaten, or had witnessed others being tortured or killed. In addition, refugees separate from family members as they run for safety and such separation causes great anxiety among refugees. Also, after resettlement, refugees experience culture shock characterized by language barriers and other behavioral and social differences as they interact with the host culture. After relocating, refugees also find it hard to develop meaningful social ties essential in offering support in times of distress. Such distress keeps refugees at increased risk for mental disorders development (Bhui et al., 2013). Table (1.1) shows the most common mental illnesses among refugees hosted at Hagadera Refugee Camp. Nevertheless not all refugees in the camp present with mental disorders. This is an indication that there are varied factors that predispose refugees to the development of mental disorders or facilitate mental health among refugees living in Hagadera Refugee Camp. The present study examined the influence of psycho-social factors; collective ties, family separation, and acculturation influence the development of mental disorders among the refugees in Hagadera Camp.

1.3 Purpose of the Study

The study focused on examining how psycho-social factors (social ties, acculturation & family separation) contributed to the development of mental disorders in Hagadera Refugee Camp. The study also sought to identify appropriate psycho-social approaches that could be used to eradicate or minimize the development of mental disorders among refugees in Hagadera camp.

1.4 Objectives of the Study

To examine the influence of collective ties on development of mental disorders in Hagadera refugee camp in Dadaab complex.

To determine the influence of acculturation on development of mental disorders among refugees in Hagadera refugee camp in Dadaab Complex.

To evaluate the influence of family separation on development of mental disorders among refugees living in Hagadera refugee camp in Dadaab Complex.

1.5 Research Hypothesis

H_1. There is a relationship between weak collective ties and development of mental disorders among refugees living in Hagadera Camp in Dadaab Complex.

H_2. There is a relationship between acculturation and development of mental disorders among the people living in Hagadera refugee camp in Dadaab Complex.

H_3. There is a relationship between family separation and mental disorders among refugees living in Hagadera refugee camp in Dadaab Complex.

1.6 Justification of the Study

Various researches have tried to associate different variables with the development of mental disorder among immigrants worldwide. Kim et al. (2016) studied the consequences of sex assaults on female North Korean refugees in the nation of South Korea. Sexual assault victims reported greater rates of suicide thoughts and alcohol use than others (Kim et al, 2016). A comparable study by Bapolisi et al. (2020) Uganda's Nakivale camp found a high frequency of mental illnesses such as generalized anxiety disorders (73%), PTSD (67%), major disorder of depression (58%) and drug misuse (30%) among refugees (Bapolisi et al. 2020). Mental illnesses also affect Hagadera refugees. According to the mental health department, refugees have a high rate of substance misuse, mental impairment, and severe emotional disorders. Hardly are there studies that have been conducted to establish the factors leading to development of mental disorders among refugees living in Hagadera camp. It, therefore, became important to conduct a study that examined the influence of psychosocial factors on the development of mental disorders among the Hagadera refugee camp population.

1.7 Scope of the Study

The present study focused on examining the influence of psychosocial factors on the development of mental disorders among refugees. The study examined several mental disorders including mood disorders, anxiety disorders, PTSD, Schizo-affective disorder,

narcolepsy, psychosis, somatic complaints, stress, and affective disorders. The study examined how collective ties, acculturation, and family separation contribute to the development of mental disorders. The study enrolled 200 participants who were visiting Hagadera Camp Mental Clinic for the first time or for continued mental health check-up.

1.8 Limitations of the Study

The study used a representative population only recruited from Hagadera refugee camp and not from other camps. The financial, time constraints and security reasons were the factors that limited the researcher to recruiting participants only from the Hagadera Camp. Findings from the study were only limited to explaining the situation in the camp and generalization to the whole refugee community was limited. Similarly, the research only focused on a few psychosocial factors as the independent variable and not other variables such as personality traits, magnitude of trauma, locality of camp, education level, gender, age or other variables that correlates with the development of mental disorders among refugees. Therefore, the findings did not reflect a correlation between the developments of mental disorders among refugees with other independent variables apart from assorted psychosocial factors. Therefore, the findings only contributed to the field of study in a limited way.

1.9 Delimitation of the Study

The study was not limited to enrolling a certain age group but focused on patients of all ages who visited the Hagadera Camp Mental Clinic.

1.10 Assumptions of the Study

The researcher made an assumption that the tools for data collection yielded accurate and apposite data. The study used questionnaires to obtain data and as such, the information obtained was subjective. Consequently, an assumption was made that the participants' response was accurate. An assumption was also made that the targeted population were willing to volunteer to participate in the study.

1.11 Significance of the Study

The study findings indicate that failure to acculturate adequately, family separation, and reduced social ties corresponds to the development of mental disorders. These challenges are common among refugees. The findings will, therefore, benefit the practice of counseling in that they will inform the appropriate approaches in addressing psychological issues surfacing from distress associated with failure to acculturate, reduced social ties, and family separation.

The findings will also benefit policy-makers involved in ensuring refugees' welfare by informing on the importance of having in place the mechanisms for addressing psychological issues among refugees. The study findings may also provide relevant knowledge that would inform Kenya's refugee department about the risk factors and preventive attributes with may alleviate or add to mental disorders among populations of refugees.

1.12 Operational Definition of Terms

Refugees: A community of people who are forcibly displaced internationally from Somalia, Sudan, Uganda, and Ethiopia and hosted at Hagadera Refugee Camp in Kenya.

Mental Disorders: Psychological disorder such as depression, anxiety, PTSD, and mood disorders that result from experiences of adversities in life.

Collective Ties: The presence of emotional, financial, informational and instrumental supports to an individual from significant others such as religious groupings and family relations.

Acculturation: The process of adjusting well to a new culture by integrating primary culture and host culture including way of relating with others, dressing code, types of foods and language.

Family Separation: Loss of family relationship through physical and emotional distance. Separation among refugees may result from deaths of family members or being resettled in different refugee camps during the process of relocating.

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

This chapter presents the empirical evidence of earlier studies on factors influencing high cases of mental disorders. It also shows the conceptual framework adopted in the study, and the theoretical framework of which guided the study.

2.2 Theoretical Framework

The study was anchored on two theories; Cognitive theory and Attachment theory that aided in the understanding of the development of mental disorders.

2.2.1 Cognitive Theory

Aaron T. Beck founded Cognitive Theory. He was motivated by his research work on depressed patients from 1963 to 1967. One of the findings from his research was that depressed persons tend to have a negative bias on how they interpreted certain life events and as result, their cognition was distorted. The theory is based on theoretical underlying principle that "how people interpret and organize their experiences affects how they feel and act." Therefore, Cognitive therapy assumes that psychological problems including mental disorders stem from commonplace processes such as making faulty inferences on the basis of wrong or insufficient information, flawed reasoning, and a difficulty to distinguish between truth and fantasy (Corey, 2009).

Beck makes an assumption that people live by rules/premises/formulas. They develop mental disorders when they interpret, label, and evaluate a set of rules inappropriately or excessively or when they evaluate rules that are unrealistic. He also contends that people expressing emotional difficulties have the tendency of committing characteristic logical errors that are responsible for tilting objective realities in the direction of self disapproval (Corey, 2009).

As such, how refugees interpret their experiences; prior to migrating, in the process of migrating and after migrating is likely to lead to mental disorders if their perception is characterized by logical error. Refugees face the challenge of having to be forced to vacate their homes, lose belongings and jobs, separate from family members and at times lose their beloved ones to death, before migration. A person with such an experience is likely to imagine that an absolute worst scenario and outcome resulting from existing natural calamities or war is about to take place. They are likely to experience anxiety and the fear of losing their lives, loved ones or what they value in life. Such type of thinking refers to "catastrophizing," a characteristic of logical error inform of arbitrary inferences.

Secondly, refugees experience a lot of hardship during transit. For instance, refugees are likely to go for days without adequate food, spend nights outside, get sick or lose track of some family members in the process. People going through such hardships are likely to develop separation anxiety disorders, depression, post traumatic stress disorders or other mental disorders (Carlson & Rosser-Hogan, 2014). Such disorders are likely to develop if an individual's thinking pattern is characterized by logical errors inform of selective abstraction where one picks only the negative experience and overlooks the positive outcomes such as being lucky to escape. A person may magnify a negative incidence like spending a night outside, making it look extreme or may over generalize such an experience holding the belief that as long as he/she is in foreign land, nothing good would come out of it.

Refugees living in camps also experience challenges such as learning the host's culture and adjusting to new life. The refugees who happen to assume that they cannot fit in the new culture and that are likely to face discrimination, are likely to develop mental disorders. That form of thinking is what Beck refers to as dichotomous thinking or labeling and mislabeling error in thinking. Unlike people living in their constant cultures, refugees struggle to make meaning of their experiences because they interact with not only their culture but also the

host's culture. Similarly, successful acculturation may not alleviate the complexity in refugees' perception of realities in their lives. Consequently, refugees are more likely to develop mental disorders compared to the people living in their natural lands. Nevertheless, cognitive theory posits that it is how the refugees interpret their experiences rather than the experiences in and of themselves that leads to development of psychological disorders.

The cognitive theory has theoretical assumptions that: An individual's internal communication is accessible to introspection (Corey, 2009). Therefore, the theory is applicable in understanding the realities faced by refugees and in guiding supportive approaches as a means of preventing and countering mental disorders common among refugees.

2.2.2 Attachment Theory

John Bowlby was the first proponent of the attachment theory. According to the theory human beings have an innate pre-existing psychobiological system. When an individual is in need, the Attachment Behavioral System will serve as a motivator, driving them to seek proximity to significant others/attachment figures. The scheme is called "the attachment behavioral system" (Forslund & Duschinsky, 2021). An individual's attachment behavioral system looks for objective support or protection in addition to the accompanying subjective feeling of safety or security in a significant others. According to Bowlby, children can develop one of four distinct attachment styles (secure, insecure, ambivalent, and anxious) during their childhood.

Refugees experience great ordeal before migration, as they transit to safer grounds and after finding settlement in foreign land where they are hosted as refugees. It's in order to argue that during such trying moments, refugees are driven by their attachment behavioral system to seek objective support, protection and the associated subjective sense of safety or security.

According to Bowlby, people present different attachment styles depending on their experiences as they attain various developmental milestones (Fleming, 2007). Therefore, refugees respond to the challenges they face in different ways depending on their attachment style.

Bowlby describes people with secure attachment style as comfortable with oneself, one's limitations, and able to bear with those of others. Additionally, such people are in a position to express a wide range of feelings, are adaptable, can comfortably depend on others, and are confident in their capacity to function within close relationships and during separations (Forslund & Duschinsky, 2021). As such, people with a secure attachment style adjust adequately even in adverse situations and their level of resilience is high. It would, therefore, be in order to argue that the refugees who bounce back and lead a fulfilling life even in refugee camps, have the secure attachment style.

In contrast, people with insecure attachment styles are generally prone to psychological distress thus more prone to developing mental disorders. Particularly, ambivalent attachment style, which, according to the theory, is associated with experiences such as the general sense of insecurity, fear, and abandonment, has been linked to psychological distress (Fleming, 2007). Refugees exhibiting insecure attachment styles would, therefore, have issues with symbolic attachment figure during transit as well as in refugee camps. Also, they are more likely to be intoxicated by outside forces or internal though systems on how they perceive and relate with symbolic attachment figures. Also, attachment theorists hold that people with insecure attachment styles exhibit an under-regulated affect and are hyper-vigilant to signs of rejection.

Attachment theory also holds that people with insecure attachment styles are more prone to experiencing separation anxiety disorder. The disorder is indicated by the expression of an

inappropriate and excessive anxiety about imagined or actual separation from major attachment figures or from home environment. One of the emotional challenges that refugees face is anxiety resulting from the fears of persecution in their home country, uncertainty during transit as well as while in refugee camps. Additionally, refugees experience loss of property, identity, security, dignity as well as the loss of loved ones when hosted in different camps or death occurs to some members before departure or during transit. Such occurrences lead to distress, which results in dysfunction and development of various mental disorders (Carswell et al. 2011).

2.3 Empirical Review

Since the 2000s, there's been an increasing interest in refugees' mental health (Tempany, 2009). The trend is motivated by the merging perspective that giving mental health care to refugees should be a top priority after their fundamental requirements are satisfied (Tempany, 2009). There is, however, the degree and form of emotional factors amongst asylum seekers and refugees are subject to debate (Lindert & Schinina, 2012).

According to Hauff and Vaglum (2004), the frequency of mental illnesses and syndromes, such as Depression, anxiety, and PTSD, differs substantially amongst refugee and asylum-seeking populations in different nations. Between 3% and 80% of adult migrants have major depressive disorder, while between 3% and 86% have PTSD (Carlson & Rosser-Hogan, 2014).

Several systematic reviews have examined the frequency of psychopathology among refugees and immigrants. Fazel et al. (2005) analyzed 20 psychiatric studies comprising of non-selected refugees population hosted in seven affluent countries in the western hemisphere. The analysis indicated that asylum-needing individuals were ten-fold more probable to develop PTSD as compared to the general population. Methodological approaches including sample size, diagnostic measure, and contextual factors such as period after resettlement, had

impact on prevalence rates. The rate of mental illnesses among asylum-needing individuals and the displaced is also impacted by environmental factors. The research on the psychosocial wellness of asylum-needing individuals and the displaced has major flaws, especially in sampling procedures and quantitative assessment instruments. These limitations need further examination because they make it harder to prevent and treat mental disorders in the community. Even while some refugees do not fulfill the clinical standards for mental disorder, many are severely distraught. For instance, the study by Schweitzer et al. (2006) indicated that less than 5% of the Sudanese migrants in Australia who participated in the study had PTSD, but 25% presented with clinical levels of mental distress. Generally, refugees suffer from mental and psychological illnesses that eventually hinder their adaptability and success in a new environment.

Other factors that refugees experiences post-migration, have implication on their psychosocial wellness. The development of mental diseases is influenced by a number of variables, including legal status, the socioeconomic standing of the host country, exposure to injustice, and social alienation (Sinner et al., 2007; Porter & Haslam, 2005). As an illustration, a Norwegian study discovered that asylum seekers had greater incidence of PTSD versus refugees (45% vs. 11%), perhaps as a result of their more ambiguous legal status (Iverson & Morken, 2004). Additionally, cultural mourning raises the risk of psychiatric and emotional illnesses if it is not effectively processed (Eisenbruch, 2001).

Laban et al. (2008) claim that persistent pressures in the host nation connected to fiscal, judicial, and social aspects pose a serious threat to the mental health of asylum-needing individuals and the displaced by aggravating earlier traumas as from pre-migration period. In return, problems with mental health may make it harder for asylum-needing individuals and the displaced to deal with the hardships of daily life, like locating safe housing or a job. The need for social services and mental health treatment among refugees could then grow even

more as a result. As a result, it is crucial to consider the wider economic, societal, and governmental circumstances in which the mental health needs of the refugee population occur (Laban et al. 2008; Watters, 2001). Since the experiences of refugees cannot be described as equal globally, and different researchers have employed diverse methodologies and population, there is a need to identify the psycho-social factors that contribute to the psychological wellness or distress among the refugees hosted in Hagadera camp of Dadaab Refugee Complex.

The psychological and social wellbeing of refugee relatives is significantly influenced by social networks and social alienation. A crucial protective element in the psychological adjustment of refugee children is the social assistance provided to the refugee family in the host nation (Hodes, 2002; Lustig et al., 2004). Families of refugees living in the host nation who have gone through similar things are frequently a valuable source of social support. In their qualitative research of 13 displaced from Sudanese in Australia, Schweitzer et al. (2007) discovered that social support to be one of the key themes that marked the perspective of the 42 refugees who were resettled, along with the significance of faith. The notion that the current study broadens trauma research by concentrating on the elements that contribute to psychological wellbeing is a crucial contribution. It also made use of a qualitative technique, which is perhaps ideally adapted to comprehending the experience of refugees and the significance of implying in participants' comprehension of their circumstances. In a similar vein, a survey by Kanji and Cameron (2010) highlighted the value of the society as a resilience role for Afghan refugees, particularly the faith/religious society, which played a significant role in aiding kids and families manage with hardship.

Many studies on anxiety symptoms among the displaced and asylum-needing individuals are restricted, as per Lindert et al. (2009); nonetheless, a morpho of 36 demographically studies on mental health within refugees reported combined prevalence rates for depression and

anxiety of 44% and 40%, respectively. These percentages are far greater than those experienced by the regular populace, according to reports (Annual Tripartite Consultations on Resettlement [ATCR], (2011). An analysis of 20 clinical assessments, on the other hand, revealed a combined incidence rate for suicidal ideation of 5%, which is comparable to levels observed in "modern" general populace (Fazel et al., 2005).

In 59 research that contrasted a refugee population to a control group of non-refugees, Porter & Haslam (2005) proposed that a systematic and formal of mental distress was developed from the varied outcome measures utilized in the studies (Porter & Haslam, 2005). Regardless of whether the comparison group had already been allowed access to potentially stressful events, it was discovered that refugees had much higher levels of psychological distress than the non-refugee treatment group. It was discovered that methodology and social forces, such as living in a rural area, having unstable accommodation, and having little job prospects, affect unhappiness rates. Despite its limitations, Norredam et al. (2009) found that the population of refugees had higher than average rates of somatic symptoms and chronic pain.

Problems with psychological health are important for social reintegration. For instance, an absence of social cohesion amongst refugees residing in Switzerland has been strongly associated with a decline in wellness life quality of life, impaired functioning, and the intensity of depressive, anxiety, and PTSD symptoms. Furthermore, PTSD and melancholy signs indicated integrating challenges (Schick et al., 2016).

The incidence rate of PTSD amongst refugees in industrialized powers was roughly 9%, which is far lower than often publicized figures, according to a meta-review of 20 research conducted in seven western countries, such as Norway (Fazel et al., 2005). Nonetheless, increased numbers of PTSD among refugees are reported in Norway by both clinical

investigations (Larsen & Skreslet, 2002; Lavik et al., 2007) and studying information (Oppedal & Røysamb, 2004; Lavik et al., 2006; Lie et al., 2001; Hauff & Vaglum, 2007; Hauff, 2008). Additionally, contrasted to ethnic Norwegian kids, kids from immigrant households may have more serious issues with stress, bodily sickness, difficulties adapting, anxiety, and melancholy (Lie, 2003).

PTSD is among the most often examined variables in relation to the psychiatric health outcomes observed in this community. The three different types of psychological distress are: repetitive re-experiencing of the trauma (thru the burdensome pictures or bad dreams), a state of excitable arousal (represented by hypervigilance, reduced sleep, indignation, misdeeds, and acting out), and enduring prevention of stimulation that are connected with the trauma or an emotional numbness of general attentiveness. PTSD is categorized by exposed to a highly stressful event or circumstance. Other factors that have been extensively researched as potential psychological effects in the kid and displaced adolescent population include anxiety and depression. PTSD is among the few treatments in the Diagnostic and Statistical Manual of Mental Disorders published by the Psychiatric Association that links symptoms to a specific psycho-social incident. In recent years, both youngsters and adults who have been subjected to a number of traumatic circumstances have been shown to exhibit or be labeled with post- PTS. PTSD is a nosological instrument that may help comprehend the psychological consequences of the refugee experience, as per Friedman and Jaranson (2004).

Fazel et al. (2005) described 5 surveys comprising 260 refugee children who had relocated to Western nations but were previously from Rwanda, Bosnia, Iran, Central America and Kurdistan. As per interview-based examinations, with a range of 7–17%, 11% of people have been identified with PTSD. In addition, 47% of the 46 Cambodian refugee children in a research who were monitored for several years had an Axis 1 diagnoses, and comorbidities was widespread (Fazel & Stein, 2002). According to this study, rates for PTSD were 40%, for

depression 21%, and for anxiety 10%. Shortly afterward, levels also were substantial, and years later, 48% of people were still showing signs of PTSD and 41% of people were depressed. It is noteworthy to notice that sadness is connected to recent life challenges or stresses like spoken English (Sack et al., 2006) and parental mental health issues, but the existence of PTSD appears to be related to prior war trauma and immigration pressure (Fazel & Stein, 2002). These last findings were supported by a psychological diagnosis of mental wellness, which places an emphasis on understanding how the kid interacts with their surroundings and looking at structural and environmental impacts on the child's behavior and mental well-being. Some other excellent analysis, this one by Porter and Haslam (2005), looked at 56 studies that contrasted the subjective stress levels of all UNHCR communities with non-refugee groups. Communities of worry performed 0.41 SD worse than the other categories in terms of mental health consequences.

Hode et al. (2008) looked into the severity of PTSD and mood disorders, as well as underlying protective and risk factors that could exacerbate or lessen this distress in orphaned children and adolescents requesting refuge (UASC). 28 volunteers, mostly from the Balkans and Africa, ranged in age between 13 to 18 and were part of a comparative evaluation (between accompanying and unattended refugee adolescents) conducted in London. When compared to accompanying refugees of a comparable age, it was discovered that the UASC had suffered from a very top standard of war trauma and family bereavement. The majority of the UASC were residing in foster families, autonomous living situation, or both. They experienced substantially higher levels of post-traumatic stress symptoms than the cohort who were escorted, with over half of them being at risk for post-traumatic ptsd. The fact that this study seems to be the first attempt to contrast solitary asylum seekers and accompanying refugee children living within the same city is just one of its advantages. Other benefits include the possibility that this group is comparable towards the UASC sponsored through

other public bodies in the UK as well as other nations because to the diversity of its ethnic heritage, allowing the results to be applied to other regions. However, because the investigation was cross-sectional, the relationship between the relationships' causative directions was unable to be established.

According to Bean et al. (2007), becoming a female and also being unattended were both related with higher degrees of post-traumatic symptoms. Extensive research with teenage refugees in several regions have discovered the connection between the experiences of prior war trauma and post-traumatic distress and mood disorders (Hodes et al. 2008). According to research with adult immigrants, depression is a more prevalent issue than Trauma (Webster & Robertson, 2007). Nevertheless, a research that evaluated Bosnian refugee children using established diagnostic tools found that 68% of them had Symptomatology that were clinically significant, as opposed to 47% for sadness and 29% for anxiousness (Papa-Georgiou et al., 2000). Age - related changes or other characteristics, including the type of traumatic event, the degree of exposure to trauma, the nationality and ethnic heritage of the displaced, or the accessibility of post-migration government welfare, may account for the discrepancy between these outcomes..

The breadth of feelings and experiences expressed might not be viewed as difficult in their home cultures, and refugees' views of trauma or distress are built via their life circumstances. It has previously been stated that PTSD is mostly applicable to persons from Western cultures and has little relevance to individuals from other civilizations (German, 2004). It is therefore attacked for pathologizing "natural" reactions to hardship and failing to take ethnic variance in these reactions into consideration.

2.3.1 Collective Ties and Mental Disorders Development

Globally, conflicts and natural disasters result in unparalleled surfs of residents' movement, both nationally and internationally. Such occurrences are connected with immediate effects such as devastation to the environment, displacement, distress, and infections. Additionally, there seem to be secondary socio-economic interruptions in the form of loss of organizational, human, and physical resources as well as lost opportunities like starvation brought on by agricultural disturbance. The interruption of trade and schooling is another factor contributing to poverty (Carswell et al. 2011). Consequently, people who are forcibly displaced experience a lot of distress as their close ties are disrupted.

Precisely, the process of migration among the refugees is always very complicated and stressful at the same time. The movement involves leaving the home country that one is accustomed to, adapting to a different environment and culture as well as various life situation. Additionally, it's important to note that refugees experience stressful events before departure, during transit and on arrival. In most cases, refugees before departing their homes face various challenges. For instance, before departure, refugees survive wars, droughts, relatives pass on as a result of war or hunger, and lose the properties they had acquired and were attached to (Carswell et al. 2011; Hynie, 2018)

In the process of migration, refugees undergo many hardships such as carrying heavy loads of their personal belongings, falling ill, hunger, separation from family members, death of relatives or people known to them and language barriers. Upon arrival in the host country, refugees struggle to accustom to the new environment, often with a different social context (Birman et al. 2008). While in refugee camps, refugees must contend with the impacts of involuntary detention in shelters, the consequence of limited possibilities to perform tasks like job or education in the host nation, along with the cost of unstable accommodation and

unstable immigration/residential status (Mollica, 2014). Consequently, refugees struggle to integrate into the social context of the hosting country fully.

Another source of distress among the refugees is that only a few of them get a permanent solution to their problems. For instance, out of the 65.6 million people who were forcibly immigrated in 2016, only 552,200 went back to their nationality. Additionally, approximately 23,000 refugees naturalized in the host country while 189,300 reaped from various resettlement programs where they are partitioned and identified for permanent resettlement in a third country (Hynie, 2018).

The distressful experiences faced by refugees affect them psychologically and socially to the extent of hindering their healthy functionality at personal and social spheres. The psychological aspect of a person that gets affected by life hardships includes the internal thought and emotional processes, feelings and reactions. On the other hand, the social element interfered with after displacement includes cultural practices, social values, family and community networks as well as different types of relationships (Carswell et al. 2011; Birman et al. 2008; Mollica, 2014; Murray et al. 2010). Psychosocial support (which refers to an approach that addresses both the psychological and the social needs of a person), comes in hand to help alleviate the level of distress and prevent or treat the associated psychological disorders (Murray et al. 2010). Some of the psychological/mental disorders commonly diagnosed among the refugees include psychological disorders including somatoform disorder, affective disorders, severe anxiety, PTSD, depression and anxiety illnesses, and severe anxiety, intellectual disability, migraine, psychotic disorders such as schizophrenia and bipolar disorders, alcoholism, illicit drug use, as well as dementia in advanced age (Birman et al. 2008; Carswell et al. 2011; Mollica, 2014; Murray et al. 2010; WHO & UNHCR, 2012). Collective ties which refers to the presence of people willing to give

emotional, instrumental, financial, informational and spiritual support, comes in handy to help alleviate the level of distress among refugees.

There has been a lot of scientific research done on the relationship between social support and health. For example, Cohen and Wills (2005) discovered in their study that interpersonal connections have positive effects on people regardless of whether they are under pressure, despite the fact that there is evidence linking support networks to health for people who are under pressure. Another research result is that social network density generally appears to be correlated with improved disease results (Dalgard, 2005; Nguyen & Pechard, 2003; Berry & Sam, 2007). The importance of social support systems in influencing immigrants' and refugees' well-being has also been emphasized (Williams, 2003). Several studies have shown that unaccompanied minor refuge seekers are exposed to more traumatic factors when compared to other refugee groups. Such a study conducted by Oppedal and Idsoe (2015), was intended to examine the societal welfare effect from significant others on mental health, discrimination and acculturation among vulnerable minors and youths. The study population was 895 unaccompanied children who were resettled in diverse regions across Norway between 2000 and 2010. Their ages were an average of 18.5 years and had been staying in Norway for a minimum of 3.5 years. Subjects' answers to surveys were utilized to compile the data. The research found that the minors had suffered from depression and high levels of ongoing war trauma. They were also struggling to adapt to their new way of life. According to the study's findings, depression and social support are directly related (Oppedal & Idsoe, 2015).

Social support increases cultural competence that helps the refugee minors in dealing with discrimination. Mental health problems common among young people are associated with parental loss and other challenges common with refuges. Such conditions have negative impact on children and compromise their ability to form supportive relationships with others.

Therefore, the ability to form new supportive associations with others in the country of asylum is vital for the psychological adjustment of the unaccompanied refugee minors. Supportive social relationships before, during and after exposure to traumatic events aid in preventing the development of post-traumatic stress syndrome, in addition to helping the individual manage stressful situations (Oppedal &Idsoe (2015).

Other studies have also shown that there is a relationship between family welfare and mental health in terms of self-esteem development and internalization of symptoms among refugees. Family contact in the host country provides a sense of continuity and thus furthering the development of cultural competence this leading to improved social, emotional and mental wellbeing. Establishing close relationships provides a sense of cultural and social continuity and also facilitates adaptation to the new culture. Lack of social support may lead to perceived discrimination which has a negative impact on the mental health of an individual due to the decreased level of self-esteem (Jankovic-Rankovic et al., 2022).

Jankovic-Rankovic et al. (2022) explored the connection between physiological indicators, support networks, and psychological wellbeing in refugees settled in two refuge centers in Serbia. The research incorporated the mixed-method study of asylum seekers through the cross sectional research design. The study had 76 participants where 41 were males and 35 females. The mean age of the study population was 30.1 years. Semi structured interviews in regards to the journey to Serbia, their stay in Serbia, social support and the trauma and loss experienced. Mental well-being self-reported data was also collected in addition to physiological markers relevant to recurrent exposure to chronic mental stress such as levels of cortisol hormone on fingernail. Previous research has showed that forced migration due to circumstances like war and political unrest lead to poor mental health well-being due to the repeated exposure to excessive violence and traumatic events (Jankovic-Rankovic et al., 2022).

The research found that refugees that travelled long distances conveyed lower social support compared to those that traveled shorter distances. The refugees that reported lesser social support also reported having lower mental well-being, higher levels of post traumatic stress syndrome related symptoms when compared to those with more developed social support. It was concluded that traumatic and stressful experiences experienced by refugees break existing social relationships and also impairs the development of new sources of social support. It is due to the tendency to self-isolate from family and friends in the refugee camps thus weakening social ties which directly impacts on the mental well-being of the refugee. It is thereby vital to establish support programs in refugee camps that are aimed at improving the refugees existing social relationships and also developing new ones thus improving their social well-being and improving their overall quality of life including the mental well-being (Jankovic-Rankovic et al., 2022).

In their qualitative research of 13 Sudanese refugees in Australia, Schweitzer et al. (2007) identified support networks with the significance of religious as among the central themes that characterised the experiences of refugees who had been resettled. Parallel to this, a research by Kanji and Cameron (2010) showed the value of the neighborhood for Afghan refugees, especially the spirituality organization, which played a significant role in aiding children and families in overcoming adversity. The children's role in welfare protection and wellness has become a recurring academic theme. Individuals who suffer from mental illness frequently depend on family support and guidance before requesting expert help. According to Kleinman et al. (2008), between 70% and 90% of all self-reported episodes of illness were treated solely without the assistance of a competent healthcare provider. This is achievable because the family is better placed to address the need for love and affection, instill values, and encourage members to be able to hope, to be confident and to have a sense of self-worth. As indicated above, different studies have shown variance in the level of psychological

disorders. The proposed research will, therefore, be intended to illuminate the incidence of mental illnesses in Hagadera camp by identifying the psycho-social factors that influence the status quo.

2.3.2 Acculturation and Mental Disorders Development

Each culture has its own history, ideas, problem-solving methods, and communication styles. People's cultures affect how they interpret personal and public events. When removed from their social, environmental, spiritual, and economic surroundings, people often become melancholy. Experiencing a lack of belongingness in a new culture is particularly distressing and makes one vulnerable to developing mental disorders (Hamilton et al., 2000).

Locals, officials, and humanitarian workers in the country where refugees seek asylum may speak a different language, practice a different religion, and observe different customs than the refugee community. Such experiences results into discrimination and inability to associate with people of the host culture. Such experiences can lead to general distress which is a precursor for mental disorders (Berry, 2019; Hamilton et al., 2000). In cross-cultural contexts, children, especially those whose families have recently moved, "lose" their cultural identity more quickly as compared to adults who had an already developed a distinct culture (Berry, 2019).

Berry (2019) categorized acculturation into four categories, some of which are good and others can induce undesirable behavior. Each of these outcomes, which include absorption, alienation, exclusion, and incorporation, is foreseen by a certain series of events. When acculturating individuals do not want to keep their native culture and instead aim to fully assimilate into the host population, integration is the most likely method of indoctrination. Assimilation's results include acquiring the customs, dialect, and characteristics of the host culture but also losing one's own heritage. Learning new language may pose major challenges

because one needs to comprehend not only the words but also the dialectical differences, and accent. Inability to adequately learn a language can cause distress and so does general cultural cringe (an internalized inferiority complex of one's culture) causes mental distress (Mangistu & Manolova, 2019). The converse of assimilation is separation. When a previously marginalized person wants to maintain their own cultural practices and conventions while avoiding contact with both the host society, the absorption method is anticipated. Such an approach leads to performance difficulties, discrimination, and isolation. The integration strategy, in contrast hand, is more probable when a person wants to retain both their own identity and the rules, techniques, and values of the host community. The preferred strategy is thought to be this one. Stigmatization, which happens when people don't adopt the native culture or preserve their original way of life, is indeed the least adaptable alternative. This is frequently accompanied by a lack of completely functioning language proficiency. When people have negative sentiments toward both their own heritage culture and the culture that is dominant, alienation is a potential result. (Fazel & Stein, 2011).

According to Mangistu and Manolova, (2019) refugees are particularly susceptible to negative psychological effects including increased risk of drug use due to acculturation. The research assessed literature on the relationship between acculturation and mental health among adult forced immigrants. The literature indicated that the relationship between parents and adolescents affects the acculturation process and also has a negative impact on mental health. Other factors that impact the relationship between acculturation and mental health include the social and political aspects of the hosting country and refugees residing in multicultural towns. Residing in multicultural towns is socially challenging for the refugees as they are exposed to competing dynamic cultures of the host town thus complicating the acculturation process. This includes aspects such as discrimination during employment and isolation from the hosts' communities (Mangistu & Manolova, 2019).

Lorenzo-Blanko et al. (2001) conducted a study on Acculturation, Gender, Depression, and Smoking Cigarette among Hispanic youth from the U.S. The findings were that discrimination as Hispanic youth acculturate to the American culture increased risk of developing depressive symptoms as well as cigarette smoking habits. The study population comprised of Hispanic male and female students in 9th to 11th grade in Southern California. The participants were 1124 students, with fifty-four percent females and forty-six percent males all of Hispanic descent. The study used the three-wave-longitudinal study. The first wave data was collected when the youths were in the 9th grade, the second wave data when they were in grade 10 and the last wave data was collected while they were in grade 11. Another finding was that females had more adverse effects to acculturation than the males. In addition, the relationship between perceived discrimination and cigarette smoking was only found in girls (Lorenzo-Blanko et al., 2001). A similar study involving youths indicated that first generation adolescents experienced educational and socio-economic disadvantages and lack of belongingness to German society and were diagnosed with varied mental disorders (Klein et al., 2020).

Starck et al. (2020) investigated the association between cultural inclination, traumatic experiences and depression among female refugees from Eritrea, Syria, Somalia, Iran, Afghanistan and Iraq in Germany. The research employed the cross-sectional design. The sample population comprised of 98 adult females. The findings were that women mental health was described to be more at risk compared to that of men despite women not being in the frontline during war. They face other traumatic events such as rape, domestic violence, forced abortion, forced marriage, killing and sex trafficking. Women from dominant patriarchal cultures with strong traditional gender hierarchies experience prolonged delay in acculturation which can also lead to depressive symptoms. The study findings found that the

more the traumatic experiences the women reported, the more their depressive symptoms (Mangistu & Manolova, 2019).

A qualitative study on the coping and adaption of Somali refugee children in Wales was carried out by Maegusuku-Hewett et al. in 2007. Focused groups and semi-structured interviews were used in the investigation. The results showed that a feeling of beneficial interpersonal identification had been discovered to be significant in many circumstances, among the various external or environmental influences that influence a person's capacity to adapt to or cope with adversity. The results were consistent with those of a study by McCarthy et al. (2010), who found that indoctrination was among the variables that might either promote or inhibit happiness in a cohort of 16 kids aged 10 to 21 years. This specific study was intriguing because it adopts a proactive stance toward comprehending the mental health of refugee children by looking into what happiness implies to young displaced and asylum-needing individuals. During their initial days in the U.K., all volunteers spoke of experiencing "cultural differences," which was made worse by their inability to communicate in the local tongue (English). McCarthy et al. (2010) discovered that many people had become so accustomed to life in the UK that they viewed it as their homeland, either out of choice or need. The respondents were not randomly chosen, despite the fact that the study pioneered a new strategy to investigate welfare with a vulnerable and excluded group of adolescents and children. This means that the study's subjects could not have been representative of individuals who needed the most social and health services because they were either getting or had previously got support from charity.

Fazel et al. (2012) showed that culture pressure and the processes of assimilation were a risk of 39 protective variables in 11 of the 44 research analyzed in their evaluation of studies of risk factors for psychiatric, behavioral, or developmental issues. Incorporation with the host society was connected to better psychosocial functioning in an Australian research on

acculturation in teenage refugees (Kovacev, 2004). Stigmatization had detrimental consequences, whereas separation (primarily upholding the individuals personal own culture) or integration (adapting to the ideals of the host population) were not predictive of psychological functioning. The study's authors concur that a degree of cultural adequacy is probably helpful.

Other studies examining the relationships between acculturation and psychological disorders gave diverse findings. For example, immigrants such as Korean and Muslims who express low levels of acculturation to U.S. culture reported high prevalence for depression (Abu-Bader et al. 2011; Jang et al. 2007). These results were alike to that of a study involving Latinos. The findings showed that Latinos who had assimilated into mainstream American society were much more likely to experience psychological distress than Latinos who had remained rooted in their native customs (Torres et al. 2010). According to a study by Elbin et al. (2001), acculturation—more specifically, a methodology of assimilation or proof of identity with popular U.S. culture—was associated with some bad results for Latino adolescents' mental health, such as higher rates of alcohol and drug use and depression (McQueen et al. 2003). Girls have also observed that preserving Latino culture has a protective impact on internalizing problems (Lorenzo-Blanco et al. 2011). Nevertheless, research on the cultural assimilation practices of young people of different ethnic backgrounds showed that incorporation was associated with lower problems with mental health (Bhui et al., 2012). Similar to the previous study, Nakash et al. (2012) found that immigrant youth generally had poorer wellbeing than the native-born youth in their comparison of immigrant and native-born Israeli teens. Particularly, assimilation-related immigrant youth displayed more mental health problems than incorporated teenage immigrants. It would be in order to conclude that the role of acculturation in determining psychological wellness varies across different cultures, age group as well as personal

meaning. There was a need, therefore, to conduct a study in Hagadera camp which holds refugees from different cultures to ascertain if nature of acculturation correlated with development of mental disorders.

2.3.3 Family Separation and Mental Disorders Development

Even though family members including extended family, in most cases live together, disasters can separate them (Dwivedi, 2000). Such separation deters parents and children from communicating in a deep, meaningful, and caring way. Additionally, the trip from the country of origin to a place of resettlement can pose great danger to people migrating. Accidentally or on purpose, children are separated from their families as they relocate to safety. For instance, children are sometimes given to people smugglers to help them cross borders, and as such unaccompanied refugee children are among the most at-risk. Also, children with no legal or customary primary caregiver are more vulnerable to distress (Ayott & Wiliamson, 2001).

Dwivedi reported in 2000 that unaccompanied children in Western countries were rising and made up 2–5% of any refugee population. Up to 100,000 separated children are thought to be in Western Europe alone. Without family and community, these children are more likely to be neglected, sexually assaulted, and injured (Dwivedi, 2000). Savic et al. (2013) studied the impact of family separation on Sudanese refugees in Australia's mental health and coping techniques. The study adopted qualitative design to conduct in-depth interviews for data collection. On analyzing the data obtained thematically, the study revealed that separation harmed the emotional health of the study participants. Poor mental health reflected in concern for family members left in home country and role adjustments. To bridge the separation gap, family reunification and technology were prioritized.

Separation from family causes continued stress for refugees in camps or in other countries, which affects their mental health. This was in addition to other migration experiences. Resettled refugees felt guilty in that they couldn't send money home making them feel as though they had failed. Such feelings harmed their self-esteem and mental health (Savic et al., 2013). Luci, (2020) investigated refugees' displacement, home, and trauma variables and self as experienced by refugees. The study evaluated whether refugee life changes can be so severe as to create mental health issues. The article argued that traumatic events among immigrants caused inner displacement, reorganizing mental life and resulting to traumatic complexes (Luci, 2010)

A similar study by Lobel and Jacobsen, (2020) studied family reunion and refugees' mental health in Germany. The study population was randomly sampled from 2013-2016 refugees. Reuniting and resettling migrants enhanced their mental health, according to the study. The findings confirmed that family separation caused mental distress because family union offers affirmation, self-identity, and sustenance. Refugees and their families need support to manage acculturative stress. Family helps reduce social isolation during difficult times by providing support, guidance, and understanding as they may have experienced the same terrible circumstances. The study shows that nuclear family separation affects resettled refugees' mental health. The study also demonstrated that separation from a spouse and children posed more distress as compared to separation from extended family.

Miller et al. (2018) found that refugees' biggest source of stress was family separation. People were upset in many ways, including concern for their families being endangered, cultural interruption, and a feeling of helplessness. Researchers analyzed quantitative data to determine how family separation affected refugees' PTSD, depression/anxiety, and quality of life. Separation from a family member significantly affected all three mental health

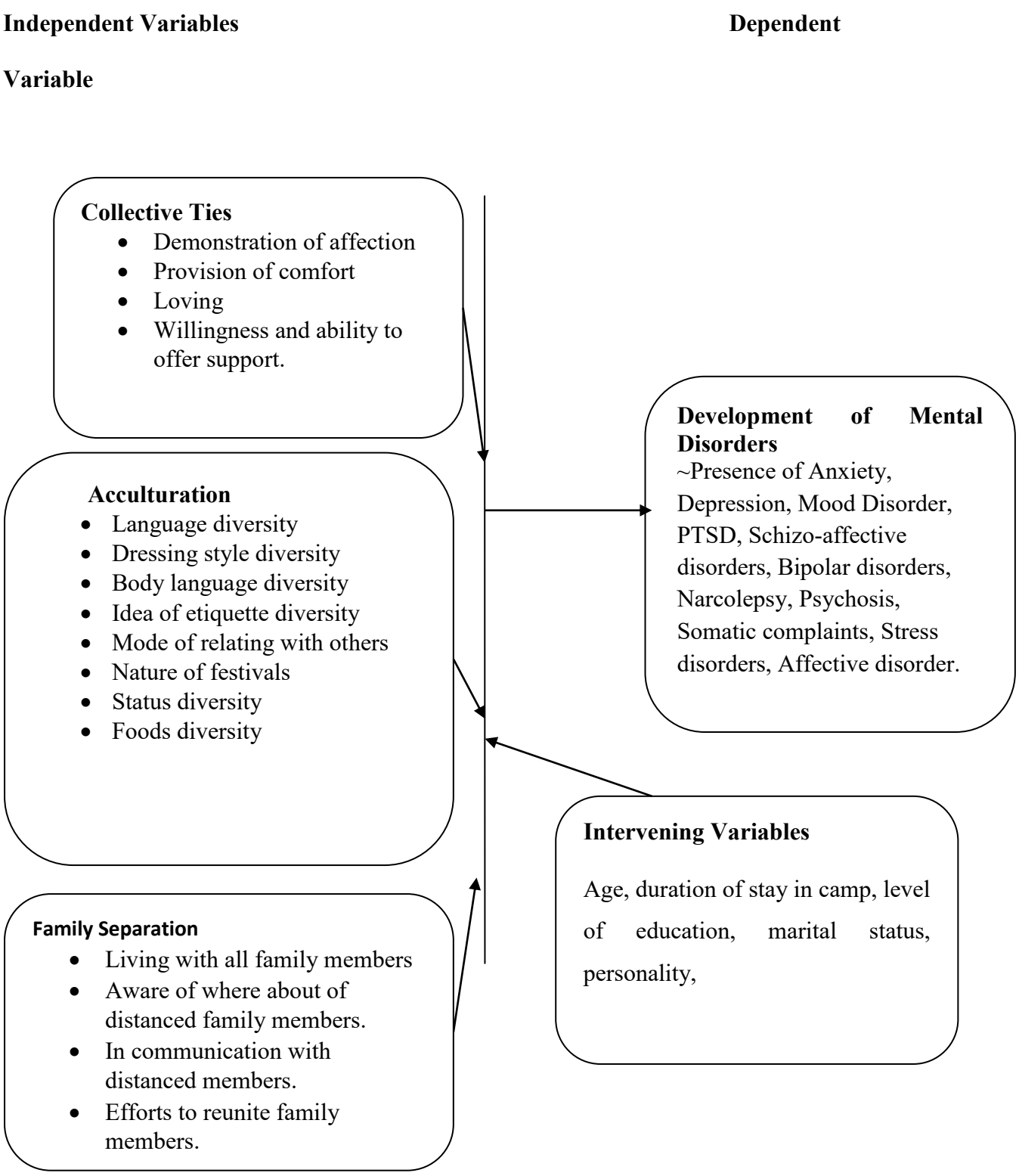
indicators. It explained extra variation in all three measures, even when participants' overall trauma experience was considered (Miller et al., 2018).

A comparable research of refugees in Albuquerque, New Mexico from Iraq, Afghanistan, and the Great Lakes Region of Africa found that being separated from their family caused them the most mental distress and was considered a disability (Faze et al. 2012). Weine et al. (2004) found comparable results. The study discovered that separation from family and role shift are the most common post-migration stressors.

The above study shows that being cut off from family is painful. People are born into intimate families, and staying with them means life or death. No one can survive childhood without adult care, affection, and attention. This fundamental need never goes away (Ayott & Williamson, 2001; Roscoe, 2009). Instead, early reliance grows into an emotional attachment that makes adults feel their lives depend on their loved ones. Family relationships with other relatives, shifts in the family's duties and responsibilities, family memories and communications, and loss of loved ones all have diverse effects (Ayott & Williamson, 2001). Severing family relations causes distress and can, therefore, lead to development of mental disorders.

2.4 Conceptual Framework

Figure 2.1



CHAPTER THREE:

RESEARCH METHODOLOGY

3.1 Introduction

The study's research methodology and data collection techniques are covered in this chapter, along with study site, population and its determination, sample design, data gathering procedure, reliability and validity, data analysis and presentation adapted in the study.

3.2 Research Design

The study was descriptive and quantitative. The design was considered appropriate because it examines a phenomenon occurring in a specific place and time. Also, the design concerns itself with existing practices, relationships, conditions, structures, differences and held opinions as well as ongoing processes and evident trends (Hair et al., 2011). A descriptive research was, therefore, considered more ideal since it gave the investigator the opportunity to collect data from participants without manipulating their environment and obtain participants' opinion regarding influence of the specific psychological factors on the development of mental disorders.

3.3 Location of the Study

The study was conducted in Garissa County, Northern Kenya's Hagadera Refugee Camp. The camp's population made it ideal for data collection. The researcher also considered Hagadera camp more ideal for the study because of its proximity to where the researcher resided.

3.4 Target population

Ngechu, (2004) defines a population as a well-defined group of people, services, elements, events, things, or houses under inquiry. This guarantees a consistent population of interest. The study target population was refugees attending Hagadera Refugee Camp psychiatric clinic for treatment. The clinic treats approximately 600 patients monthly. The study

collected data from 200 participants comprising of 93 females and 107 males. Additionally, the researcher intended to recruit a few medics, social workers as well as village elders to participate in the study. However, it was not possible to conduct focus group discussion and interviews because of restrictions from gatherings as a result of Covid-19 epidemic.

3.5 Sampling Method

The researcher visited Hagadera Mental Clinic where study participants were identified. The clinician introduced the researcher to the patients who visited the clinic for the first time or for clinical follow-ups. The clinician also provided contacts for some clients whose treatment was in progress. The researcher administered 240 questionnaires to the respondents who were identified by simple random sampling method as they attended the mental clinic and to them whose contacts were randomly picked from the mental health records. Only 200 questionnaires were fully filled and used for data analysis.

3.6 Sample Size Sampling

There are some populations whose sheer size makes it impossible to use them for research in their entirety. In situations like this, a sample is utilized. One definition of a sample describes it as a subset of a population (Rukwaru, 2007). The practice of picking a small number of individuals from a much larger population is referred to as sampling. The purpose of this selection is to serve as a representative sample of the wider group (Mugenda & Mugenda, 2003). The study employed the Yamane [1994] formula to compute the sample size based on the monthly average of 600 patients, and the results were as follows:

$$\mathrm{n} = \frac{N}{1 + N(e)^2}$$

$$\mathrm{n} = \frac{600}{1 + 600(0.05)^2}$$

$$\mathrm{n} = 240$$

Thus, the study engaged 240 patients attending the mental clinic based at Hagadera Refugee Camp. Although the researcher had intended to enroll an additional participants comprising of medics, social workers and village elders to participate in focused group discussion, the plan was disregarded because of the Covid-19 epidemic restrictions. A selected sample was carefully chosen and applied in the sampling procedure to collect the representative from of the size of the population. The study used simple random sampling technique to identify the study population.

3.7 Data-Collection Tools

The researcher recruited patients visiting the Hagdera Mental clinic for their regular check ups. As such, the participants recruited into the study had a diagnosed mental disorder and they were receiving treatment. The research relied on data obtaining from clinical records to measure mental disorders which happens to be the study's dependent variable. The clinicians used DSM-V to diagnose mental disorders presented by individual participants. To collect data on the independent variables; collective ties, acculturation, and family separation, the researcher used questionnaires. Survey participants self-completed questionnaires that were sent to them. The researcher considered using questionnaires in data collection because of its cost-effectiveness and its ability to allow for anonymity of the participants.

3.8 Data Collection Procedure

The investigator asked for approval to gather data from Kenya Methodist University Scientific Ethics and Review Committee body and from NACOSTI (National Commission for Science Technology and Innovation). Before participating, the participants were requested to fill out a consent form or give verbal consent. The researcher then sent questionnaires to provided email addresses and others were issued physically to the respondents and all were requested to fill out questionnaires at their convenient time. Participants' identities were kept confidentially private. The researcher gave the questionnaire to the identified participants

(200 electronic copies were emailed, and 40 paper copies were provided), and they were instructed to respond and return it.

3.9 Data Analysis and Presentation

The data collected in the study was purely quantitative and was analyzed by the use of descriptive statistics, including mean, standard deviation, and percentage. Inferential statistics were done by use of ANOVA, model analysis, and multivariate regression analysis. Findings were presented by use of tables. Frequencies, cross-tabulation, and descriptive ratio statistics were produced.

3.10 Validity/reliability

Data quality is determined by reliability and validity of a toll used to collect data. Reliability is key to a tool's validity (Kafka & Kozma, 2002). The study adopted self-structured tool. The study tool was designed in a way it was short and concise to reduce ambiguity and increase response rate. The tool did not capture personal data as a way of increasing accuracy in data. Pre-testing the tool assured that the tool captured what it was intended to test. The piloting done on five respondents had a Cronbach's alpha value of α 0.79 and tool was, therefore, reliable and valid.

3.11 Piloting

Before data collection, the study instrument was piloted on five individuals. Piloting was used to discover faults, ensure questions and instructions were clear, and ensure participants understood the questionnaire. After evaluating pilot study data, the researcher recognized the method to measure mental disorders (PTSD, alcohol misuse, and generalized anxiety) was redundant. The clinic's doctors had diagnosed mental disorders using DSM V. The section wasn't included in the main study. The amended questionnaire was given to other respondents.

3.12 Ethical Considerations

Before conducting the study, the researcher sought ethical approval from Kenya Methodist University's Scientific and Ethical Review Committee, NACOSTI, and Hagadera Refugee Camp psychiatric facility. Participants were also required consent to study participation before they were engaged. By completing the consent form, the interviewees were requested to express their readiness to take part in the study. As such, the freedom of respondents to make choice on whether to or not to participate was taken into consideration. The relevant research was treated carefully to protect responders' privacy rights and confidentiality. The researcher used codes in place of personal information to conceal the true identity of the participants. The participants were also assured of non-maleficence. The researcher ensured that the study procedures did not pose any danger to the participants' psychological, emotional, spiritual or physical wellbeing. The researcher also adhered to the principle of beneficence by formulating the study topic in such a way it targeted to close a gap in the area of study. The researcher informed participants that the benefit emanating from the study would accrue for years in the future and not necessarily immediately. That way, the researcher remained truthful to the participants who wished to benefit directly from the study findings.

CHAPTER FOUR:

DATA ANALYSIS AND FINDINGS

4.1 Introduction

This chapter discusses the study findings for the research conducted to ascertain the influence of psychosocial factors on development of mental disorders among refugees living in Hagadera Refugee Camp, Daadab Complex in Garissa County, Kenya. The study objectives were:

1. To examine the influence of collective ties on development of mental disorders in Hagadera refugee camp in Dadaab complex.
2. To determine the influence of acculturation on development of mental disorders among refugees in Hagadera refugee camp in Dadaab Complex.
3. To evaluate the influence of family separation on development of mental disorders among refugees living in Hagadera refugee camp in Dadaab Complex.

4.2 Response Rate

The researcher administered 240 questionnaires to the respondents who were randomly identified as they attended the mental clinic and to them whose contacts were randomly picked from the mental health records. The questionnaires were self-administered to the respondents. Some were sent to the respondents' emails (200 copies) while others (40 copies) were issued to the participants at the clinic. The study targeted 240 refugees seeking health services at Hagdera Mental Clinic. The response rate is depicted in Table 4.1:

Table 4.1:

Response rate

	Frequency	Percent
Responses received	200	83.3
Non-responses	40	16.7
Total	240	100.0

Out of the 240 administered questionnaires, 200 (83.3%) dully filled questionnaires were returned. According to Heeringa et al. (2017) a response rate that is above 60% is adequate for data analysis. As such, a percentage of 83.3% was deemed adequate for data analysis in the current study.

4.3 Demographic Information of Respondents

The study tested demographic profile of the participants. The first section covered the respondents' biographic information: gender, age, marital status, academic qualification, duration in camp, and duration of diagnoses. The results are as depicted in the sub-sections:

4.3.1 Respondents' Gender Distribution

The researcher asked respondent's gender. The outcomes were as shown on table 4.2

Table 4.2

Distribution by Gender

Gender	**Frequency**	**Percentage**
Females	93	46%
Males	107	54%
Total	**200**	**100%**

Out of the 200 participants, 107 (53.5%) were males and 93 were female (46.5%). The findings imply that mental disorders affect both genders. However, there are a higher proportion of men as compared to women. The study findings correspond to the study

findings of the research conducted by Schweitzer at al. (2006) that indicated that across the board, mental disorders and psychological distress was common among refugees. The study also indicated that more men presented with mental disorders compared to women. The study findings differed from the findings of the research by Piccinelli and Wilkinson (2000) and the study by Hapke et al. (2006) which indicated prevalence of PTSD and depression among women. The difference in findings could be due to the context in which the study was done.

4.3.2 Age Distribution and Development of Mental Disorders

The study aimed at evaluating the relationship between participants' age distribution with the development of mental disorders. The findings are shown in table 4.3:

Table 4.3

Participants Age Distribution and Mental Disorders

Age	Total
21-30	74 (37%)
31-40	93(46.5%)
41-50	20 (10%)
>50	13(6.5%)
Total	**200 (100%)**

The findings indicated that 74 (37%) of the respondents were in the (21-30) age group, 93 (46.5%) were in the (31-40) age group, 20 (10%) in the (41-50) age group, and 13 (6.5%) were in the (>50). This means that younger people in the age bracket (21-40), 167 (83.5%) presented more with mental disorders as compared to those aged 41years and above (16.5%). The possible reasons behind these findings are that young people have a lot to worry about including how to advance in their lives, starting and managing a family, as well as taking care

of their elderly parents. This finding corresponds to the study findings by Stawski et al. (2008) which indicated that less burden is placed on older people than young adults and were less reactive to stress. The the results of the investigation corroborated these conclusions in the study by Hollander et al. (2011) which showed that the frequency of mental problems was higher among refugees below the age of 40 years.

4.3.3 Marital Status and Mental Disorders

The purpose of the study was to determine the impact of marital status on the development of mental disorders. The findings were as shown in table 4.4:

Table 4.4

Participants' Marital Status

Marital Status	Males	Females	Total
Married	61(30.5%)	43(21.5%)	104 (52%)
Single	56(28%)	14(7%)	70(35%)
Divorced/Separated	8(4%)	18(9%)	26 (13%)
Total (100%)	**125(62.5%)**	**75 (37.5%)**	**200**

104 (52%) of the participants were married, 26 (13%) were divorced/separated, and 70 (35%) were singles. The findings implied that more married people presented with mental disorders as compared to non-married. The findings correspond with the results of the study by Mangrio et al. which indicated that the worry about family members' whereabouts was an additional psychological burden among the married couples as compared to the unmarried. The findings support the study results by Schweitzer et al. (2006) that indicated that across

the board, mental disorders and mental disorders psychological distress was common among refugees.

4.3.4 Level of Education Mental Disorders

Table 4.5 Participant's Level of Education

The goal of the study was to determine how participants' educational levels affected the results on mental disorders and Table 4.5 presents the findings:

Table 4.5

Participant's Level of Education

Education Level	Males	Females	Total
<Secondary cert	7	3	10
Secondary certificate	26	38	64
College	73	52	125
Higher Diploma/Degree	1	0	1
Total	**107**	**93**	**200**

The findings indicated that the highest number of participants 125(62.5%) had a college level of education. The second highest number of participants 64 (32%), had a secondary certificate level of education and 10 (5%) had not attained a secondary certificate level of education. Only 1 (0.5%) participant had a higher diploma/degree. The findings imply that mental disorders were more common among the refugees with higher educational levels as compared to those with lower levels of educational. The findings could be explained by high levels of stress related to inability to secure jobs among the refugees with relatively good education. A study by UNHCR indicated that a staggering 78 percent of the displaced were unemployed, compared to 35 percent of hosts from Turkana and 26 percent of Kenyans as a

whole (UNHCR, 2021). Also a report by Hackl, (2021) indicated that despite having a high skill background, securing a decent job was hard for refugees (Hackl, 2021).

4.3.5 Duration of Stay in the Camp

The study wished to find out the relationship between the participants duration of stay in the camp with the mental disorders. The study findings are indicated in table 4.6:

Table 4.6

Respondent's Duration in the Camp

Duration/Age	21-30	31-40	41-50	>50	Total
< 1 year	0	1	0	0	1(0.5%)
1-5 years	29	37	1	0	67(33.5%)
6-10 years	37	46	17	0	100 (50%)
>10 years	8	9	2	13	32(16%)

1 participant had lived in the camp for less than 1 year, 67 (33.5%) had lived in the camp for a period between 1- 5 years, 100 (50%) had lived in the camp for a period between 6-10 years, and 32 (16%) had lived for a period exceeding 10 years. The findings imply that mental disorder was high among refugees who had stayed relatively longer in the camp. The findings confirm the results yielded by the study conducted by Fazel and Stein, (2002) which showed high levels of PTSD, depression, and anxiety among refugees who had stayed above three years in refugee camp.

4.4 Prevalence of Mental Disorders among the Refugees

The study dependent variable was development of mental disorders. As such, the researcher sought to find out the nature of mental disorders the participants were diagnosed with at the

clinic. The researcher relied on data obtained by clinicians by the use of DSM-5 in diagnosing mental disorders at the clinic. The findings were as presented in table 4.7:

Table 4.7

Frequency of Different Mental Disorders

Mental Disorder	Frequency	Percentage
Anxiety Disorder	78	39%
Depression	56	28%
Mood Disorder	17	8.5%
Post traumatic stress disorders	18	8%
Schizo -affective disorders	9	4.5%
Bipolar disorders	8	4%
Narcolepsy	7	3.5%
Psychosis	3	1.5%
Somatic complaints	3	1.5%
Stress disorders	2	1%
Affective disorder	1	0.5%
Totals	**200**	**100%**

The study findings indicated that the respondents presented with diverse forms of mental disorders with mood disorders (including depression & bipolar disorders) 81 participants (40.5%) being the most predominant form of mental disorders. The other forms of mental disorders common among the participants were anxiety disorders (39%), PTSD (8%), schizo-affective disorders (4.5%), narcolepsy (3.5%), psychosis (1.5%), somatic complaints (1.5%), stress disorders (1%), and affective disorder (0.5%). The findings indicated that the most

prevalent form of mental disorders in the camp was mood disorder. The findings reflect confirm the studies' results done by Birman et al. 2008; Carswell et al. 2011; Mollica, 2014; Murray et al. (2010), and WHO and UNHCR, (2012), which indicated that the mental disorders commonly diagnosed among the refugees somatoform disorder, affective disorders, severe anxiety, PTSD, depression and anxiety illnesses, and severe anxiety, intellectual disability, migraine, psychotic disorders such as schizophrenia and bipolar disorders, alcoholism, illicit drug use, as well as dementia in advanced age.

4.5: Collective Ties and Development of Mental Disorders

The first objective of the study was to determine the influence of collective ties on development of mental disorders among the refugees seeking services at the mental clinic located at Hagadera Refugee Camp in Garissa County. The tool used in collecting data captured the participants' level of agreement with various statements portraying the influence of collective ties on the development of mental disorders among refugees. The responses were rated using a scale of 1 to 5 where 1 indicated strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree. The findings were as indicated in 4.8:

Table 4.8:

Influence of Collective Ties on Development of Mental Disorders

Statements	Mean	Std. Dev
There are some people who truly like me.	3.89	0.526
Whenever am not feeling well, other people show me that they are fond of me	3.46	0.869
Whenever am sad, there are people who cheer me up	3.69	0.761
There is always someone there for me when I need comforting	2.49	0.893
I know some people upon who I can always rely on for help	3.40	0.213
When I am worried, there is someone who comforts me	3.84	0.587
There are people who offer me help when I need it.	3.97	0.347
When everything becomes too much for me to handle, others are there to help me	3.64	0.797
Overall Scores	**3.54**	**0.624**

The study findings indicate that the participants' were sure of getting support whenever they were unwell (mean 3.46), sure if other people showed them that they were fond of them (mean 3.69), sure if when sad there were people who would cheer them up (mean 3.40), sure if they had some people upon whom they could always rely on for help, and when worried that someone would comforts them (mean 3.84). Participants also indicated that there were people who would offer them help when they needed it and when everything became too much for them to handle, others would come to their help (mean 3.64). Lastly, the table indicates that the participants agreed that there was always someone there for them when they needed to be comforted (mean 2.49). The findings indicated that there were collective ties

among refugees at Hagadera camp not very strong as the highest mean 3.97. These low collective ties could mean no strong bond among the refugees, hence high prevalence of mental disorders at the camp. The study findings complement Schweitzer et al. (2007), who found that social support and religion helped relocate immigrants. Kanji and Cameron (2010) found that faith and community support assist children and families cope with adversity. Other research show social isolation raises mental health risks (Jankovic-Rankovic et al., 2022; Oppedal &Idsoe 2015; Porter & Haslam, 2005; Sinner et al., 2007).

4.6: Influence of acculturation on Development of Mental Disorders

The study intended to establish if there was a correlation between acculturation and the development of mental disorders. The respondents were asked to respond to the prompts indicating level of acculturation. The responses were on a Likert scale where 1 indicated Completely of my native culture; 2. Mostly of my native culture; 3. Mostly of host culture; 4. Completely of host culture (Somalia); and 5. Both of host & my native culture. The findings were presented in table 4.9.

Table 4.9:

Influence of Acculturation on Development of Mental Disorders

Statements	Mean	Std. Dev
The language I speak	2.77	1.432
The languages of TV programs I watch are	2.87	0.621
The language of Radio programs I listen to	3.01	0.760
The style of my dressing	2.77	1.047
The gestures I use in talking are	3.40	1.147
My ideas on etiquette and good manners are	3.43	1.149
My attitude toward teasing and joking is	3.06	1.355
The festivals I celebrate are	2.39	0.707
I prefer going to parties at which the people are	3.07	0.790
The people I visit or visit me are	3.45	0.895
My ideas on how members of a family should behave toward each other are	2.97	0.769
My ideas on how relatives should behave towards each other are	3.01	0.827
My ideas on how a man should court his future wife are	2.76	0.871
My idea of having fun is	1.92	1.083
The foods I eat is	2.81	0.607
Overall Score	**2.90**	**0.937**

As indicated by the figures on table 4.9, it becomes noticeable that the participants scored low on most indicators of effective acculturation (integrating both host & native culture). The

findings indicate that the Participants' opinions on social graces, as well as their perspective on joking and taunting, preference for parties attended, people they visited or visit and their ideas on how relatives should behave towards each other were of host culture as indicated by a mean of (3.45; 305; 3.07; 3.45) respectively. The findings also showed that the participants' spoken language, language of TV and radio programs they watch and listen, their dressing style, the festivals they celebrate, their idea on how family members should behave towards each other, the idea of how a man should court a wife, and the foods preference were mostly of their native culture as indicated by the means scores of (2.77; 2.87; 2.79; 2.76; 2.39; 2.97; 2.76; 2.81) respectively. The data also showed that the participant's idea of fun was native (mean 1.84). The study linked acculturation to mental disorders. Abu-Bader et al. (2011) and Jang et al. (2007) found that Koreans and Muslims with low acculturation to U.S. culture had significant depression prevalence. Torres et al. (2010) found that assimilated Latinos were more prone to depression symptoms than native Latinos. Nakash et al. (2012) found that assimilated immigrant youth had worse mental health than integrated youths. When a person fails to adequately fit in a new culture, he/she is likely to get distressed and becomes vulnerable to developing mental disorders (Eisenbruch, 2001).

4.7: Family Separation and Development of Mental Disorders

Additionally, the study tried to determine the impact of family separation on development of mental disorders. The study findings were as indicated on table 4.10:

Table 4.10:

Family Separation on Development of Mental Disorders

Statements	Mean	Std. Dev
I live with all family members in this camp	2.76	1.273
Some of my family members don't live in this camp but I know where they live.	3.32	1.486
I'm in constant communication with the family members not living with me in this camp.	2.68	1.455
There are efforts in progress to reunite all family members.	4.02	0.940
There are plans for repatriation back to my home country.	3.02	0.848
Average scores	**3.16**	**1.200**

The findings presented in table 4.10 show that the participants did not live with all of their family members in the camp (mean 2.76) and that they were unaware of where some of their family members lived (mean 3.32). The findings also indicated that the participants were not in a constant communication with family members living apart (mean 2.68). Also, the participants reported that they slightly agreed that there were plans in progress to reunite all family members (mean 4.02) but slightly agreed that there were plans underway for repatriation back to their home country (mean 3.02). The study results suggest that participants felt separated from their families, which may have contributed to mental disorder. Insufficient social reintegration is significantly linked to lower health-related level

of life, cognitive disability, and degree of depression, worry, and PTSD symptoms, according to a study by Schick et al. (2016). Family separation is a key source of distress among refugees and is highly connected with PTSD, depression, and anxiety disorders. Family separation, role shift, and concern for relatives in the home country were the most common post-migration stresses, according to Weine et al. (2004) and Faze et al. (2012).

4.8 Inferential Analysis

The area of statistics known as "interpretive statistics" deals with inferences, generalisation, forecasts, and estimates utilizing sample evidence (Mugenda & Mugenda, 2009). The study conducted inferential statistics such as Analysis of Variance (ANOVA), multivariate regression equation, and model summary.

4.8.1: ANOVA (Analysis of Variance)

When there is a quantitatively significant distinction between the means of our predictor factors, the variance calculation shows that.

Table 4.11 shows the analysis of variance test results as produced by SPSS. The objective of the study was to determine the model's importance.

Table 4:11

ANOVA (Analysis of Variance)

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	5.216	3	1.739	6.822	.0000[a]
	Residual	17.293	43	2.55412		
	Total	22.509	46			

a. Dependent Variable: Development of Mental Disorders
b. Predictors: (Constant), Acculturation, collective ties, family separation

Table 4.13 displays ANOVA results and whether independent variable means differ significantly. The significance value is 0.000, below 0.05. The regression model proved

statistically significant in predicting how acculturation, social relationships, and family alienation influence mental disorder development among Hagadera Camp refugees. F value of 6.822 was greater than F critical value, confirming the model's fitness (4.12).

4.8.2: Multivariate Regression Analysis

Multivariate regression analysis allows the assessment of the degree to which the dependent variable and numerous independent factors are correlated.

Table 4.12

Multivariate Regression Analysis

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig./P
	B	Std. Error	Beta		
(Constant)	5.415	.899		6.014	0.000
CT	-.518	.234	.217	2.936	.021
ACCLT	-.180	.160	.118	1.021	.012
FS	.502	.163	.417	.3086	.001

Table 4.12 shows a substantial negative and significant link between mental disorder development and collective ties (beta = -0.518, p = 0.021 0.05). Similarly, acculturation was negatively and significantly associated with mental disorders development (beta = -0.180, p = 0.012<0.05). A beta coefficient of 0.502 and a p value of 0.001<0.05 showed a statistically significant positive connection between mental disorders and familial separation.

Table 4.13:

Hypothesis Testing

Hypothesis	Method and Criteria	Remark
H_1: There is no significant relationship between collective ties and development of mental disorders	Multivariate regression analysis (P=0.021<0.05)	Reject Null Hypothesis
H_2: There is no significant relationship between acculturation and development of mental disorders	Multivariate regression analysis (P=0.012<0.05)	Reject Null Hypothesis
H_3: There is no significant relationship between family separation and development of mental disorders	Multivariate regression analysis (P=0.001<0.05)	Reject Null Hypothesis

Table 4.13 indicates the probability values (p-value) for each null hypothesis formulated in the study.

First, there was no link between communal bonds and mental disorders. Hypothesis p-value: 0.021. 0.021 suggests there's a 2.1% chance the findings were random (happened by chance). This percentage is too low, indicating that the null hypothesis is false and that communal bonds are linked to mental disorders.

Second, there was no link between acculturation and mental disorders. Hypothesis p-value: 0.012. A p-value of 0.012 suggests that randomness is a 1.2% possibility (happened by chance). This percentage is too low, indicating that the null hypothesis is false and that acculturation and mental problems are linked.

Third, there was no link between familial alienation and mental disorders. Hypothesis p-value was 0.001. 0.001 suggests there's a 0.1% possibility the findings were random (happened by chance). This percentage is too low, indicating that the null hypothesis is false and that familial separation and mental disorders are linked.

4.8.3: Model Summary

To gauge the model's importance, the investigator used the simulation result: How much variance in development of mental disorders was explained by the combination of independent variables (acculturation, collective ties and family separation). R2 (or adjusted R2) is used to calculate the overall magnitude of variance, meanwhile the F-statistic is used to assess whether all of the model's coefficients are statically important in the development of mental disorders among refugees is explained by all the independent variables (acculturation, collective ties and family separation) in combination.

Table 4:14

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.801[a]	.642	.592	1.21621

R square value reflects the variance in dependent variables owing to independent variable adjustments. R square is 0.642, which suggests that 64.2% of the dependent variable (development of mental disorders) was related with changes in the three predictor variables (acculturation, collective ties and family separation). 35.8% of the difference in mental disorder development among immigrants can be explained by other factors (independent variables) not examined in the study.

CHAPTER FIVE

SUMMARY OF FINDNGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The study sought to examine the psychological factors influencing the development of mental disorders among refugees living in Hagadera Refugee Camp. The chapter presents the summary of the research findings, conclusions and recommendations of the study.

5.2 Summary of Study Findings

The summary of the findings were presented according to the study objectives;

5.2.1: Demographic Findings

The study findings on gender indicated that more men presented with mental disorders compared to women (males (107, females 93 participants).

Findings on age indicated that younger people in the age bracket (21-40), (83.5%) presented more with mental disorders as compared to those aged 41years and above (16.5%).

Findings on marital status indicated that more married people (52%) presented with mental disorders as compared to non-married (48%).

Findings on level of education implied that mental disorders were more common among the refugees with higher educational levels (63%) as compared to those with lower levels of educational (37%).

Findings on duration of stay in the camp indicated that prevalence of mental disorders was high among refugees who had stayed relatively longer (66%) in the camp.

5.2.2 Collective Ties and Development of Mental Disorders

The study findings revealed that development of mental disorders among refugees living in Hagadera camp was strongly influenced by collective ties. This was evidenced by

participants low means on getting support whenever they were unwell (mean 3.89, std.0.526), being cheered when sad (mean 3.46, std.0.869), comforted when worried (mean 3.69, std. 0.761), getting help when in need (mean 2.49 std.0.893) and not sure if other people were fond (mean 3.40 std. 0.213) of them. The participants also point out that they had no close people upon whom they could always rely on for help (mean 3.84, std. 0.587). The findings indicated that collective ties were a significant psychosocial factor that influenced development of mental disorders among refugees living in Hagadera Camp in Garissa County, Kenya. Participants presented with various mental disorder and they reported weak levels of collective ties. This was an indication of a negative correlation between collective ties and the development of mental disorders. The participants' social support was weak and could have contributed to the development of the mental disorder.

5.2.2: Acculturation and Development of Mental Disorders

The study findings indicated that acculturation influenced development of mental disorders among refugees living in Hagadera Camp. The assertion is evidenced by relatively low means from the participants which indicated that their ideas on etiquette (mean 2.77, std.1.432) and good manners (mean 2.87, std. 0.621), attitude toward teasing and joking (mean 2.79, std. 0.760), preference for parties attended (mean 2.76 std.1.043), people they visited (mean 3.40 std. 0.147) and their ideas on how relatives should behave towards each other (mean 3.43 std.1.154) were founded on host culture. The participants also pointed out that their spoken language (mean, 3.05 std. 1.366), language of TV (mean 2.90, std.0.707) and radio (mean, 3.07 std. 0.790) programs they watched and listened to, their dressing style (mean, 3.45 std. 0.889), the festivals they celebrated (mean, 2.97 std. 0.769), how a man should court a wife (mean, 3.01 std. 0.827), ways of having fun (mean,2.76 std. 0.871), and their foods preference (mean, 1.84 std.0.996) were mostly of their native culture. The responses indicated a low level of acculturation which influenced the development of mental disorders

among refugees living in Hagadera Camp in Garissa County, Kenya. There was a negative correlation between acculturation and the development of mental disorders. On average, the participants scored slightly above the mean, an indication that they were not fully integrated and this could have contributed to the development of mental disorders they presented.

5.2.3: Family Separation and Development of Mental Disorders

The results from the current study indicated that family separation influenced the development of mental disorders among refugees living in Hagadera Camp. This is supported by the responses given by the participants which indicated that participants did not live together with all of their family members (mean 2.76, std. 1.273), were unaware of where some of their family members lived (mean 3.32, std.1.486), were not in a constant communication with family members living apart (mean 2.68, std.1.455), were not assured of being reunited with estranged family members (mean 4..02, std.0.940), or getting repatriated back to their home country (mean 3.02, std.0.848). The responses indicated a high level of family separation which influenced the development of mental disorders among refugees living in Hagadera Camp in Garissa County, Kenya. There was a positive correlation between family separation and the development of mental disorders. The participants reported high levels of family separation which is a common occurrence among refugees and may have contributed to development of mental disorders to a significant level.

5.3: Conclusions

The study findings strongly resonate with models of mental health and psychological wellbeing that emphasizes psychosocially determined and contextually embedded nature. The study findings foreground the emotional conditions of refugees' lives such as living apart from the rest of family members, integration into a new culture, and subsistence collective ties that play a significant role in development of mental disorders. The study findings foreground that one consequence of experiencing compromised collective ties, family

separation, and inability to acculturate accurately among refugees is the development of mental disorders. This understanding fortifies the relevance of feasible and acceptable psychological interventions aimed at addressing psychological issues associated with reduced social ties, inadequate acculturation, and family separation among refugee communities.

5.4: Recommendations

The findings emphasize the significance of early and continuous psychiatric care, extending past the time of initial relocation, to improve refugees' health.

5.4.1 Recommendation for the Counseling Psychologists

I. Refugees are prone to acculturation process, family separation, and compromised social ties. Therefore, counseling psychologists need to be guided by study findings to develop appropriate counseling approaches in addressing psychological issues associated with acculturation process, family separation, and reduced social ties.

II. Psychologists need to actively facilitate emotional healing among refugees as a result of grief and loss they undergo.

III. Psychologists need to play a facilitating role in helping refugees acculturate appropriately by integrating their culture with host's culture as a means of lessening distress.

5.4.2 Recommendation to the Policy-Makers/Government

I. Hosting government and non-governmental organizations (NGOs) should enhance humanitarian services such as repatriation by the process of reuniting and facilitating communication among refugees' families as a way of reducing distress caused by family separation.

5.4.3 Recommendations for Further Studies

Taking the limitations and the delimitations of the study, the researcher recommends:

I. Similar studies need to be conducted in different localities to establish if acculturation, family separation and social ties factors have a high correlation with mental disorders among refugees.

II. Studies focusing on other psychosocial factors other than family separation, social ties and acculturation should be carried out to determine the reasons as to why there are high rates of mental disorders among refugees living in Hagadera Refugee Camp and other camps globally.

REFERENCES

Abu-Bader, S. H., Tirmazi, M.T., & Ross-Sheriff, F. (2011). The Impact of Acculturation on Depression among Older Muslim Immigrants in the United States. *Journal of Aging Studies, 54(4),* 425–48. https://pubmed.ncbi.nlm.nih.gov/21547830/

Alfadhli, K., & Drury, J. (2016). Psychosocial support among refugees of conflict in developing countries: a critical literature review. *Intervention Journal, 14(2),* 128-141. https://www.researchgate.net/publication/299560925_Psychosocial_support_among_refugees_of_conflict_in_developing_countries_a_critical_literature_review

Annual Tripartite Consultations on Resettlement. (2011). *Protecting the Family: Challenges in Implementing Policy in the Resettlement Context, 56(2),* 132-148. https://www.unhcr.org/3b30baa04.pdf

Ayott, L., &Williamson, L. (2001). *Separated Children in the UK: An Overview of the Current Situation*. London: The Refugee Council and Save the Children, .https://archive.crin.org/en/library/publications/separated- children-uk-overview-current-situation.html

Bapolisi, A. M., Song, S. J., Kesande, C., Rukundo, G. Z., & Ashaba, S. (2020). Post-traumatic stress disorders, psychiatric co-morbidities and associated factors among refugees in Nakivale camp in southwestern Uganda. *BMC Psychiatry, 53(6),* 106-123. https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020-2480-1

Belsky, J. (2002). Developmental origins of attachment styles. *Attachment and Human Development, 4(2),* 166-170. https://www.tandfonline.com/doi/abs/10.1080/14616730210157510

Berry, J. (2019). *Acculturation: A Personal Journey across Cultures* (Elements in Psychology and Culture). Cambridge: Cambridge University Press, *87(6),* 23-42. https://www.researchgate.net/publication/335191631_Acculturation_A_Personal_Journey_across_Cultures

Bhugra, D. & Becker, M.A. (2005). Migration, cultural bereavement, and cultural identity. *World Psychiatry, 4*(1), 18-24 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414713/

Bhui, K., Abdi, A., Abdi, M., Pereira, S., Dualeh, M., Robertson, D., Sathyamoorthy, G., Ismail, H. (2013). Traumatic events, migration characteristics and psychiatric symptoms among Somali refugees—preliminary communication. *Social Psychiatry and Psychiatric Epidemiology, 38*(1), 35-43. https://pubmed.ncbi.nlm.nih.gov/12563557/

Bhui, K.S., Lenguerrand, E., Maynard, M.J., Stansfeld, S.A., & Harding, S. (2012). Does Cultural Integration Explain a Mental Health Advantage for Adolescents? *International Journal of Epidemiology, 41(3),* 791–802. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3396315/#:~:text=Cultural%20integratio.

Birman, D., Beehler, S., & Harris, E. (2008). International Family, Adult, and Child Enhancement Services (FACES): A Community-Based Comprehensive Services Model for Refugee Children in Resettlement. *American Journal of Orthopsychiatry, 78(1),*121-32.

https://www.academia.edu/22252282/International_Family_Adult_and_Child_Enhancement_Services_FACES_A_community_based_comprehensive_services_model_for_refugee_children_in_resettlement

Capstick, T. (2018). *Language for Resilience: Cross-Disciplinary Perspectives on the Role of Language in Enhancing the Resilience of Refugees and Host Community (Ed), 66(7),* 88-101.**https://www.britishcouncil.org/sites/default/files/language_for_resilience_-cross-_disciplinary_perspectives_0.pdf**

Carlson, E. B., & Rosser-Hogan, R. (2014). Trauma experiences, posttraumatic stress, dissociation, and depression in Cambodian refugees. *The American Journal of Psychiatry, 148(7)*, 1548-1551. https://pubmed.ncbi.nlm.nih.gov/1928471/

Carswell, K., Blackburn, P., & Barker, C. (2011). "The Relationship between Trauma, Post-Migration Problems and the Psychological Well-Being of Refugees and Asylum Seekers. *International Journal in Social Psychiatry, 57(3),* 123-160. https://pubmed.ncbi.nlm.nih.gov/21343209/

Corey, G. (2009). *Theory and Practice of Counseling and Psychotherapy 8th ed*. Thomson.

Curry, L.A., Nembhard, I.M., & Bradley, E.H. (2009). Qualitative and Mixed Methods Provide Unique Contributions to Outcomes Research. *Circulation, 119(10),* 1442-1452. https://www.ahajournals.org/doi/10.1161/circulationaha.107.742775

Dwivedi K. (2000). *Post Traumatic Stress Disorder in Children and Adolescents*. Whurr Publishers.

Eisenbruch, M. (2001). From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Science and Medicine, 33(2)*, 673-680. https://pubmed.ncbi.nlm.nih.gov/1957187/

Elbin, V.J., Sneed, C.D., Morisky, D.E., Rotheram-Borus, M.J., Magnusson, A.M., & Malotte C.K. (2001). Acculturation and Interrelationships between Problem and Health-promoting Behaviors among Latino Adolescent. *J Adolesc Health, 28(6),* 62–72. https://www.researchgate.net/publication/12191118_Acculturation_and_interrelationships_between_problem_and_healthpromoting_behaviors_among_Latino_adolescents

Fanzel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet, 365(7)*, 1309-1314.

https://www.researchgate.net/publication/7914253_Prevalence_of_serious_mental_disorder_in_7000_refugees_resettled_in_Western_countries_A_systematic_review

Faze, M., Reed, R.V., Panter-Brick, C., & Stein, A. (2012). Mental Health of Displaced and Refugee Children Resettled in High-Income Countries: Risk and Protective Factors.

The Lancet, 379(11), 266-282. https://www.thelancet.com/journals/lancet/article/PIIS0140673611600 51- 2/fulltext

Fleming, T. (2007). *A secure base for adult learning: Attachment theory and adult education.* Cenage Publishers.

Forslund, T., & Duschinsky, R. (2021). *Attachment theory and research: a reader*. Willey & Sons Ltd.

Gorst-Unsworth, C. (2002). Adaptation after torture: some thoughts on the long-term effects of surviving a repressive regime. *Med War, 8*(3), 164-168.

https://pubmed.ncbi.nlm.nih.gov/1406464/

Hackl, A. (2021). *Towards decent work for young refugees and host communities in the digital platform economy in Africa: Kenya, Uganda, Egypt*.

https://www.ilo.org/wcmsp5/groups/public/---edemp/documents/publication/wcms_816539.pdf

Hapke U, Schumann A, Rumpf H.J, John U, & Meyer C. (2006). Post-traumatic stress disorder - The role of trauma, pre-existing psychiatric disorders, and gender. *European Archives of Psychiatry and Clinical Neuroscience, 256(5),* 299-306. https://pubmed.ncbi.nlm.nih.gov/16783498/

Hauff, E., & Vaglum, P. (2004). Chronic posttraumatic stress disorder in Vietnamese refugees: A prospective community study of prevalence, course, psychopathology, and stressors. *Journal of Nervous and Mental Disease, 182(12),* 85-90. https://pubmed.ncbi.nlm.nih.gov/8308537/

Heeringa, S., West, B. T., & Berglund, P. A. (2017). *Applied survey data analysis*. CRC Press.

Hollander, A.C., Bruce, D., Burstrom, B., & Ekblad, S. (2011). Gender-related mental health differences between refugees and non-refugees immigrants: A cross-sectional register- based study. *BMC Public Health, 180(11),* 66-85.

https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11- 180

Hynie, M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry, 63(5),*297-303. https://pubmed.ncbi.nlm.nih.gov/29202665/

Jang, Y., Kim, G., Chiriboga, D., & King-Kallimanis, B. (2007). A Bi-dimensional Model of Acculturation for Korean American Older Adults. *Journal of Aging Studies, 21(3),* 267- 275. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034290/

Jankovic-Rankovic, J., Oka, R. C., Meyer, J. S., Snodgrass, J. J., Eick, G. N., & Gettler, L. T. (2022). Transient refugees' social support, mental health, and physiological markers:

Evidence from Serbian asylum centers. *American Journal of Human Biology*, *23(7),* 7-19. https://doi.org/10.1002/ajhb.23747

Keller, A., Lhewa, D., Rosefeld, B., Sachs, E., Aladjem, A., Cohen, I., Smith, H., & Porterfield, K. (2013). Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. *The Journal of Nervous and Mental Disease, 194*(3), 188-194. https://pubmed.ncbi.nlm.nih.gov/16534436/

Kim, J. Y., Kim, H. J., Choi, K., & Nam, B. (2016). Mental health conditions among North Korean female refugee victims of sexual violence. *International migration, 55(2),* 68-79. *https://www.researchgate.net/publication/310515409_Mental_Health_Conditions_Among_North_Korean_Female_Refugee_Victims_of_Sexual_Violence*

Kinzie, J.D., Boehnlein, J.K., Leung, P.K., Moore, L.J., Riley, C., Smith, D. (2000). The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees. *American Journal of Psychiatry, 147*(7), 913-917. https://pubmed.ncbi.nlm.nih.gov/2356877/

Klein, E.M., Muller, K. W., Wolfling, K., Dreier, M., Ernst, M., & Beutel, M.E. (2020).The relationship between acculturation and mental health of 1st generation immigrant youth in a representative school survey: does gender matter? *Child Adolescent Psychiatry Mental Health, 14(29),* 201-213. https://capmh.biomedcentral.com/articles/10.1186/s13034-020-00334-

Kuckartz, U., & Radiker, S. (2018). *Analyzing qualitative data with MAXQDA*. Springer

Laban, C. J., Komproe, I. H., Gernaat, H. B., & de Jong, J. T. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 43(9),* 507-515.https://www.researchgate.net/publication/5295506_The_impact_of_a_long_asylum_procedure_on_quality_of_life_disability_and_physical_health_in_Iraqi_asylum_seekers_in_the_Netherlands

Larkin, W., & Morrison, A. P. (2007). *Trauma and psychosis: New directions for theory and therapy*. Routledge.

Lindert, J., Ehrenstein, O. S., Priebe, S., Mielck, A., & Brahler, E. (2009). Depression and anxiety in labor migrants and refugees – a systematic review and meta- analysis. *Social Science and Medicine, 69(8),* 246-257. https://www.academia.edu/6867944/Depression_and_anxiety_in_labor_migrants_and_refugees_A_systematic_review_and_meta_analysis

Lindert, J., Schinina, G. (2012). Mental health of refugees and asylum-seekers. In B. Rachel (Ed.), Migration *and health in the European Union*. Open University Press.

Lobel, L. M., & Jacobsen, J. (2021). Waiting for kin: a longitudinal study of family reunification and refugee mental health in Germany. *Journal of Ethnic and*

Migration Studies, *47(7),* 2916-2937. https://www.tandfonline.com/doi/full/10.1080/1369183X.2021.1884538

Lorenzo-Blanco, E.I., Unger, J.B., Ritt-Olson, A., Soto, D., & Baezconde-Garbanati, L. (2011). Acculturation, Gender, Depression, and Cigarette Smoking among U.S. Hispanic Youth: The Mediating Role of Perceived Discrimination. *Journal of Youth and Adolescence, 40(11),* 1519–1533. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753367/

Luci, M. (2020). Displacement as trauma and trauma as displacement in the experience of refugees. *Journal of Analytical Psychology*, *65(2),* 260-280. https://onlinelibrary.wiley.com/doi/abs/10.1111/1468-5922.12590=

Mangrio, E., Sjostrom, K., Grahn, M., & Zdravkovic, S. (2021). Risk for mental illness and family composition after migration to Sweden. *Public Library of Science, 16(5),* 301-317.https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0251254&type=printable

McQueen, A., Getz, J.G., & Bray, J.H. (2003). Acculturation, substance Use, and Deviant Behavior: Examining Separation and family Conflict as Mediators. *Child Dev, 74(6),* 1737– 50. https://pubmed.ncbi.nlm.nih.gov/14669893/

Mengistu, B. S., & Manolova, G. (2019). Acculturation and mental health among adult forced migrants: A meta-narrative systematic review protocol. *Systematic reviews*, *8(1),* 1-8.

https://systematicreviewsjournal.biomedcentral.com/track/pdf/10.1186/s13643-019-1103-8.pdf

Miller, A., Hess, J. M., Bybee, D., & Goodkind, J. R. 2018). Understanding the Mental Health Consequences of Family Separation for Refugees: Implications for Policy and Practice. American Journal of Orthopsychiatry, *88(1),* 26-37. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5732089/

Mollica, R.F. (2014). The Enduring Mental Health Impact of Mass Violence: A Community Comparison Study of Cambodian Civilians Living in Cambodia and Thailand. *International Journal of Social Psychiatry, 60(1),* 6-20. https://www.semanticscholar.org/paper/The-enduring-mental-health-impact-of-mass-

Mugenda, O. M., & Mugenda, A. G. (2003). *Research methods: qualitative and quantitative approaches*. Acts Press.

Murray, K, Davidson, G, Schweitzer, R. 2010. "Review of Refugee Mental Health Interventions Following Resettlement: Best Practices and Recommendations. American Journal of Orthopsychiatry, *80(4),* 576-585. https://www.semanticscholar.org/paper/Review-of-refugee-mental-health-interventions-best-Murray-Davidson/df1601f120cd559023f86e2f6fe91c957b924664

Nakash, O., Nagar, M., Shoshani, A., Zubida, H., & Harper, R. (2012). The Effect of Acculturation and Discrimination on Mental Health Symptoms and Risk Behaviors among Adolescent Migrants in Israel. *Culture Divers Ethnic Minor Psychology, 18(3),*228-238.https://www.researchgate.net/publication/225294463_The_Effect_of_Acculturation_and_Discrimination_on_Mental_Health_Symptoms_and_Risk_Behaviors_Among_Adolescent_Migrants_in_Israel.

Norredam, M., Garcia-Lopez, A., Keiding, N., & Krasnik, A. (2009). Risk of mental disorders in refugees and native Danes: A register-based retrospective cohort study. *Social Psychiatry & Psychiatric Epidemiology*, *44(12),* 1023-1029. https://pubmed.ncbi.nlm.nih.gov/19294322/

Oppedal, B., & Idsoe, T. (2015). The role of social support in the acculturation and mental health of unaccompanied minor asylum seekers. *Scandinavian journal of psychology*, *56(*2), 203-211. https://doi.org/10.1111/sjop.12194

Piccinelli M, Wilkinson G. (2000). Gender differences in depression. *Critical review. British Journal of Psychiatry, 177(8),* 486-492. https://europepmc.org/article/MED/11102321

Pincock, S. (2013). Exposing the horror of torture. *Lancet, 362(9394),* 1462-1464.

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)14730-7/fulltext

Porter, M. & Haslam, N. (2005). Pre-displacement and post displacement factors associated with mental health of refugees and internally displaced persons: Ameta-analysis. *Journal of the American Medical Association, 295(5),* 602-612.https://www.semanticscholar.org/paper/Predisplacement-and-postdisplacement-factors-with-a-Porter-Haslam/3dd5a0f7b3a847193e5ab62289e2be28702ab84b

Roscoe, K.D. (2009). Critical social work practice a narrative approach. *International Journal of Narrative Practice, 1(1),* 9-18. https://pureportal.coventry.ac.uk/files/53768059/Critical_Social_Work.pdf

Rukwaru, M. (2007). *Fundamentals of social research*. Nairobi: Signal Press Limited, *30(2),*46-60.https://textbookcentre.com/catalogue/fundamentals-of-social-research_12501/

Savic, M., Chur-Hansen, A., Mahmood, M. A., & Moore, V. (2013). Separation from family and its impact on the mental health of Sudanese refugees in Australia: a qualitative study. *Australian and New Zealand journal of public health*, *37(*4), 383-388.https://doi.org/10.1111/1753-6405.12088

Schweitzer, R., Brough, M., Vromans, L., & Asic-Kobe, M. (2007). Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post migration experience. *Australian and New Zealand Journal of Psychiatry*, *22(9),* 1-9.

https://www.semanticscholar.org/paper/Mental-Health-of-Newly-Arrived-Burmese-Refugees-in-Schweitzer-Brough/9042f7e1a13eb3b6c4b340a431b06395609b234f

Silove, D., Momartin, S., & Marnane, C. (2010). Adult separation anxiety disorder among war-affected Bosnian refugees: Co-morbidity with PTSD and associations with dimensions of trauma. *Journal of Trauma and Stress, 23(8),* 169-172. https://pubmed.ncbi.nlm.nih.gov/20135680/

Sinnerbrink, I., Silove, D., Field, A., Steel, Z., & Manicavasagar, V. (2007). Compounding of premigration trauma and post-migration stress in asylum seekers. *The Journal of Psychology: Interdisciplinary and Applied, 131(32)*, 463-470. https://www.tandfonline.com/doi/abs/10.1080/00223989709603533

Sleijpen, M., Mooren, T., Kleber, R. J., & Boeiji, H. R. (2017). Lives on Hold: A Qualitative Study of Young Refugees' Resilience Strategies. *Sage Publications Childhood Journals, 24(3),* 348-365. **https://journals.sagepub.com/doi/full/10.1177/0907568217690031**

Starck, A., Gutermann, J., Schouler-Ocak, M., Jesuthasan, J., Bongard, S., & Stangier, U. (2020). The relationship of acculturation, traumatic events and depression in female refugees. *Frontiers in Psychology*, *11(10)*, 906-717. http://doi.org/10.3389/fpsyg.2020.00906

Stawski, R.S., Sliwinski, M.J., Almeida, D.M., & Smyth, J.M. (2008). Reported exposure and emotional reactivity to daily stressors: The roles of adult age and global perceived stress. *Psychology and Aging.* 2008(23), 52–61. https://pubmed.ncbi.nlm.nih.gov/18361654/

Stone, D. (2018). Refugees then and Now: Memory, History and Politics in the Long Twentieth Century: An Introduction Patterns of Prejudice. https://www.tandfonline.com/doi/full/10.1080/0031322X.2018.1433004

Tempany, M. (2009). What research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: a literature review. *Transcultural Psychiatry, 46(9)*, 300-315. https://pubmed.ncbi.nlm.nih.gov/19541752/

The United Nations High Commissioner for Refugees. (June 2019). Africa: Sub- Saharan-Total Population of Concern to UNHCR/End 2018. https://reliefweb.int/map/world/africa-sub- saharan-total-population-concern-unhcr-end-2018

Torres, L. (2010). Predicting levels of Latino depression: acculturation, acculturative stress, and coping. *Cultural Diversity and Ethnic Minority Psychology, 16(4),* 256–263.https://epublications.marquette.edu/cgi/viewcontent.cgi?article=1011&context =psych_fact.

UNICEF Report. (2015). *Taking Child Protection to the next Level in Kenya*. http://www.alternativecare.or.ke/wp-content/uploads/2019/09/Kenya_CP_system_case_study-1.pdf

United Nations Department of Economic and Social Affairs. (2018). *Refugees and Social Integration in Europe, 11(3),* 36-48. https://www.un.org/development/desa/family/wpcontent/uploads/sites/23/2018/05/Robila_EGM_2018.pdf

United Nations High Commissioner for Refugees. (2013). *Overview of the Refugee Situation in Africa*. https://www.unhcr.org/54227c4b9.pdf

United Nations. (2008). Convention relating to the status of refugees: Protocol relating to the status of refugees. *United Nations Audiovisual Library of International Law, 56(7),* 223-239. http://legal.un.org/avl/ha/prsr/prsr.html

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science and Medicine, 52(6)*, 1709-1718. https://pubmed.ncbi.nlm.nih.gov/11327142/

Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A, & Mujagic, A. (2022). Family Consequences of Refugee Trauma. *Family Process, 43(2),* 147-160. https://www.academia.edu/21048790/Family_Consequences_of_Refugee_Trauma

Wild Health Organization & United Nations High Commissioner for Refugees (2012). *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings* http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/

World Health Organization (2018). *Mental Health Promotion and Mental Health Care in Refugees and Migrants*. Copenhagen: WHO Regional Office for Europe.http://www.euro.who.int/__data/assets/pdf_file/0004/386563/mental-health- eng.pdf?ua=

Appendix I: Informed Consent Form

Informed Consent Form

Kenya Methodist University

P. 0 Box 267-00200,

Meru, Kenya

Subject: Informed Consent

Dear Respondent,

My name is Saadia Mohamed. I am a Masters student from Kenya Methodist University. I am conducting a study titled "Influence of Psychosocial Factors on Psychological Disorders among Refugees in Hagadera Camp in Dadaab, Garissa County". The information obtained will be used to review current policies for improving health worker performance in public health facilities and contribute towards strengthening health service delivery to those who need and when they need them.

Procedure to be followed

Participation in this study will require that I ask you some questions and also access the hospital and the staff. I will present to you the attached self-administered questionnaire for your honest action and response and record information on your responses to the Key Informant Interview Guide.

You have the right to refuse participation in this study. You will not be penalized nor victimized for not joining the study and your decision will not be used against you nor affect you at your place of work.

Please remember that participation in the study is voluntary. You may ask questions related to the study at any time. You may refuse to respond to any questions and you may stop an interview at any time. You may also stop being in the study at any time without any consequences to the services you are rendering.

Discomforts and risks

Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens; you may refuse to answer if you choose. You may also stop the interview at any time. The interview may take about 40 minutes to complete.

Benefits

If you participate in this study you will help me to formulate strategies for service delivery among refugees presenting with psychological disorders and mental illness in Hagadera Camp in Kenya which is important for better health service provided by competent health providers. You will benefit from this assessment because it will help us strengthen health systems in our county.

Rewards

If you agree to participate in this study it will be voluntary and that no monitory rewards will be provided but will thank you for your participation.

Confidentiality

The interviews will be conducted in a private setting within the hospital. You name will not be recorded on the questionnaire and the questionnaires will be kept in a safe place at the University.

Participant's Statement

The above statement regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will not be victimized at my place of work whether I decide to leave the study or not and my decision will not affect the way I am treated at my work place.

Name of Participant……. Date……..

Signature…….

Investigator's Statement

I, the undersigned, have explained to the volunteer in a language she/he understands the procedures to be followed in the study and the risks and the benefits involved.

Name of Interviewer……Date…….

Interviewer Signature……

Appendix II: Research Questionnaire

Section A: Bio-data

1. Which is your gender?

   Male [ ]

   Female [ ]

2. What is your age bracket? (Tick as appropriate)

   18 – 30 years [ ]

   31 - 40 years [ ]

   41 – 50 years [ ]

   Over 51 years [ ]

3. What is your marital status? (Tick as applicable)

   Single [ ]

   Married [ ]

   Divorced/Separated [ ]

   Others-specify…… [ ]

4. What is your highest level of education?

   Certificate Level [ ]

   College Diploma [ ]

   Higher Diploma [ ]

   University Degree [ ]

   Postgraduate Degree [ ]

5. How many years have you stayed here at the camp? (Tick as applicable)

   Less than 1 year [ ]

   Between 1-5 years [ ]

   Between 6-10 years [ ]

   Over 10 years [ ]

SECTION B: Prevalence of Mental Disorders

Diagnostic Criteria for Generalized Anxiety Disorder

1. Excessive anxiety and worry, occurring more days than not for at least 6 months, concerning a number of events;
2. The individual finds it difficult to control the worry;
3. The anxiety and worry are associated with at least three of the following six symptoms (only one item required in children): (Restlessness, feeling keyed up or on edge, Being easily fatigued, Difficulty concentrating, Irritability, Muscle tension, Sleep disturbance.
4. The anxiety, worry or physical symptoms cause clinically significant distress or impairment in important areas of functioning;
5. The disturbance is not due to the physiological effects of a substance or medical condition;
6. The disturbance is not better explained by another medical.

Diagnostic Criteria for PTSD

1. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
    - Directly experiencing the traumatic event(s).
    - Witnessing, in person, the event(s) as it occurred to others.
    - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

2. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
    - Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
    - Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
    - Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
    - Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
    - Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
3. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

4. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
5. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
6. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
7. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
8. Markedly diminished interest or participation in significant activities.
9. Feelings of detachment or estrangement from others.
10. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
11. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
    - Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.

- Reckless or self-destructive behavior. (Hypervigilance, Exaggerated startle response, Problems with concentration, Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

DSM-5 Diagnostic Criteria for Schizo-affective disorder

A. Two or more of the following presentations, each present for a significant amount of time during a 1-month period (or less if successfully treated). At least one of these must be from the first three below:

- Delusions,
- Hallucinations,
- Disorganized speech (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior
- Negative symptoms (i.e., diminished emotional expression or avolition)

B. Hallucinations and delusions for two or more weeks in the absence of a major mood episode (manic or depressive) during the entire lifetime duration of the illness.

C. Symptoms that meet the criteria for a major mood episode are present for most of the total duration of both the active and residual portions of the illness.

D. The disturbance is not the result of the effects of a substance (e.g., a drug of misuse or a medication) or another underlying medical condition.

Diagnostic Criteria for Psychosis

- Feel like your emotions are interfering with your work, relationships, social activities or other parts of your life
- Have trouble with drinking or drugs
- Have suicidal thoughts or behaviors — seek emergency treatment immediately

Diagnostic Criteria for Narcolepsy

- EDS that persists for at least three months
- PSG/MSLT results that show quick sleep onset and early start of REM sleep periods
- No cataplexy symptoms
- Normal or unknown levels of hypocretin found in the CSF
- No other conditions can better explain symptoms and test results

SECTION C: Influence of Collective ties on development of mental disorders

I. There are some people who truly like me.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

II. Whenever am not feeling well, other people show me that they are fond of me.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

III. Whenever am sad, there are people who cheer me up.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

IV. There is always someone there for me when I need comforting.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

V. I know some people upon who I can always rely on for help.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

VI. When I am worried, there is someone who comforts me.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

VII. There are people who offer me help when I need it.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

VIII. When everything becomes too much for me to handle, others are there to help me.
1. Strongly disagree 2. Disagree 3. Don't Know 4. Agree 5. Strongly agree

Section D: Effect of Influence of Acculturation on development of mental disorders

1. The language I speak is

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

2. The language of TV programs I watch are

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

3. The language of Radio programs I listen to are

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

4. The style of my dressing is

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

5. The gestures I use in talking are

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

6. My ideas on etiquette and good manners are

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

7. My attitude toward teasing and joking is

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

8. The festivals I celebrate are

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

9. I prefer going to parties at which the people are

   a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

10. The people I visit or visit me are

    a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

11. My ideas on how members of a family should behave toward each other are

a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

12. My ideas on how relatives should behave towards each other are

a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

13. My ideas on how a man should court his future wife are

a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

14. My idea of having fun is

a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

15. The foods I eat are

a). Completely of my native culture b). Mostly of my native culture c). Mostly of host culture d). Completely of host culture (Somalia) e). Both of host & my native culture

Section E: Influence of family separation on development of mental disorders

16. I live with all family members in this camp

1. Strongly disagree 2. Moderately disagree 3. Slightly disagree

4. Slightly agree 5. Moderately agree 6. Strongly agree

17. Some of my family members don't live in this camp but I know where they live.

1. Strongly disagree 2. Moderately disagree 3. Slightly disagree

4. Slightly agree 5. Moderately agree 6. Strongly agree

17. I'm in constant communication with the family members not living with me in this camp.

1. Strongly disagree 2. Moderately disagree 3. Slightly disagree

4. Slightly agree 5. Moderately agree 6. Strongly agree

19. There are efforts in progress to reunite all family members.

1. Strongly disagree 2. Moderately disagree 3. Slightly disagree

4. Slightly agree 5. Moderately agree 6. Strongly agree

20. There are plans for repatriation back to my home country.

1. Strongly disagree 2. Moderately disagree 3. Slightly disagree

4. Slightly agree 5. Moderately agree 6. Strongly agree

Appendix III: Research Authorization (KEMU)

KENYA METHODIST UNIVERSITY
P. O. BOX 267 ME-RU - 60200, KENYA FAX: 254-64-30162
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June 4 2021 KeMU/SERC/MCP/24/2021

Saadia Mohamed
Kenya Methodist University

Dear Saadia,

SUBJECT: INFLUENCE OF PSYCHOSOCIAL FACTORS ON MENTAL DISORDERS AMONG REFUGEES: A CASE OF HAGADERA CAMP IN DADAAB, CARISSA COUNTY

This is to inform you that Kenya Methodist University Scientific Ethics and Review Committee has reviewed and approved your above research proposal. Your application approval number is KeMU /SERC/MCP/24/2021. The approval period is 4th June 2021 — 4th June 2022.

This approval is subject to compliance with the following requirements

l. Only approved documents including (informed consents, study instruments, MTA) will be used.

ll. All changes including (amendments, deviations, and violations) are submitted for review and approval by Kenya Methodist University Scientific Ethics and Review committee.

III. Death and life-threatening problems and Serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to KeMU SERC within 72 hours of notification.

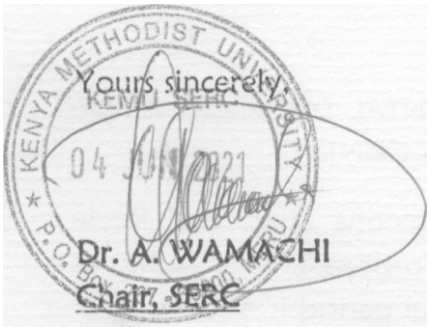
IV. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KeMU SERC within 72 hours.

V. Clearance for export of biological specimens must be obtained from relevant institutions.

VI. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.

Vil. Submission of an executive summary report within 90 days upon completion of the study to KeMU) SERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and innovation (NACOST!) https://oris.nacosti.go.ke and also obtain other clearances needed.



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY

Ref No: **44893**

Date of Issue: **2nd June 202**

RESEARCH LICENSE

This is to Certify that Ms.. Saadia Ibrahim Mohamed of Kenya Methodist University, has been licen Garissa on the topic: INFLUENCE OF PSYCHOSOCIAL FACTORS ON MENTAL DISORDERS CASE OF HAGADERA CAMP IN DADAAB, GARISSA COUNTY for the period endi

License No: **NACOSTI/P/21/1130**

44893

Applicant Identification

Director
NATIONAL COMMISSION FO
SCIENCE,TECHNOLOGY &
INNOVATIO

Verification OR

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THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

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1. The License is valid for the proposed research, location and specified period
2. The License any rights thereunder are non-transferable
3. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research
4. Excavation, filming and collection of specimens are subject to further necessary clearence from relevant Government Agencies
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