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IMPACT OF FORCED MIGRATION ON THE MENTAL HEALTH OF KASHMIRI MIGRANT WOMEN

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Abstract:-Migration literally means “change of ones residence” due to socio-geographic conditions or for better future. Migration primarily can be selective process in which people leave place of original settlement on their own due to some motivation and try to settle down at some other place. This is called free migration. Then there is forced migration in which the people are forced to leave their place of origin due to compelling circumstances it becomes difficult for them to tolerate changed political conditions created by a group of persons beyond the control of the authority or government governing the land and create environment of terrorism due to which they are forced to migrate to a safer place. (Peterson et. al., 1988) forced migration is a type of migration in which people are left with no decision of their own, rights which are due are denied. In this type of situation people try to cope with this stress and the people who are not able to cope exhibit a variety of deviations in their behavior. In Jammu and Kashmir (India), a particular community Kashmiri pandit was forced by terrorist outfits to quit their land. After migration these people faced a number of problems and try to cope with them but the people who were not able to cope exhibit a variety of deviations in their behavior. Forced migration lead to huge stresses and mental, emotional and physical health difficulties. Migration is not only a geographical transition, it is also a psycho-social transition and can result in a "cultural bereavement", grief not only for the country left behind, but also for the culture or subculture into which one is born

Keywords: Forced Migration , Mental Health , Kashmiri Migrant Women , socio-geographic .

INTRODUCTION:

Psychological aspects of migration include the dual task of resolving grief over losses and of mastering resettlement conditions. Dislocation and displacement can also be a part of the experience.

Mental health simply means a state of social, psychological, & spiritual well being – not just the absence of disease. Imbalance or disequilibrium in any area (i.e. Co native, Cognitive & Affective) of normal functioning may lead to ill-health.
Dennerstein et.al. (1993):- Mental Health is the capacity of the individual, the group & the environment to interact with one another in ways that promote subjective well being, the optimal development & use of mental-abilities. Once a person attains equality & balance in all levels (i.e. social, physical &psychological) he is considered mentally healthy (Carmen et.al. 1981). If there is deviation in one aspect of health the individual becomes mentally ill.
Mental health is the capacity of the individuals to cope constructively and successfully with the opportunities and stresses of life in ways that are consistent with their constraints of their life situations (Grampian Mental Health Forum, 1996).
If a person is not able to function normally he is considered mentally ill. There are many factors which are responsible for ill-mental health like; mental trauma, stress, maladjustment, social change, cultural change, isolation, SES, biological dysfunctions etc.
There are gender differences also in prevalence of mental disorder. The review by Dennerstein et.al. (1993) for the WHO, writes of the greater prevalence of depression, phobias, obsessive-compulsive disorder, somatisation disorder among women.

It has been found that people from culturally & linguistically diverse backgrounds face particular risk factors related to their experience prior to and after entering the country of settlement. There are some factors which have important effects/impacts on the mental health of refugees & migrants' i.e. insecure housing, social & economic-disadvantage, insecurity of unemployment, lack of recognition of qualifications obtained in their country of origin (Minas 1990, Jayasuriya et.al. 1992).
While migration per se does not result in higher rates of mental disorders, both immigration and forced migration can affect the

well-being and subsequent integration of immigrants into the host society. Forced migrants often share a traumatic past, including exposure to war-related violence, sexual assault, torture, incarceration, genocide, and the threat of personal injury and annihilation. Many women are forced to flee their home countries because they are victims of gender and sexual violence by government authorities, military units, and insurgencies, or are victims of domestic or community violence that their governments tolerate or even encourage. By various community surveys it has been found that women from migrant or refugee families undergoing cultural transition face several mental problems.

When an individual's social system is changed his or her role definitions also change. Simply when he moves from one culture to another. Within the same culture if he is not able to change his/her role definition or fail to adapt there is mental disorder (Durkhieim 1951, Cattrell 1942).

Raju et.al. (1980) reviewed a number of studies which showed a greater prevalence of depressive disorder in women, especially those in lower socio economic group.

From survey of related literature it has been assessed that forced migration has an adverse effect on physical and mental health of migrants. (Davar B.V, 1999)

Kashmiri women also faced multiple problems of adjustment due to totally different language, food habits & uncongenial atmosphere. The roots of mental heath problems of migrants can be attributed to prior experience or causes of migration.

Causes of migration in Kashmir:

There were several reasons, which forced these people to leave their mother land like :-

i)Violece, Murder
ii)Rape of young Kashmiri Girls
iii)Killing of efficient Hindu leaders, kidnapping of young Kashmiri Girls, selective killings, and threats from the militants in various ways.
iv)Force d entrances of terrorists in the homes at night and make a list of demands sometimes there were written notes on the walls outside clearly mentioning their names and asking them to leave Kashmir. Sometimes they used to ask marry their daughters to them.
v)Destruction of their properties.
vi)Even infants were murdered in different villages of Kashmir.
vii)Kashmiri pandits were given divesting calls to quit Kashmir without their women folk. These calls came through loud speaker's blarring threat to kafirs to quit or persist.
viii)Creating religious violence by burning of temples and other religious places.
ix)Social bycott by not working under kashmiri pandits.

Problems of migration and its impact on mental health of Kashmiri Migrant women:

Pre, during and post migration effects on mental health of migrant women; whether pre-migration factors or post migration events are responsible for the more powerful influences on psychological adjustment and mental health in refugees is still a debate. While pre-migration stressors such as persecution and war are responsible for strong and lasting effects, it is generally agreed that these experiences exert a greater influence on psychological distress in the earlier stages of resettlement. Post-migration circumstances, particularly economic and cultural pressures, become increasingly important overtime.(Beiser,Turner andGanesan,1989;Rumbaut,1991)it is also recognized that some pre-migration stressors exert more permanent influence over subsequent adjustment than others.Beiser et.al(1989). For example, found that although the impact of camp experiences diminished four to five years after refugee resettlement, other pre-migration events, such as bereavement, had more enduring consequences.

Before migration Kashmiri migrants were living economically, socially, physically, mentally and culturally a sound life. The literacy rate among them was higher than any other group in the valley. But migration shattered their identity and maked those to lead a miserable life.Womens faced many problems due to migration a higher rate of hypertension, diabetes, depression, stress, anxiety, low self concept etc.

Epidemiologic and anthropological data point to different patterns and clusters of psychiatric disorders and psychological distress among women than among men. The origins of much of the pain and suffering particular to women can be traced to the social circumstances of many women's lives. Depression, hopelessness, exhaustion, anger and fear grow out of hunger, overwork, domestic and civil violence, entrapment and economic dependence.

Pre-migration circumstances which are faced by refugees are terrific and shocking.Mghir et.al (1995) described the traumatic experiences of Afghan refugees which included near death incidents (60 per cent), forced separation from family(30 per cent),the witness of murder (of strangers,23 per cent, and of family or friends,16 per cent) , lack of food and water(23 per cent) , lack of shelter(21 per cent) and imprisonment(16 per cent).Bowens et.al(1992) study of refugee women from El Salvador found that 55 per cent had been victims of assault, 32 per cent victims of rape and19 per cent victims of torture. Both victims and observers of violence; witnesses to wounding, mutilation and murder are more likely to suffer psychological

distress, particularly PTSD (Hauff and Vaglum, 1993).

Refugees also face great hardships in interim camps where conditions are not always conducive to effective coping with pre-and post relocation stressors. Psychological dysfunctions and health problems such as depression, anxiety and attempted suicide, along with social problems such as domestic violence and sexual abuse, are often observed in refugee camps (Mollica et.al., 1989).

Refugees experience a wide range of life changes and are subjected to a variety of stressors upon entry to a new cultural milieu. in (1986) has enumerated eight major pre-and post migration sources of stress : loss and grief, social isolation, culture shock, status inconsistency ,accelerated modernization, pre-migration trauma, acculturation pressures are often encountered. Understandably, attachment to homeland plays a significant role in post-migration adaptation in a group of people who were forced to relocate quickly and involuntarily through the pressures of war, famine and political upheaval. Self perceptions are extremely important in case of migration. Self esteem contributes to general psychological well being in refugees (Tran, Wright and Mindel, 1987); perceptions of personal efficacy are associated with decrements in depression (Mollica, 1990); and a positive self concept is inversely related to feeling of psychological and social alienation (Nicasso, 1983; Tran, 1987).Some researchers have also suggested that construals of self embedded in a broader, world view may influence refugee adaptation.

Women were most strongly affected by traumatic premigration experiences, particularly witnessing violence and killing, but their psychological adjustment was also influenced by satisfaction with resettlement and acculturation attitudes and experiences.Older refugees may feel more social isolation as compared to younger ones.This is particularly the case for women who are frequently left on the fringe of the resettlement society with much less opportunity for social integration due to limited language ability and poor job skills.There is also some evidence that women have more negative attitudes toward cultural assimilation than do men (Liebkind,1996).For women strong feelings of dependency are frequently accompanied by conflict over cultural maintenance.

It has been observed that there are gender differences in perception of stressful life events. Women are found to be more susceptible to stress .due to forced migration people are uprooted from the old social culture and they have to make the adjustment in new social settings which affected their mental health. From review of various studies relating to mental health issue of Kashmiri migrant women who had been displaced from their natural habitat i.e. Kashmir valley by terrorist outfits since1990.

Women became the worst sufferers in process of migration by facing multidimensional problems i.e.heart problems, hypertension, depression, diabetes, non adaptability in new environment .women who live in unhygienic conditions in camps and shovels have developed skin diseases and some of them fall a prey of asthama.There is problem of privacy for young girls due to lack of accommodation.. Some are not able to adjust in new social environment due to differences in culture, diet, language, climate etc. They complaint of frequent headaches, constant worries, sleep disturbances, lack of interest in life, severe anxiety and depressive disorders due to unexpected death of their loved ones.

Studies on refugees reveals that families and communities (Farhood, Zurayk, Chaya, Meshefedjian, & Sidani, 1993; Jensen, Refugee women, who with their children account for as much as 80 percent of the refugee population, may experience additional traumas (Martin, 1991). While men are usually the active participants in war, women are often left to respond to the increasing chaos and the breakdowns in their 1994; Kaler, 1997; Lifschitz, 1975; Lyons, 1979; Murphy, 1977). In war zones, women continue to be responsible for procuring and preparing food and for caring for children, the elderly, and the ill. They face survival issues every day with massive unemployment, dramatic price increases, lack of fuel, food shortages, shelling, and sniping (Ashford & Huet-Vaughn, 1997; Mann, Drucker, Tarantola, & McCabe, 1994). After women become refugees, they often live in poverty and feel powerless to reduce the stress in their families (D'Avanzo, Frye, & Froman, 1994; Mollica, Wyshak, & Lavelle, 1987). Both women living in war and refugee women are often left to wonder if their husbands or children are alive or dead, leaving them in a living limbo (Agger & Jensen, 1996; Boss, 1999).

According to Jablensky et al. (1994), the most common symptoms and signs that appear in refugees across different cultures include anxiety disorders (i. e., high levels of fear, tension, irritability, and panic), depressive disorders (i. e., sadness, anergia, anhedonia, withdrawal, apathy, guilt, and irritability), suicidal ideation and attempts, anger, aggression and violent behavior (which often finds expression in acts of spouse and child abuse), drug and alcohol abuse, paranoia, suspicion and distrust, somatization and hysteria, and sleeplessness.

Research in a wide range of social science and health research fields suggests that although the experience of migration itself does not inevitably produce mental illness (Beiser 1999; Hyman et al. 1996), the multiple processes of dislocation, movement, and resettlement may, together, put some immigrants and refugees at risk for emotional problems (Desjarlais et al. 1995; Jenkins 1991; Losaria-Barwick 1992). For refugees in particular, experiences of war, state endorsed terror, and political persecution can result not only in physical health problems (due to torture, for example) but also may cause anxiety, stress, depression, and other emotional difficulties. For many immigrants and refugees, the process of "adjusting" to a new economic, so cial, and cultural climate in the host society can be painful (Beiser 1999; Meredith 1992). In particular, previous studies have demonstrated a strong relationship between employment and health (Beiser 1999; Freire 1995). Immigrants and refugees may have difficulties finding satisfactory or fulfilling jobs in resettlement countries, and thus many suffer from a loss of status that in turn can produce emotional difficulties such as "nerves", isolation, and loss of hope. Social researchers have argued, therefore, that health problems are intrinsically linked to¾ and cannot be understood apart from¾ social problems (Kleinman et al. 1997).

Several researchers have called for increased attention to the health and resettlement of Latin American refugees (Freire 1995; Jenkins 1991; Losaria-Barwick; 1992; Meredith 1992). War, poverty, unequal land distribution and political persecution in most Latin American countries have caused the killing, disappearance, and displacement of millions in the post-World War Two era (Desjarlais et al. 1995; Suarez-Orozco 1990). As a result. the Latin American "community" is one of the largest and fastest growing immigrant groups (most arriving as refugees) in Canada in the last decade (Vidal 1999). And since many of these individuals have been exposed to violence and political persecution in their home countries¾ as well as unemployment and underemployment in the country of resettlement¾ the mental health of Latin American refugees must be made a research priority.War-related stress, environmental factors, persistent grief, mourning, loneliness, and isolation tend to predispose women living in war and refugee women to sustained stress that leads to depression (Bryce, Walker, Ghorayeb, & Kanj, 1989; Bryce, Walker, & Peterson, 1989; Farhood et al., 1993; Fox, Cowell, & Johnson, 1995; Lipson, 1993). This is particularly relevant because mothers' depression and their children's adjustment are intrinsically linked (Downey, 1990; Field, 1995; Field et al., 1988; Field, Healy, Goldstein, & Guthertz, 1990; Murray, Kempton, Woolgar, & Hooper, 1993). There is evidence that children's reactions to stress mirror their family's responses. Symptoms related to trauma in mothers contribute to children's vulnerability, and the mother's level of depression has been shown to be the most important predictor of child morbidity (Apetkar & Boore, 1990; Chimienti & Abu Nasr, 1992–1993; Green et al., 1991; Punamaki, 1987).

Rape has a very high rate of acute PTSD and can lead to high rates of chronic PTSD, especially if left untreated (Foa, Rothbaum, Riggs, & Murdock, 1991). Female relatives of persecuted men are also at risk for psychological and health problems (Khamis, 1998). Children and adolescents also face special problems. They may be torture victims, either as a means of demeaning and demoralizing the children themselves or as a means of torturing their parents (Carlin, 1979; Krupinski & Burrows, 1986; Lonigan, Shannon, Taylor, Finch, & Sallee, 1994) consequences, despite having never been tortured themselves (Carlin, 1979; Danieli, 1998; Krupinski & Burrows, 1986; Lonigan et al., 1994; Solkoff, 1992; Westermeyer & Wahmanholm, 1996; Williams & Westermeyer, 1984).

According to the United Nations High Commissioner for Refugees (UNHCR), there are some 50 million uprooted people around the world, including both refugees and IDPs. Around 75–80 per cent of them are women and children; women and girls account for an estimated 50 per cent of any displaced population.

Relatively little applied or theoretical research has addressed the intersection of gender and nerves among immigrant and refugee populations. While some studies have suggested that nervios is largely confined to women (Bourgois 1985:300; Guarnaccia et al. 1989), other investigations have argued for increased attention to the influence of gender on the levels and expression of nervios (Low 1989a).

Cultural changes involving migration also involve greater stresses for the women than the men. The recent emphasis on the problem of displacement, the spin off development, has also been linked with greater emotion stress including expected increase in anxiety disorders, depression, somatization, alcoholism, suicide and drugs (Good, 1996)

Blazer, George & Hughes (1991)- women have a high rate of 67% vulnerability to stressors and they are more prone to anxiety.

Chakraborty (1990) stated that there are gender differences in prevalence of mental illness, in males it is 9.26 and in females the ratio is 22.50. Women are more susceptible to mental disorders.According to Canadian task force (1988) findings, immigrant and refugee women have more mental health needs than their male counterparts.Nandi et.al. (1979) reported greater prevalence of common mental distress among women including depression.

The effects of forced migration vary in different political, socio-economic, and cultural contexts, and according to factors such as gender, class, age, race, or ethnicity. Since the 1980s, there has been growing recognition that women have been disadvantaged in processes of forced migration.

In forced migration migration of Kashmir valley women have been the worst sufferers by facing double stress ,due to migration& because of being weaker sex suffered by facing double stress become a prey of physical and psychological disorders.

From review of various studies on kashmiri migrant women it is observed that migration has led to following problems in migrants:

In different political, socio-economic, and cultural context. The effects of forced migration vary intents, and according to factors such as gender, class, age, race, or ethnicity. Since the 1980s, there has been growing recognition that women have been disadvantaged in processes of forced migration.

A comparison between 400 females with menopausal symptoms after migration and equal number, who developed menopause before exile, showed that 25 women in the age group 35-40 years developed menopause after exile compared to 9 before migration. More than 36 % women become infertile by the time they reach 40 years of age after migration. (Dr. K.L. Choudhary)

A study of migrant women reveals high incidents of hypertension and diabetes among the sample. The incidence of hypertension was high between 45-55 years, whereas diabetes within 50-55 years of age group and the reasons stated by the respondents were mental tension, anxiety & lack of peace of mind (Ambika 2003). The other health problems were heart problem, Ulceration in the stomach and arthritis. Majority of women had attained early menopause. On the basis of stress score majority of respondents were falling in the average level of stress with maximum number of signs and symptoms reported as restlessness, headache, trouble in the remembering things and disturbed sleep and majority of the respondents had adopted religious measures to cope up with stress.

In his report about the Kashmiri migrant women, Muju (1999) writes that after migration men were able to give vent to their grievances in social meeting etc. the women folk suffered internally & were more worried about their new settlements in refugee camps. They felt the loss of their home and hearth more severely than probably the male counterparts & become victims of psychological symptoms more easily.

In a study of kashmiri migrants Dr. K.L.Choudhary (1995, Daily Excelsior, 3-sept-2003) reported that a majority of them showed transitory and situational maladjustment problems, several others had more acute neurotic symptoms& women are supposed to face more problems of adjustment. They are not able to adjust themselves in totally different environment with different language, food habits, life style and uncongenial atmosphere.

Studies suggested that forced migration lead to physical and psychological disorders like hypertension, depression,diabetes,insomnia,irritability,panic,suicidal ideation,aggression,drug abuse ,paranoia ,post traumatic stress disorder, loss of identity, low self esteem, all these problems lead to an imbalance in physical and mental health. (Good, 1996, Muju 1995, Henry, j.p.cassell, j.c.1969,Nandi,et.al.1979,Shelley E.Taylor 1995).

Strategies to overcome the mental health problems of women:

i)People are not generally aware of mental health and illness. They are not taking it as a serious problem.
ii)Government should launch various mental health programs to make people aware about mental illness and its consequences.
iii)More hospitals/asylums should be opened giving somatic, environmental and interpersonal treatments.
iv)There should be separate rooms for male and female patients.
v)Therapists using therapies should be an expert so that chances of relapse /reoccurrence of disorder will be less.
vi)Social organizations should launch various helping programs for such patients providing them better facilities.
vii)Family members at large should also help such members to come out of that trauma.
viii)Institutional social support can help the migrants to large extent.

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