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Returning refugees: Psychosocial problems and mediators of mental health among Malawian returnees

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Abstract

The psychosocial problems and mediators of mental health were investigated in an adult sample of 74 Malawian returnees. A semi-structured interview indicated a number of specific problems facing the returnees, including reclaiming land, discrimination and disappointed expectations. A demographic questionnaire, the Coping Strategy Indicator, the Harvard Trauma Questionnaire, and the Generalised Self-Efficacy Scale were used to identify potential mediating factors on mental health as measured by the Self Reporting Questionnaire and number of visits to a doctor/healer in the last year. Stepwise Regression analysis revealed that number of trauma events experienced, generalised self-efficacy and gender were significant predictors of mental health. However, there was no significant relationship between the measures of coping strategies and mental health. These results are discussed in relation to theories of stress, learned helplessness, and the possibility of facilitating returnee reintegration. The importance of contextualising the aims and instruments of research is emphasised.

Introduction

Africa has 53 nations and 600 ethnic groups and in 1991 had about one-third of the world's 17 million refugees. Caught in the turmoil that characterises developing nations in the 20th century, some African countries have both an inflow and outflow of refugees. The reality for many of these refugees is a condition of interminable dependency maintained within 'holding camps', although supposedly temporary it is often the case that whole generations are born and bred within these conditions.

Three durable solutions have been proposed for refugees in Africa: resettlement,

integration and repatriation. Resettlement, although desirable, is expensive and rarely offered. In the last decade less than 35,000 Africans have been resettled permanently in the West (Rogge, 1994). Local integration in the African country of asylum is frequently unacceptable to the host country due to constrained resources, and the extent of the refugee problem. Accordingly, repatriation is perceived as the 'natural' and preferred solution. Between 1971 and 1990 there were 3,511,213 'official' repatriations within Africa (Rogge, 1994).

Although, repatriation is the most popular solution, there exists a dearth of research in the area, for three main reasons (Allen &

Morsink, 1994). First, returnees tend to disperse once they get home and often deliberately seek not to be identified. Secondly, there is a heated debate about the point at which the UNHCR's mandate and responsibility for refugees ends; on, or how long after, repatriation? Finally, repatriation is perceived as the optimum solution, and as such relatively problem-free. Consequently it has not been a great focus of research to date. However, the research that is available seriously questions the tacit assumption of 'problem free repatriation' (Rogge, 1994; Ager, 1999; Dona & Berry, 1999). There have been instances where not all refugees have been willing to return, the host government has been too forceful in removing refugees, and/or the home government has not provided assistance to facilitate reintegration. In addition, a number of psychosocial factors have been identified as important for refugee reintegration.

The role of *trauma experiences* has increasingly become recognised as an important vulnerability factor when dealing with refugees and returnees (Mollica *et al.*, 1992), especially since Post Traumatic Stress Disorder (PTSD) can persist for many years (Ploeg & Klein, 1989). If PTSD, or traumatic events, are vulnerability factors for poor mental health under conditions of stress, the identification of such cases is important for reintegration, rehabilitation, and the future identification of vulnerable returnees.

Previous reports suggest that refugeehood, the social organisation of refugee camps and the way aid is provided can create dependency (Westermeyer, 1987; Morsink, 1990, Carr *et al.*, 1998), a factor that will certainly undermine *self-efficacy*. However, a search of the available literature on the CDROM database *PsychLit*, found no quantitative studies of self-efficacy in refugee returnees. Studying the possible correlates of self-effi-

cacy may facilitate a better understanding of some of the difficulties demonstrated by returnees regarding the problems of reintegration, and facilitate the development of interventions.

The considerable research into *coping strategies* as mediators of stress (Lazarus & Folkman, 1980; Folkman, 1997) has suggested that the success of some refugees, Jehovah's Witnesses, can be attributed to techniques of coping. Examining the different kinds of coping strategies employed by returnees and their relation to mental health could lead to a better understanding of the resilience demonstrated by some returnees and provide empirical guidance to facilitate psychological adjustment.

Rogge (1994) has suggested that there is 'much scope for research on repatriation so as to create a better understanding of potential problems and to facilitate better preparedness in the planning and implementation of return movements when circumstances permit' (p. 14). Accordingly, the purpose of this exploratory study was to create a better understanding of the psychosocial problems that confront returnees, by exploring the influence of the factors discussed above. Due to the dearth of research on refugee reintegration two aspects of our study were grounded in different levels of contextuality and aimed at finding a balance between quantitative and qualitative research methods (see Bryman, 1988). The first aim of the study was to investigate the psychosocial problems facing one group of returnees, with keen attention to their particular context, by allowing issues to emerge through content analysis of semi-structured interviews. The second aim of the study, derived primarily from western research literature, was to investigate the role of coping strategies, trauma experiences and generalised self-efficacy in mediating the influence of psychosocial stress.

Method

Participants and context

About 85% of the Malawian population is involved in subsistence agriculture, and the Malawian economy is characterised by chronic unemployment, trade imbalances, persistent inflation and external debt pressures, all of which is reflected in the high prevalence of poverty. In terms of health, relative to other 'developing' countries, Malawi is considered to have very high rates of malnutrition, infant mortality and AIDS.

In the mid-1960s Malawi gained independence from Great Britain and Dr Banda who had been instrumental in the fight for independence became the president. Dr Banda began to assume increasing amounts of power and persecute those who opposed him, which caused many Malawians to flee into exile, often because of the government's suspicion of their subversive political activities. These refugees fled mainly to neighbouring countries; Mozambique, Zimbabwe, Tanzania, and Zambia (others to Russia, Europe and the USA) (see also, Cornish *et al.*, 1999).

The Jehovah's Witnesses were involved in a different persecution. Due to their interpretation of the Bible, they refused to be political and become members of the one party system. In 1972 their persecution peaked and it is estimated that 21,000 managed to get to the border of Zambia, where they were latter chased back into Malawi, then into Mozambique, and finally, back to Zambia. Here they lived in large camps along the boarder areas, described by visitors as being among the most relaxed, neatest and self-sufficient. Jehovah's Witnesses believe that the Bible prophesies their persecution.

In 1993, the Banda regime, pushed by the church and international pressure, reached a political climax, culminating in a referendum on multi-party democracy. The Malawi Par-

liament declared a general amnesty to all Malawians in exile, and acknowledged their obligation to receive, resettle and as necessary rehabilitate the returnees (Hansard, Government of Malawi, 1993).

A survey of returned refugees in 1995 estimated there were about 5000 returnees, increasing by 200 per month, of which 14.2% had access to land, 1.7% had their own shelter and 0.7% had found employment (Centre for Human Rights and Rehabilitation, 1995). By early 1996, still no mechanisms for resettling the returnees had been implemented. Accordingly, a subgroup of returnees, from the capital, Lilongwe, forced their way into, and began occupying, the Social Welfare Centre (SWC). Here almost 150 returnees (about half children) lived in one large room, sharing minimal facilities (see Peltzer, 1996, for a fuller account of these returnees).

All adults living at or attending the SWC were invited to take part in the study through a public announcement of the researcher's desire to have an understanding of their experience as returned refugees. This resulted in a convenience sample of 74 (51 males, 23 females) adult returnees who volunteered to participate in the study. The mean age of the returnees was 40.93 (range 18–92, SD=18.8).

Materials

Demographic questionnaire

A demographic questionnaire sought information on the following: (1) name; (2) whether their parent took them into exile or was it their own choice and responsibility; (3) reason for exile; (4) date of birth; (5) gender; (6) years education; (7) marital status; (8) number of children; (9) type of accommodation in country of exile; (10) accommodation in Malawi since return; (11) year of exile; (12) year of return to Malawi; and (13) if they were employed.

Semi-structured interview

Semi-structured interviews were used to encourage returnees to talk about what they wanted, to help establish a rapport and to investigate areas either too broad for, or unforeseen by the psychometric instruments (see below). Returnees were invited to (1) tell 'their story' of going into exile, refugeehood and returning to Malawi; (2) they were asked to describe any problems they were experiencing at the present; (3) to investigate alternative coping strategies, they were asked, given their problems, how they were coping with them; and (4) to analyse the construct validity of the mental health measure, they were asked if they had been to see a doctor or healer in the last year, if so how often and for what problem.

Generalised Self-Efficacy Scale (GSES)

The GSES (Schwarzer, 1993) is a 10-item scale which attempts to measure general beliefs about one's ability to respond to and control demands and challenges from the environment. It consists of 10 statements, which the respondent is asked to rate on a four-point scale from 'not at all true', to 'exactly true'. There is no normative data from African countries.

The Coping Strategy Indicator (CSI)

The Chichewa translation (Ager & MacLachlan, 1998) of the CSI (Amirkhan, 1990) comprising three subscales, problem-solving, seeking support and avoidance, was used. The CSI requests a description of a stressful event which 'was important and caused you worry' in the last 6 months. The extent to which the different coping strategies are used by respondents is indicated by means of a three-point scale (a lot, a little, or not at all). Ager & MacLachlan's (1998) study confirmed the original factor structure of problem solving and seeking support, re-

ported by Amirkhan, while questioning the validity of the third factor, avoidance.

The Self Reporting Questionnaire – 20 (SRQ)

The SRQ (Harding *et al.*, 1980) was developed in a study set up by the WHO to investigate mental illness in developing countries. It consists of 20 health-related questions, which request a yes/no response. While the results from validation studies in developing countries are positive, there has been much variation in the proposed cut-off points for establishing 'caseness', ranging from 5/6 in India, to 10/11 in Colombia (Harding *et al.*, 1980). Therefore, because no validated cut-off point has been established in Malawian samples, it was felt more appropriate to use the SRQ to reflect a continuum of mental distress, rather than to attempt discrete diagnosis or categorical classification.

The Harvard Trauma Questionnaire (HTQ)

The HTQ was designed to measure the traumatic events and symptoms of Indochinese refugees (Mollica *et al.*, 1992). The first section includes 17 traumatic events from 'lack of food or water' to 'torture' and 'rape'. For each of the 17 items there are four categories of response: 'experienced,' 'witnessed', 'heard about' and 'no'. The second section consists of open-ended questions that ask the respondent to describe the most terrifying event(s) that have happened to them. The third section includes 30 symptoms related to torture, trauma and refugee experience.

Procedure

All the questionnaires were translated into Chichewa, and then back-translated into English by a second translator. A large number of the returnees were illiterate, making the self-

report technique redundant. The process of administration was for the translator, to 'go through' the questionnaires with the returnees by reading the Chichewa translation. Then, if the returnee failed to understand the statement or question, that item was explained in a thorough way to ensure full comprehension of the item, before participants gave their response.

The general demographic questionnaire was conducted first, followed by the interview, the Self-Efficacy measure (about 10 min), the CSI measure (about 45 min), the SRQ measure (about 15 min), and finally the HTQ (section 1, 15 min; section 2 and 3, 30 min). Due to the considerable time demands, and the problems facing the returnees, they were all given modest payment for their participation (approximately 1 US\$).

Results

Demographic questionnaire

Analysis of the demographic questionnaire revealed that 52 (70.3%) of the returnees were exiled because they were Jehovah's Witnesses, and 22 (29.7%) were exiled for political reasons. Five (6.8%) were living in their own house, 30 (40.5%) were living in rented accommodation, and 39 (52.7%) were living at the Social Welfare Centre. The mean number of years spent in education was 5.97 (SD=4.43), with a range of 0–16 years. Fourteen (18.9%) had never received any form of formal education.

Year of departure ranged from 1964 to 1982. The mean number of years back in Malawi was 1.48, with a standard deviation of 0.78 years, and a range of 0–3 years. Overall the mean number of years in exile was 23.62 (SD=3.61) with a range of 13–31 years.

It was impossible to clearly establish the economic situation of these returnees, only

one (1.4%) had a steady income and 4 (5.4%) were in a position to farm a plot of land. In an attempt to make some money 24 (32.4%) of the returnees were trying to make baskets from plastic waste in order to sell them, five (6.7%) were going to school and 36 (48.6%) pursued no recognised activities. The number of living children the participants had ranged from 0 to 13, with a mean of 3.96 (SD=3.19).

Content analysis of the semi-structured interview data

Psychosocial problems are intricately interwoven with the context in which they are presented. Table 1 summarises some of the main themes that emerged from the semi-structured interviews. A random subsample of 10 (13.5%) of the semi-structured interview data were given to another investigator to content analyse. The agreement rate was 74%.

Twenty (27%) of the returnees specifically mentioned that they were *having trouble reclaiming their land*. This is largely because the majority of the returnees had no proof of having owned any land, so the main way to reclaim land was to go to that land and talk to the people now living there. Given the interests of those who now occupied their land, and that it has been on average over 23 years since the returnees left, it is perhaps not surprising that so many returnees identified this as a problem. In many cases, the returnees were either too young when they left to be recognised by neighbours, or not yet even born. These returnees emphasised how important the issue of land was for them, it being both a source of food and income. Ten (50%) of these returnees mentioned that land was crucial to their survival; one old man described it as his pension, without it he would end up a beggar on the street. Twelve (60%) of the returnees further mentioned that they feared the consequences of witchcraft if they were to reclaim their land. Although only 12

Table 1: Summary of the themes that emerged from content analysis

Themes	Sub-issues	Overall percentage	Sub-percentage	Total number
Trouble reclaiming land		27	100	20
	fear of witch-craft	16.2	60	12
	land as crucial for survival	13.5	50	10
Felt disappointed with no mechanisms for reintegration		14.8	100	11
	expected more	10.8	72.7	8
Felt discriminated against		17.6	100	13
	by government	10.8	61.5	8
	by locals	9.5	53.8	7
Felt angered to the point of violence		6.8		5
Angered by organisation of cooking		5.5		4
Felt that there was corruption		5.5		4
Planned to return to Zambia after receiving money for reintegration		2.7		2

returnees mentioned this, it was against the religion of all the returnees to believe in witchcraft, so it is possible that others were also scared but reluctant to admit to this fear.

Another frequently mentioned issue was that of *being let down*. Eleven (14.8%) of the returnees mentioned that they were angered that no mechanism had been put in place for their 'resettlement and reintegration'. When asked what this mechanism should include, the majority wanted money to buy land and a house. In turn, eight of these returnees said specifically that they had expected a lot more, that they had come to Malawi with hopes and dreams to 'help rebuild the country'. Expectations varied from loans to amounts of money given as 'gifts'.

A further theme that emerged from the content analysis of the interviews was *discrimination*. Eight of the returnees mentioned that there was very little progress on

mechanisms of reintegration because although there had been a change of government, there had been no change of the people working in the Ministry responsible. Hence, they argued that members of the Ministry, who had been involved in their persecution, were less than enthusiastic about helping them to reintegrate. In addition, seven (9.5%) of the Jehovah's Witnesses said that they were being discriminated against by locals who may have been involved in their persecution.

To illustrate some of the issues which emerged through the interviews, and the sense of desperation felt by some returnees, a section is reproduced here verbatim from a returnee who spoke English. In this section of the interview, the themes of disappointment with the government, need for land, feelings of discrimination and helplessness, and the threat of anti-social behaviour are all evident:

Table 2: Coping strategies identified

Coping strategy	Percentage	Number
Problem-solving	25.7	19
Uncertain (no strategy reported)	24.3	18
Reading the Bible	21.6	16
Asking for God's help/praying	14.9	11
Seeking support from friends	14.9	11
Going to church/Mosque/bible classes	13.5	10
Dreaming/sleeping	10.8	8
Drinking local beer/smoking marijuana	9.5	7
Dialogue with organisations	8.1	6
Walking through town	8.1	6
Trying to cope is hopeless	6.7	5
Struggle on	4.1	3

'Time is running out, we can not be in suspense too long, our future is passing, we are not kids. Some resolution, for better or for worse. Stop the suspense. A yes or no provides the basis. We can not be kept like babies, we survived outside (Malawi), we can survive inside. We need to plant in this season. We are cooked up in here like chickens. It's the suspense, it prevents me from doing what I want. They are torturing us mentally, trying to play with our minds, I don't like it at all... I am not violent, but anyone can be violent when cornered. Everybody has a right to live free, ... we are just like Ping-Pong balls, being sent from one government department to another, and again. That is what annoys me most... I could have been somebody.'

Participants were asked to identify any of the mechanisms they were using to try to *cope* with their problems. The content analysis identified the coping strategies presented in Table 2. The most frequent coping strategy mentioned was problem solving (25.7%), comprising mainly attempts to find work. Many of the coping strategies identified were structured around religion; reading the bible,

praying/asking God for help or advice, and partaking in religious activities.

Returnees were also asked if they had been to a *doctor*, either a traditional or biomedical (Dr) practitioner, in the last year, if so how many times, and for what reasons. The mean number of visits made to a doctor in the last year was 0.8 (SD=0.91) and the range was 0 to 4. The content analyses of the health complaints are presented in Table 3. The most notable finding here is the frequency of body pains mentioned, although this frequently overlapped with other reasons.

Table 3: Reasons identified for visiting a doctor

Health complaint	Percentage	Number
Body pains	41.9	31
Constipation	14.7	11
Fever	10.8	8
Hot flushes	6.8	5
High blood pressure	6.8	5
Weakness	6.8	5
Cough	5.4	4
Hallucinations	4	3
Dizzy spells	4	3
Ulcers	4	3
Other	18.9	14

Table 4: Comparing mean scores to Amirkhan (1990) and Ager & MacLachlan (1998)

	Amirkhan mean (SD)	Ager & MacLachlan mean (SD)	Returnees mean (SD)
Problem-solving	26.55 (4.82)	27.94	29.46 (3.87)
Support seeking	23.42 (5.63)	24.67	28.37 (4.02)
Avoidance	19.03 (4.37)	21.55	23.39 (3.45)

Psychometric behaviour of instruments used

All the tests used in the study were developed and standardised outside Africa, which raises various methodological issues (Kleinman, 1995). Accordingly, a review of the relevant statistical investigation of the psychometric properties of these measures is briefly presented in order to establish their validity.

The mean scores for the *SRQ* was 9.04 (SD=3.86, range=0–18). The number of visits participants had made to a doctor in the last year was positively correlated with the total *SRQ* score ($r=0.320$; $p<0.01$), thus supporting the construct validity of the *SRQ* in the present context.

The mean score obtained on the *General Self-Efficacy* measure (31.42; SD=5.48, range=17–40) was within one standard deviation of that found by Schwarzer (1993) (mean=29.28; SD=4.6) in the German validation sample. Reliability analysis revealed that the internal consistency of the scale in the present sample (Cronbach's alpha coefficient=0.72) was not as strong as was previously found by Schwarzer (1993) which ranged from 0.82 to 0.9.3 over five samples.

Table 4 shows the mean scores for each of the *CSI* scales, compared with two previous validation studies. Their classification with respect to norms established in the initial *CSI* validation study are in all cases 'average', defined as within one standard deviation of the norm mean. Overall the mean scores

were closer to those obtained with Malawian students (Ager & MacLachlan, 1998). High mean scores on the problem solving (PS) and support seeking (SS) scales, both about one standard deviation from the maximum score (33) indicates the possibility of a ceiling effect (see Gillespie *et al.*, under review, for a more detailed analysis of the behaviour of the *CSI* in the present sample).

The mean number of *trauma* events heard about, witnessed or experienced, as reported on the *HTQ*, was 16.24 (SD=1.89; range 4–17). This is within one standard deviation of what Mollica *et al.* (1992) found (15.23; SD=2.99) in the validation study. However, because it is less than half a standard deviation from the maximum score, analysis was directed to just the trauma events *actually experienced* which revealed a mean of 5.35 (SD=3.12; range 1–13). Focusing on only the trauma events experienced provided greater differentiation between returnees and this statistic was therefore used in the subsequent analyses. The number of traumatic events actually experienced was positively correlated with *SRQ* score ($r=0.33$, $p<0.01$) and the number of visits to a doctor ($r=0.38$, $p<0.01$), supporting the construct validity of each of these measures of distress. The percentage of returnees who experienced each of the 17 listed trauma events is presented in Figure 1.

Sixteen of the 74 returnees reported experiencing trauma events, which they described as very frightening. One returnee claimed to

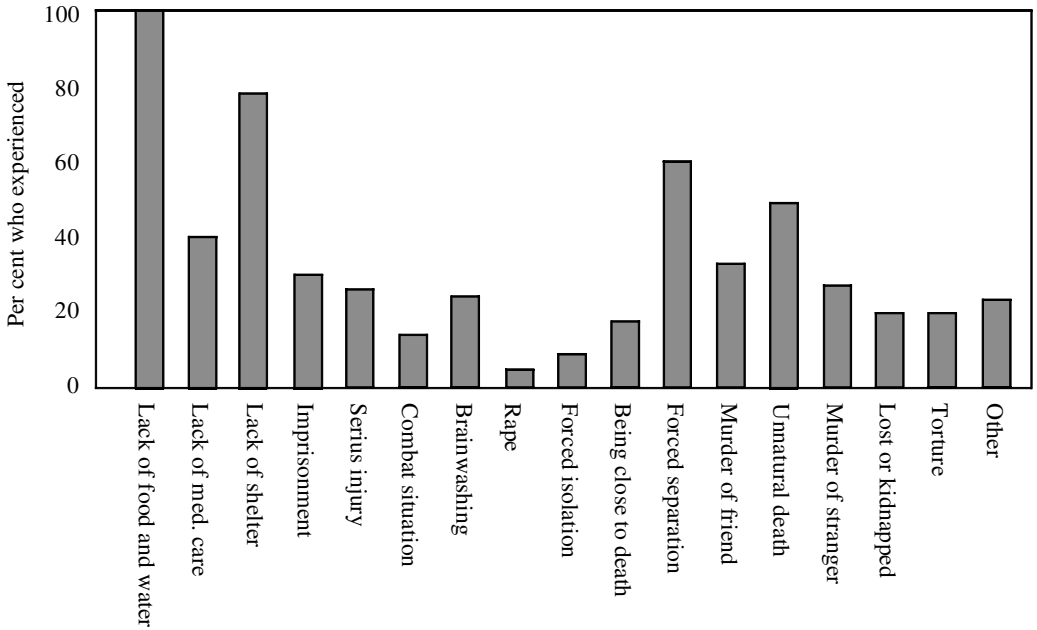


Figure 1: Traumatic events experienced by returnees.

have been involved in traumatic fighting in Mozambique, while the other 15 reported some form of physical torture. One of the returnees claimed to have had his head submerged in water and four said they lost consciousness during the torture. Seven of these 16 returnees fulfilled the DSM-III-R criteria for PTSD, as indicated by the HTQ.

Testing for differences between Jehovah's Witnesses and other returnees

The possibility of heterogeneity within the sample between Jehovah's Witnesses and other returnees, due to their distinctive beliefs and philosophy of life, was explored using discriminant function analysis. Linear combinations of variables (PTSD, total SRQ score, anxiety score, depression score, self-efficacy score, number of visits to a doctor/healer in the last year, CSI Problem-Solving scale, CSI seeking support scale, CSI avoidance scale) were used to try and discriminate

between a 'Jehovah's Witness Returnees' group and an 'Other Returnees' group. However, none of these variables was a significant predictor of group membership and thus the groups were indistinguishable in terms of the variables we assessed.

Testing for mediators of mental health

Stepwise multiple regression on demographic variables, number of trauma experiences, coping strategies and self-efficacy, with the SRQ and the number of visits to a doctor/healer in the last year, was used to examine the effects of each of these variables, while controlling for the effects of the others. Fifteen cases had missing variables and a *t*-test revealed that these clustered with lower age ($t=5.05$; $df=0.72$; $p<0.01$). Accordingly, only the data from 59 returnees was used in the regression. The role of demographics (gender, Jehovah's Witness or other, working or not, years in education,

amount of time back in Malawi, number of children, and living in the SWC or elsewhere), number of trauma experiences, self-efficacy and CSI coping strategies were assessed as variables predicting the variance on SRQ score and number of visits to a doctor in the last year. Sex, work, accommodation and reason for exile were all coded as indicator variables. Age and the CSI Avoidance scale were removed from the analysis to reduce error in regression coefficients resulting from multicollinearity.

The number of traumatic events experienced and self-efficacy score accounted for 11.62% of the variance ($F=4.482; p<0.05$) of SRQ scores. Number of trauma events experienced accounted for 6% of the variance ($b=0.30; p<0.05$), and self-efficacy accounted for an additional 5.62% of the variance ($b=-0.27; p<0.05$). The equation used to predict a returnees SRQ score was $12.77 + 0.39$ (number of trauma experiences) $- 0.19$ (self-efficacy). Analysing predictors of number of visits to a doctor/healer in the last year revealed that 20.28% ($F=5.50; p<0.01$) of the variance could be explained by the three variables; self-efficacy ($b=-0.290; p<0.05$), number of trauma events experienced ($b=0.25; p<0.05$), and gender ($b=0.34; p<0.01$). The frequency of visits to a doctor/healer is predicted by the equation: $2.80 + 0.08$ (number of trauma experiences) $- 0.05$ (self-efficacy) $- 0.64$ (gender: 1 for male, 2 for female).

Discussion

The semi-structured interviews highlighted the themes of difficulty reclaiming land, feeling let down, experiencing discrimination, as well as seeking employment and using spiritual beliefs as coping mechanisms. The prevalence of bodily pains as the principal reason for consulting a doctor or healer also

emerged from the semi-structured interviews. Concerning the psychometric instruments, no significant relationship was found between the measure of coping strategies and any of the health measures, which is contrary to previous studies (Amirkhan, 1990; Majodina, 1995). It seems unlikely that this is due to methodological flaws for three main reasons. First, a similar factor structure emerged on problem-solving and seeking support subscales (see Gillespie *et al.*, under review) to that obtained in the original CSI validation samples (Amirkhan, 1990) and that of a Malawian student sample (Ager & MacLachlan, 1998). Secondly, the problem-solving and seeking support scales had a relatively high level of internal consistency ($\alpha=0.784$, $\alpha=0.834$, respectively). Finally, there was a positive correlation between the self-efficacy measure and problem-solving and seeking support, as previously identified (Moos & Billings, 1982). However, the avoidance scale had poor factor structure, weak internal consistency ($\alpha=0.396$) and was significantly correlated to problem-solving.

Folkman (1997) has proposed a development to an earlier theory of coping (Lazarus & Folkman, 1984) based on evidence for the co-occurrence of positive and negative psychological states, in the partners of men with AIDS, throughout care-giving and during bereavement. This modification comes after the coping process which has led to an unfavourable resolution of the situation. Folkman suggests that in such a scenario people do not just experience distress but may enter into *meaning based coping*, including positive reappraisal, revising goals and activating spiritual beliefs, so as to induce positive affect and thus sustain the coping process. 'The negative psychological states associated with significant and enduring stress may actually motivate people – consciously or unconsciously – to search for and create positive

psychological states in order to gain relief, if only momentary, from the distress' (Folkman, 1997, p.1216).

Content analysis of what the returnees described, in the semi-structured interview, as their methods of coping, supported the CSI's factors of problem solving and seeking support, but also indicated the importance of the activation of spiritual beliefs. Some returnees mentioned that praying, reading the bible or going to religious gatherings would not solve their problems, but that such activities provided hope, and strength to continue. Although Folkman's revised model does not account for the positive association found here between avoidance and problem solving, it is possible that a further development of the concept of *coping with the failure of coping*, through the generation of positive affect, could account for these results. It is possible that some returnees who were actively trying to solve their problems rationally, were also using some avoidance strategies to provide relief from the resultant distress due to failure, and possibly help restore psychosocial resources. Thus, some of the avoidance items may have been tapping attempts to cope with the failure of coping, as opposed to coping with the stressor *per se*. Due to the small size and specific context of the present sample, there is insufficient data to formulate such an extension to coping theory, but it does provide a future research hypothesis.

The strongest result to emerge from the regression analysis was that the number of traumatic events experienced was a significant predictor of mental health, which is consistent with previous research (Mollica *et al.*, 1992). Generalised Self-Efficacy was also a significant predictor of total SRQ and number of visits to a doctor in the last year. The belief that one can control the stressful events in one's life has, like coping strate-

gies, been related to wellbeing, and postulated as a possible mediating factor in stress (Thompson & Spacapan, 1991; Kaplan, 1996).

The interplay between experiencing traumatic events and having low self-efficacy could augment feeling of helplessness. Learned helplessness suggests that certain people when exposed to repeated uncontrollable events develop a negative attributional style, to account for such events (Abramson *et al.*, 1978). Seligman (1975) has suggested that learned helplessness is characterised by lowered response motivation, a decrease in perception of control, heightened emotions, loss of appetite, lowered aggression and increased levels of anxiety and depression.

Although there are no norms for the SRQ in Malawi, the means obtained in this sample are high when compared to studies in other 'developing' countries (Harding *et al.*, 1980; Penayo *et al.*, 1990) and the type of traumatic events experienced, generally uncontrollable, are in line with the learned helplessness thesis. Torture has been noted as particularly likely to result in the development of a sense of helplessness (Basoglu, 1992). Also, many of the returnees had been living in refugee camps, noted for breeding dependency (Morsink, 1990), and were during the period of the study living in a sort of 'camp', waiting for irregular responses from the government, which is also reputed to engender dependency (Westermeyer, 1987).

Across a wide range of investigations, the belief that one can control the stressful events in one's life has been related to emotional wellbeing, successful coping and good health (Thompson & Spacapan, 1991). Also, the construct has successfully been used in interventions (Taylor, 1995). It is therefore possible to suggest that any help given to returnees should be structured to facilitate a perception of control. A primary aim with returnees

should be to move them from dependence to independence. It is therefore suggested that the 'reintegration and rehabilitation' of returnees may be facilitated by fostering a perception of control, ideally by genuinely playing an active part in 'rebuilding the country'.

Clearly this study was conducted in a very specific context, not just in terms of the events surrounding the Centre for Social Welfare in Lilongwe, but also in terms of the history of flight and persecution of many of the returnees. It would therefore be wrong to try and generalise such specific aspects of this study to other refugee settings, which would of course have their own particular historical, geographic, economic and political circumstances. Allen & Morsink (1994) argue that to use the label 'returnees' is to impose a simplistic category on a complex social situation and 'as a result, it is difficult to generalise sensibly about returnees in one region, let alone to do so at an international level. An insight about a specific group of returnees in Zimbabwe is less likely to be of direct relevance in Mozambique than an understanding of the local sociological, political, historical, cultural and economic contexts' (p. 7). While supporting this argument we would also suggest that while the *content of context* will vary from one setting to another, the *process of psychological adjustment* will have certain features in common. As such, our results may be valuable for suggesting psychosocial processes of adjustment that are salient to other refugee reintegration contexts, especially those that involve refugees in 'holding camps'.

Conclusion

Both the CSI and the GSES represent attempts to develop widely applicable mea-

asures, and accordingly implicitly assume a form of universalism. However, this may be the source of the insensitivity observed in the present study. It is possible that there comes a point when the gap for generalisation becomes so large that the measures and assumptions become essentially meaningless. The question is, rather than focus on increasingly general and insensitive measures, should there be an increased recognition of the diversity and influence of culture, and a subsequent emphasis on specific and sensitive measures.

The fact that given the vast differences in culture, history, and context, the measures of self-efficacy and number of trauma events experienced could account for just under 12% of the variance on the SRQ score suggests that these instruments, and the variables they measure, do have value outside the context in which they were developed. As such, they indicate aspects of refugee reintegration that are important to assess in other contexts. However, there remains considerable unexplained variance and it may be that the more psychology is generalised, and the less emphasis that is placed on the context, the less predictive value it will have. There is a need for research to investigate the relations among contextual factors, guided by the values, which generate knowledge for that culture (MacLachlan, 1997, 2000). With such an approach it may be possible for the variance in salient factors to be more comprehensively accounted for.

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References

- Abramson, L. Y., Seligman, M. E. & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, **87**, 49–74.
- Ager, A. (1999). *Refugees: Perspectives on the experience of forced migration*. London: Cassell.
- Ager, A. & MacLachlan, M. (1998). Psychometric properties of the Coping Strategy Indicator (CSI) in a study of coping behaviour amongst Malawian students. *Psychology & Health*, **13**, 399–410.
- Akol, J. O. (1994). A crisis of expectations. In T. Allen & H. Morsink (Eds.), *When Refugees Go Home*. London: James Currey Ltd.
- Allen, T. & Morsink, H. (1994). Introduction: When refugees go home. In T. Allen & H. Morsink (Eds.), *When Refugees Go Home* (pp. 1–13). London: James Currey Ltd.
- Amirkhan, J. H. (1990). A factor analytically derived measure of coping: The Coping Strategy Indicator. *Journal of Personality and Social Psychology*, **59**, 1066–1074.
- Basoglu, M. (1992). *Torture and its Consequences: Current treatment approaches*. Cambridge: Cambridge University Press.
- Bryman, A. (1988). *Quantity and Quality in Social Research*. London: Unwin Hyman.
- Carr, S.C., Mc Auliffe, E. & MacLachlan, M. (1998). *Psychology of Aid*. London: Routledge.
- Centre for Human Rights and Rehabilitation (1995). *A report on the analysis of needs and opportunities for Malawi returnees submitted to the government of Malawi and the donor community*. Lilongwe: CHRR.
- Cornish, F., Peltzer, K. & MacLachlan, M. (1999). Returning strangers: The children of Malawian refugees come 'home'. *Journal of Refugee Studies*, **12**, 264–283.
- Dona, G. & Berry, J.W. (1999). Refugee acculturation and re-acculturation. In A. Ager (Ed.), *Refugees: Perspectives on the Experience of Forced Migration*. London: Cassell.
- Folkman, S. (1997). Positive psychological states and coping with severe stress. *Social Science and Medicine*, **45**, 1207–1221.
- Harding, T. W., Arango, M. V., Baltazar, J., Climent, C. E., Ibrahim, H. H. A., Ignacio, L. L., Murthy, R. S. & Wig, N. N. (1980). Mental disorders in primary health care: A study of their frequency and diagnosis in four developing countries. *Psychological Medicine*, **10**, 231–241.
- Kaplan, H. B. (1996). Themes, lacunae, and directions in research on psychosocial stress. In H.B. Kaplan (Ed.), *Psychosocial Stress: Perspectives on structure, theory, life-course and methods* (pp. 369–403). London: Academic Press.
- Kleinman, A. (1995). Do psychiatric disorders differ in different cultures? The methodological questions. In N. R. Goldberger & J. B. Veroff (Eds.), *The Culture and Psychology Reader*. London: New York University Press.
- Lazarus, R. S. & Folkman, S. (1984). *Stress, Appraisal and Coping*. New York: Springer.
- MacLachlan, M. (1997) *Culture and Health*. Chichester: Wiley.
- MacLachlan, M. (2000) (Ed.) *Cultivating Health: Cultural perspectives on health promotion*. Chichester: Wiley.
- Majodina, Z. (1995). Dealing with difficulties of return to South Africa: The role of social support and coping. *Journal of Refugee Studies*, **8**, 210–227.
- Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S. & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and post traumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease*, **180**, 111–116.
- Moos, R. H. & Billings, A. G. (1982). Conceptualising and measuring coping resources and processes. In L. Goldberger & S. Breznitz (Eds.), *Handbook of Stress: Theoretical and clinical aspects*. New York: Plenum Press.
- Morsink, H. (1990). *UNRISD and its research into social and economic aspects of mass voluntary return of refugees from one African country to another*. Unpublished UNRISD, Geneva.
- Peltzer, K. (1987). A model of African socialization: Authority, group, body–mind–environment dimensions. In P. Ebigbo and K. Peltzer (Eds.), *Clinical Psychology in Africa*. Nigeria: IFE Centre for Psychological Studies.
- Peltzer, K. (1996). *Counselling and Psychotherapy of Victims of Organised Violence in Sociocultural Context*. Frankfurt: IKO Verlag.
- Ploeg, H. M. & Klein, W. C. (1989). Being held hostage in the Netherlands: A study of long term after effects. *Journal of Traumatic Stress*, **2**, 153–169.
- Rogge, J.R. (1994). Repatriation of Returnees. In T. Allen & H. Morsink (Eds.), *When Refugees Go Home* (pp. 15–49). London: James Currey Ltd.

- Schwarzer, R. (1993). *Measurement of Perceived Self-Efficacy: Psychometric scales for cross-cultural research*. Berlin: Freie Universitat.
- Seligman, M.E.P. (1975). *Helplessness*. San Francisco: Freeman.
- Taylor, S.E. (1995). *Health Psychology* (3rd edn.). New York: McGraw-Hill.
- Thompson, S.C. & Spacapan, S. (1991). Perceptions of control in vulnerable populations. *Journal of Social Issues*, **47**, 1–22.
- Westermeyer, J. (1987). Prevention of mental disorder among refugees in the US: Lessons from the period 1976–1986. *Social Science and Medicine*, **25**, 941–947.