Prevalence and Nature of Aggressive Behavioural Tendencies among the Rohingya Communities:

Myths and Realities

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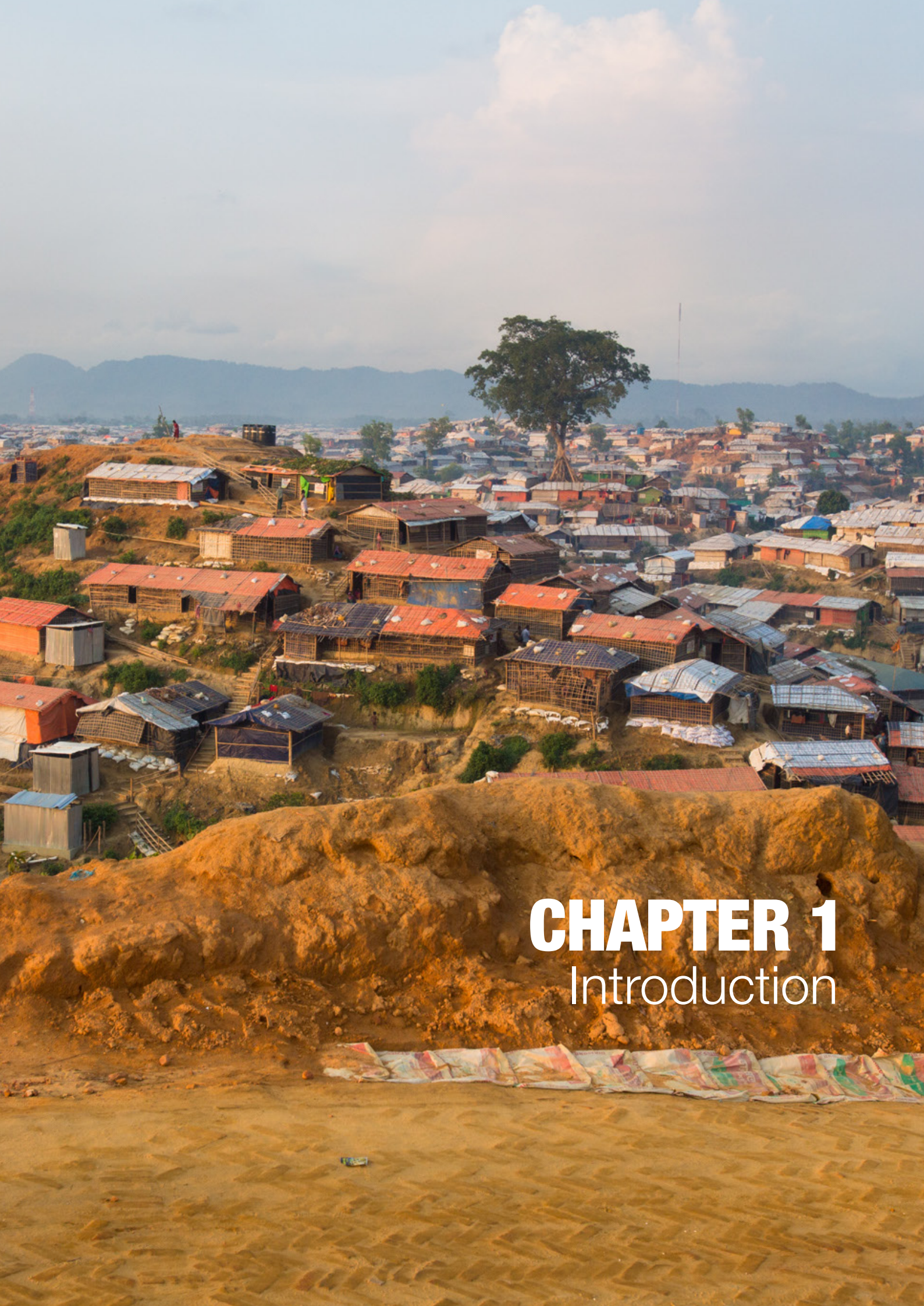


CHAPTER 1
Introduction

1.1 Background of the study

The World Health Assembly declared violence a significant public health issue in 1996. To follow up on this resolution, on 3 October 2002, WHO released the first World Report on Violence and Health (Krug et al., 2002). Violence exposure is associated with several mental health issues such as depression, suicidal ideation, and post-traumatic stress disorder (PTSD) (Pynoos et al., 1987; Pynoos& Nader, 1988; Fitzpatrick &Boldizar, 1993; Freeman, Martinez &Richters, 1993; Osofsky, Wewers, Hann, & Pick, 1993; Richters& Martinez, 1993; DuRant, Cadenhead, Pendergrast, Slavens, & Linder, 1994).

Exposure to violence has a unique relationship with PTSD symptomatology. Specifically, the relationship between violence exposure and PTSD symptomatology remained significant after controlling for depression and suicidal ideation severity. (Mazza & Reynolds,1999). Researchers found that high levels of violence exposure for urban youths indicate a range of psychiatric symptoms and poor adjustment (Stone et al., 1999). It is also found that one can develop excessive aggression and violence due to generally disturbed emotional regulation, such as abnormally high or low levels of anxiety and vice versa (Neumann et al., 2010). Anxiety is usually known as a feeling of unease, such as worry or fear, that can be mild or severe. Anxiety disorders are a group of mental disorders characterised by powerful feelings of anxiety and fear (DSM 5, 2013).

Researchers also suggested that violence exposure directly affected both proactive and reactive aggression (Myers et al., 2018). Early programmes for violence prevention in childhood and adolescence are intended to prevent or reduce aggressive behaviour to decrease the risk for short- and long-term developmental impairments (Pawils & Metzner, 2016).

United Nations High Commissioner for Refugees (UNHCR) statistics reported that 42 million people worldwide are currently uprooted. While 16 million are refugees who have fled across national borders, the majority – 26 million people – are displaced within their own country as internally displaced persons (IDPs) (UNHCR, 2009).

Studies on the experience of fleeing and subsequent post-migration ordeals have been found to affect the psychological wellbeing of forcefully displaced populations (Thomas & Thomas, 2004). The impact of war and displacement on children and adolescents has received specific attention. They are simultaneously considered the most vulnerable due to their developmental status and dependence on adults, yet also most resilient in the face of adversity (Betancourt & Khan, 2008). Despite mental health difficulties, severe and lasting psychological effects have been extensively documented through many displaced children and adolescents who continue to function normally (e.g., Barenbaum, Ruchkin, & Schwab-Stone, 2004). A wide range of psychological symptoms have been observed, such as post-traumatic stress disorder (PTSD), depression, anxiety disorders and behaviour problems (e.g., Paardekooper, de Jong, & Hermanns, 1999; Derluyn, Broekaert, & Schuyten, 2008).

Depression, clinical depression or major depressive disorder is a common and severe medical condition that negatively affects people's feelings, thoughts, and behaviours. According to DSM 5 (2013), depression causes feelings of sadness and/or a loss of interest in activities a person once enjoyed. It can also lead to various emotional and physical problems and can decrease the ability to function at work and home. On the other hand, post-traumatic stress disorder (PTSD) is also a psychiatric illness that may occur when people experience or witness traumatic events, such as natural disaster, serious accident, terrorist act, war or combat, rape, death, sexual violence, injury etc. (DSM 5, 2013).

Causes of aggression:
Behavioural and social scientists have different theories about the causes of aggression. According to the psychoanalytic theory of Sigmund Freud, aggression is an innate drive or instinct in each of us, like sexuality (Stoff et al., 1997). However, psychologists and social scientists theorise that it is not an inborn drive but a response to frustration that every human experiences almost from birth. For example, the basic principle of social learning theory is that children are not aggressive by nature; they learn to be aggressive where learning is hypothesised to occur both as a result of one's behaviour (enactive learning) and as a result of viewing other's behaviour (observational learning) (Huesmann, 1998). In his Bobo doll experiment, Bandura (1973) operationalised that young child showed more aggressive behaviour in their play after watching a model being aggressive to a Bobo doll. In particular, children were observed to imitate the precise actions of the model, indicating that imitation was the principal way in which children learned to be aggressive. In addition to imitation, observational learning is another crucial process by which children learn to be aggressive. It has been repeatedly shown that children who are exposed to violence in the family are more likely to be violent and aggressive as adults themselves (Herrera & McCloskey, 2003; Litrownik, Newton, Hunter, English, & Everson, 2003). Research also indicates that biological processes (internal stimuli) may serve a role in predisposing to aggression. Five specific biological processes are- (1) brain dysfunction, (2) testosterone, (3) serotonin, (4) birth complications, and (5) nutrition deficiency (Liu J, 2004).

Evolutionary perspective:
Credence in the innate aggressive tendencies of human beings—that the ability to be aggressive toward others in different circumstances is part of our fundamental human makeup is consistent with the principles of evolutionary psychology. Such tendencies of human beings prevent others from harming us and those we care about. We may be aggressive against others because it helps us achieve access to essential resources, such as food and desirable mates, or protect ourselves from direct attack by others. And we might be aggressive when we feel that our social status is threatened. Therefore, if aggression helps with our survival and the survival of our genes, the process of natural selection may well reason humans, as it would any other animal, to be aggressive. Thus, human beings require to be able to aggress in certain conditions, and nature has provided us with these types of skills (Buss & Duntley, 2006). Thus, almost all of us can be aggressive in the right situation. However, just because we can aggress does not mean that we will be aggressive. It is not necessarily evolutionarily correct to aggress in all circumstances. Being aggressive can be costly for one if the other person aggresses back. Therefore, neither human beings nor other animals are aggressive all the time. Instead, they become aggressive only when they need to be aggressive (Berkowitz, 1993a).

The focus of this study is violence exposure and behavioural and psychological symptoms of the Rohingya community in Bangladesh. Near 100,000 Rohingya people, over half of them children, have fled violence from the Myanmar's Rakhine State and arrived in Cox's Bazar since 25 August 2017 (Plan International, 2018).

Rohingya refugees in Bangladesh usually refer to Forcibly Displaced Myanmar Nationals (FDMNs) from Myanmar living in Bangladesh now (Muslim Global, 2017). These Rohingya people have experienced ethnic and religious persecution in Myanmar for decades, and many of them have fled to other countries in Southeast Asia, including Malaysia, Indonesia, and the Philippines (foxnews.com, 27 September 2018). However, most Rohingya people fled from the Rakhine state of Myanmar to Bangladesh. The number of Rohingya refugees in Bangladesh has increased rapidly for the escalated violence in Myanmar. According to the UN Refugee Agency (UNHCR, 2017) report, more than 723,000 Rohingya have fled to Bangladesh since 25

August 2017. The government of Bangladesh provided them shelter in Cox's Bazar from a humanitarian ground.

Rohingyas are Muslim minority people in Myanmar perceived by many Buddhist people of Myanmar as illegal migrants from Bangladesh (The Independent, 2017). Thus, Rohingya people are denied citizenship in Myanmar and have been described as the world's most persecuted minority (Kullab & Samya, 2017).

According to the United Nations High Commissioner for Refugees (UNHCR), only few studies have been published on mental health concerns of the Rohingya populations living in Bangladesh. However, there is a concerning number of cases found on explosive anger, psychotic symptoms, somatic or medically unexplained symptoms, impaired function and suicidal ideation, along with a documented history of reported high anxiety, hypervigilance, depression, and appetite loss within the population (Tay et al. 2018). The factors suggested causing such prominent mental health concerns to involve daily stressors of refugee living situations and the immediate trauma endured before arrival and protracted traumatic or stressful experience being persecuted in the Rakhine State before fleeing (Riley, 2017).

1.2 Objectives of the research

The objectives of the research are:

1. To investigate the nature and prevalence of violent ideation and aggressive behaviour among young Rohingya adults and the host community.
2. To investigate whether there is any exposure of violence on psychological states (such as stress, anxiety, depression and aggression) on Rohingya and host community.
3. To look into whether psychosocial support affects emotional healing and behavioural changes of the young Rohingya adults.

1.3 Variables of the research and their definitions

The variables of the study are as follows:

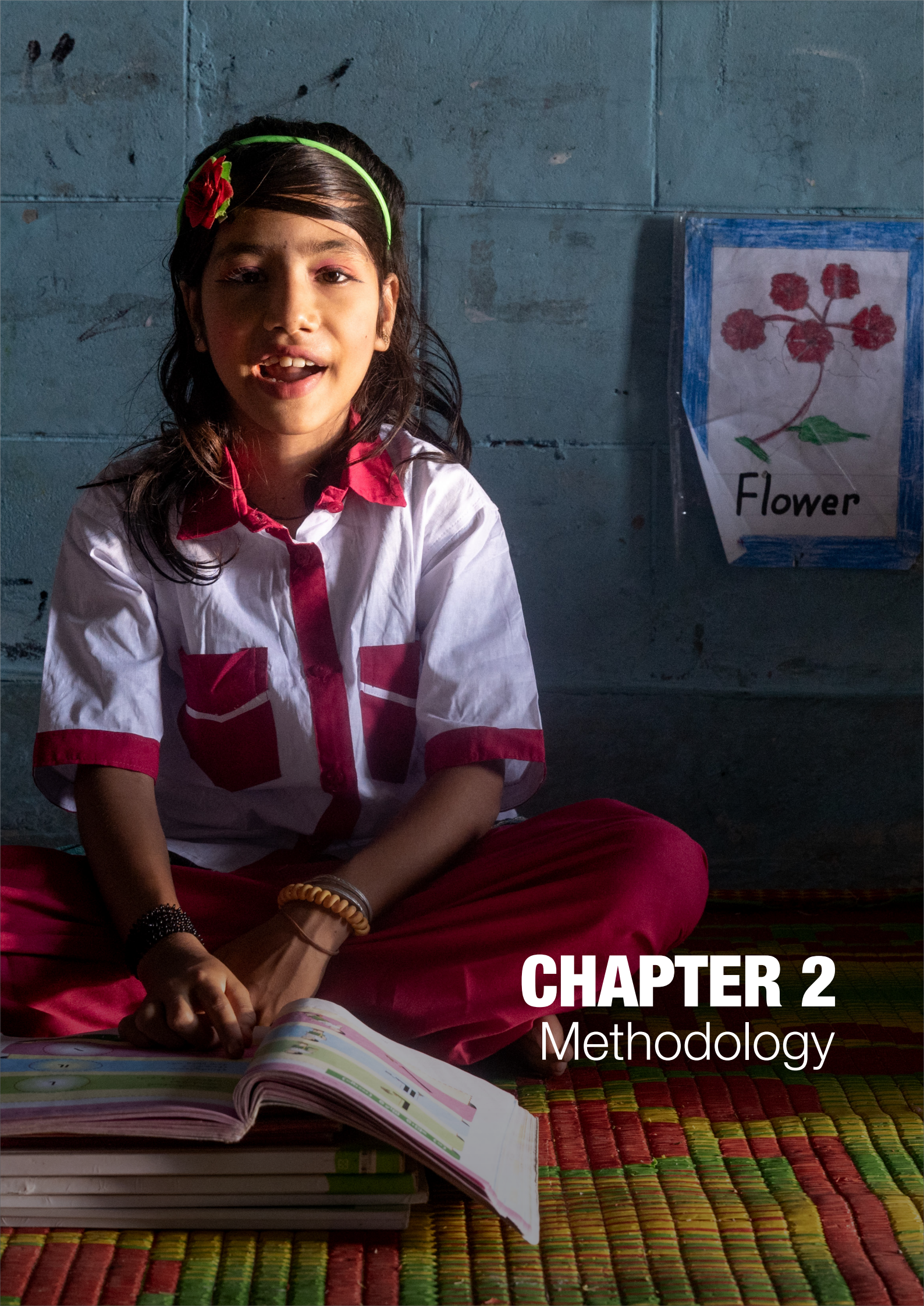
Independent variable	Dependent variables
Exposure to violence/ traumatic past	Stress Anxiety Depression Aggression behaviour and Violent ideation

The definitions of study variables are given below:

- Violent Ideations can be defined as thoughts, daydreams or fantasies of inflicting harm on another person
- Aggression refers to actions that involve the target of harm or injuring others and not merely the conveyance of such consequences (Feshbach, 1970). There are two common types of aggression which are as follows: (1) Overt/direct aggression refers to that aggression that is openly focused on its target; and (2) Covert/indirect/relational aggression refers to that aggression which amiss to damage or interfere with another person's relationships, psychological wellbeing or reputation.

The study focuses on four types of aggression:

- Physical Aggression (PA) and Verbal Aggression characterise an instrumental or motor component of aggression.
- Anger is the emotional or affective component that indicates psychological stimulation and grounding for aggression.
- Hostility charaterises the cognitive component of aggressive behaviour.
- Stress is a feeling of emotional or physical tension. It can come from any event or thought that makes one feel frustrated, angry, or nervous. Stress is our body's reaction to a challenge or demand.
- Anxiety is an emotion characterised by tension, worried thoughts and physical changes. Anxiety is both a mental and physical state of negative expectation. Mentally it is characterised by increased arousal and apprehension tortured into distressing worry and physically by unpleasant activation of multiple body systems—all to facilitate response to an unknown danger, whether real or imagined.
- Depression is a mood or emotional state that is marked by feelings of low self-worth or guilt, sadness and a reduced ability to enjoy life.



CHAPTER 2
Methodology

2.1 Design of the study

A mixed-method design, i.e., a combination of quantitative and qualitative methods, was followed in this research. The quantitative part was a cross-sectional survey by which the participants' current state of aggression, violent ideation, stress, anxiety, and depression were measured. The qualitative methods were In-depth Interviews (IDIs) and Focused Group Discussions (FGDs) through which the nature of violence exposure and the nature of aggression, violent ideation, stress, anxiety, and depression of the participants were explored.

Participants of the sample survey

- For the sample survey, the participants of this research were **1,244** young adults aged between 18 to 30 years.
- **430** (male=211, female=219) were young Rohingya adults who came to Bangladesh during the 2017 influx, known as New Rohingya.
- **409** (male=204, female=205) were Rohingya young adults who came to Bangladesh before the 2017 influx, commonly known as Old Rohingya. and
- **405** (male=205, female=200) participants were young adults of the host community in Cox's Bazar.

2.2 Sampling procedure

The sampling procedure used two stages random sampling methods. Ten new Rohingya camps, two registered Rohingya camps, and six unions in Ukhiya and Teknaf Upazila were selected for data collection. Probability Proportion to size (PPS) was used to decide the sample size in each camp and the union. Considering the density of the population, interviews were conducted in the camps keeping the household intervals 5 and 3 in the host community. For qualitative inquiry, 30 IDIs and 12 FGDs were conducted.

Table 1: Percentage of demographical and socio-economic variables of the three groups of sample

Categories of variable	Levels	New Rohyinga % (n) n= 430	Old Rohyinga % (n) n=409	Host community % (n) n= 405
Sex	Male	49.1(211)	49.9(204)	50.6(205)
	Female	50.9(219)	50.1(205)	49.4(200)
Age	18 to 23 years	46.7(201)	45.7(187)	50.1%203
	24 to 30 years	53.3(229)	54.3(222)	49.9(202)
Expenditure	Below 5000	41.2(177)	23.5(96)	7.7(31)
	5001 to 10000	45.6(196)	48.7(199)	30.1(122)
	10001 to 50000	13.3(57)	27.9(114)	62.0(251)
	More than 50000	.0(0)	.0(0)	.2(1)
Income	Below 5000	40.0(172)	19.1(78)	3.7(15)
	5001 to 10000	42.3(182)	43.3(177)	23.2(94)
	10001 to 50000	17.4(75)	37.2(152)	71.9(291)
	More than 50000	.2(1)	.5(2)	1.2(5)
Marital Status	Unmarried	22.8(98)	28.9(118)	40.7(165)
	Married	74.9(322)	68.5(280)	56.8(230)
	Others	2.3(10)	2.7(11)	2.3(10)
Children of married sample	No child	29.8(128)	35.9(147)	45.2(183)
	1 to 3 children	56.0(241)	50.6(207)	46.9(190)
	More than 3 children	14.2(61)	13.5(55)	7.9(32)
Number of family members	1 to 3	15.6(67)	13.9(57)	10.9(44)
	4 to 7	67.9(292)	63.8(261)	74.6(302)
	8 to 10	16.5(71)	22.2(91)	14.6(59)

2.3 Scales used in the study

For data collection, the following scales were administered:

i) **Bangla Buss-Perry Aggression Questionnaire (Buss & Perry, 1992):** This questionnaire measures four types of aggression, these are physical aggression, verbal aggression, anger, and hostility. The Bangla adapted version (Dash & Shingha) have high reliability and validity.

ii) **Bangla translated version of Patient Health Questionnaire-4 (PHQ-4) (Kroenke et al., 2009):** The PHQ-4 has four items. Generalised Anxiety Disorder 2 item (GAD-2) and PHQ-2 were also used, with responses provided on a Likert scale.

The PHQ-2 measures depression, which includes the first two items from the longer depression measure, the PHQ-9. The GAD-2 measures anxiety. It also included the first two items from the GAD-7. It showed satisfactory reliability and validity. The researchers following standardised translation procedure prepared the Bangla translated version.

iii) **Bangla translated version of Perceived Stress Scale-4 (PSS-4) (Cohen et al., 1983):** The short version, PSS-4, is an economical and

straightforward psychological instrument to administer, comprehend, and score. It measures the degree to which situations in one's life over the past month are appraised as stressful. Items were designed to detect how unpredictable, uncontrollable, and overloaded respondents find their lives. The PSS-4 poses general queries about relatively current levels of stress experienced by the participants. It has good psychometric properties. The researchers following standardised translation procedure prepared the Bangla translated version

iv) **Bangla translated version of Violent Ideation Scale (VIS) (Murray et al. 2018):** The VIS was developed to measure violent ideation of older adolescents. The original scale is in the Swiss-German language developed by Murray et al. (2018) with sound psychometric properties. Standard adaptation procedure was used to adapt the scale into Bangla by the researchers.

Demographic variables scuh as age, education level, place of residence, trauma related experiences etc. were collected using the questionnaire.

For the qualitative inquiry, checklists and guidelines for IDIs and FGDs prepared by the research team were used to collect data.

2.4 Data collection

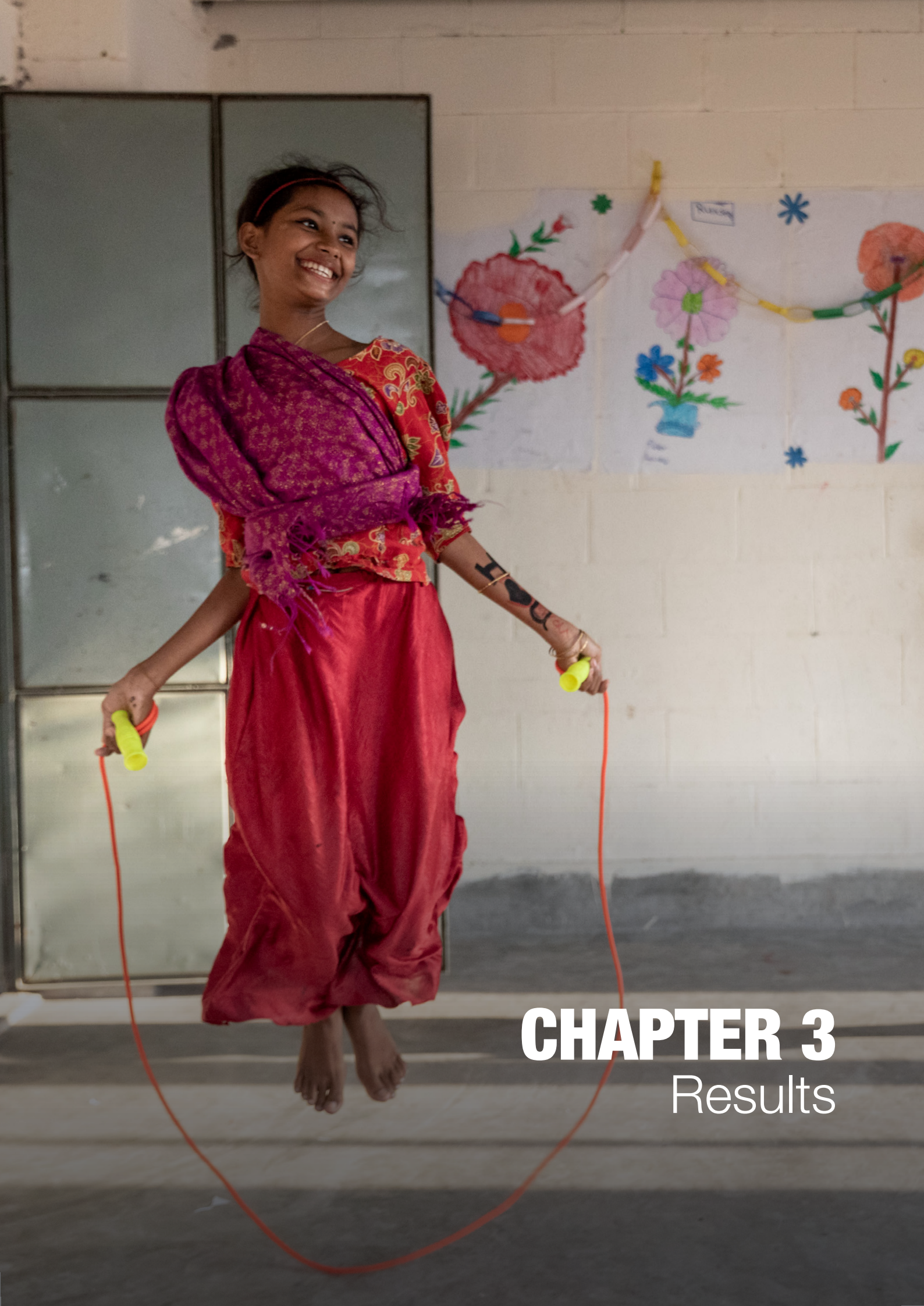
As this was mixed-method research, the procedures for the quantitative and qualitative parts were different. A total of 17 research assistants were involved in data collection. They were skilled in the native dialect of Rohingya people and the data collection process of psychological research. A 2-day training was provided to the research assistants to provide them with a clear understanding of the data collection procedure for both the quantitative and qualitative parts of the present study. Separate data collectors were used for the quantitative and qualitative parts.

Quantitative data collection: For the quantitative part of the research, 1,244 individual structured interviews with close-ended questionnaires were completed. The duration of each interview was 40-45 minutes. Before starting the interview, informed consent was taken from each participant. Primary mental health care was provided for the emotionally vulnerable participants. Every participant was informed about the available mental health services so that they could get support if they felt discomfort due to the interview. The participants were not provided with any fees or other privileges.

Qualitative data collection: In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs) were conducted as part of the qualitative data collection. A total of 30 IDIs and 12 FGDs were conducted for this research. The participants were recruited through purposive sampling. The participants were provided with informed consent before starting every IDI and FGD. The research assistants treated the participants compassionately and offered psychological first aid for those triggered emotionally during the process. For documentation, the interviewers kept audio records and took backup notes. FGDs were conducted with local NGO employees working with Rohingya population, data collectors, host community leaders etc. The duration of each FGD was from 1 hour to 1.5 hours. IDIs were conducted with both male and female young Rohingya adults, local journalists, historians etc., and the duration of each IDI was 30-45 minutes.

2.5 Ethical consideration

Ethical permission was granted from the Ethics Committee of the DECP, University of Dhaka. Moreover, permission was taken from the Office of the Refugee Relief and Repatriation Commissioner for conducting the study. The concept note and questionnaire were submitted to both offices for review and feedback, duly incorporated in the tools.



CHAPTER 3
Results

3.1 Nature and prevalence of violent ideation and aggressive behaviour among the youth in Rohingya and host communities

The first objective was to measure the nature and prevalence of violent ideation and aggressive behaviour among young Rohingya adults and the host community. To achieve this objective percentage of family-related adverse experiences and exposure to violence were calculated for three groups (New Rohingya, Old Rohingya, and Host). For statistical analysis, the Analysis of Variance was calculated for total aggression and sub-scales (physical aggression, verbal aggression, anger, and hostility). Moreover, the mean difference of the total and sub-scales of aggression scores was calculated for different groups according to sex. Correlations between violent ideation and aggressive behaviour scores were calculated for the entire sample and different groups. These are presented in the following tables (Table 2 to 8).

Table 2: Percentage of family-related adverse experiences among three groups

S L	Questions	New Rohyinga % of Yes (n)	Old Rohyinga % of Yes (n)	Host % of Yes (n)	Total % of (N)
1.	Do you have a good relationship with with your parents?	34.7 (295)	30.9 (263)	34.4 (293)	100% (851)
2.	Is any of your family members addicted (cigarette and betel leaf)?	33.4 (334)	32.2 (332)	33.3 (339)	100% (999)
3.	Is any of your family members addicted (heroin and yabba)?	32.4 (12)	**43.2** (16)	24.3 (09)	100% (37)
4.	Is any of your family members has been punished through justice/law system for criminal activities?	32.2 (73)	**36.8** (86)	32.1 (75)	100 (234)
5.	Is any of your family members mentally sick?	31.7 (57)	**35.00** (64)	33.9 (62)	100 (183)
6.	Are you exposed to family violence or abused or tortured?	30.7 (131)	**37.2** (159)	32.1 (137)	100 (427)
7.	Have you been physically abused by your family members?	**36.4** (297)	30.8 (252)	32.8 (268)	100 (817)
8.	Have you been emotionally abused by your family members?	**36.4** (297)	30.8 (252)	32.8 (268)	100 (817)
9.	Has your family neglected you?	**36.4** (297)	30.8 (252)	32.8 (268)	100 (817)
10.	Have you been sexually abused by your family members?	0.00 (0)	83.0 (5)	16.0 (1)	100 (6)

The highest number of respondents responded to question no. 2. Responses of all three groups are similar. The third question yielded the highest response from Old Rohingyas though only a few responded affirmatively in this particular question. Old Rohingyas produced the highest score for the third, fourth, fifth, and sixth questions. Old Rohingya adults answered affirmatively on being addicted to yabba/heroin, punished by law for criminal activities, family members being mentally sick, and being exposed to family violence/torture compared to New and Host communities.

On the other hand, more New Rohingyas responded to questions 7, 8 and 9. New Rohingyas responded to have been neglected, physically and emotionally abused by family more than the Old and the Host community. Question 10 (sexually abused by family) elicited the lowest responses.

Table 3: Percentage of exposure to violence/witnessing violence among three groups

SL	Questions	New Rohyinga % (n)	Old Rohyinga % (n)	Host community % (n)	Total % (N)
1	Have you experienced any type of violence/ kidnapping or severe assault?	36.5 (70)	36.5 (70)	27.1 (52)	100 (192)
2	Have you seen someone getting killed or being subject to severe violence?	46.4 (245)	33.0 (174)	20.6 (109)	100 (520)
3	Do you often hear stories of someone being killed or being a victim of extreme violence?	34.3 (389)	34.5 (391)	31.2 (354)	100 (1134)
4	Have you ever taken any type of addictive items like cigarettes or betel leaf?	40.8 (285)	30.9 (216)	28.2 (197)	100 (698)
5	Have you ever taken any type of addictive items like heroin or yabba?	21.1 (4)	47.4 (9)	31.6 (6)	100 (19)
6	Have you ever received any type of counselling for emotional support?	38.1 (278)	37.8 (276)	24.1 (176)	100 (730)

Among 1,244 respondents, 1,134 answered positively in Question 3, and responses were similar for both Old and New Rohingyas. Nearly half of the New Rohingyas reported witnessing someone being killed or being a victim of extreme violence compared to the Old Rohingya and the host community. Old Rohingyas reported experiencing addictive items like heroin or yabba (47.4%). Similar responses were received from Old and New Rohingyas for question 6, where they were asked about receiving counselling services for emotional wellbeing. It shows host communities have very little access to such services.

Table 4: Aggressive score (total and sub-scales) according to three groups

Sub-scale of aggression	Categories of sample	Mean	SD	F	Sig.
Physical Aggression	New	9.05	5.22	1.200	.301
	Old	9.56	5.22		
	Host	9.48	5.05		
Verbal Aggression	New	6.47	3.98	7.606	·001**
	Old	7.51	3.92		
	Host	7.12	3.74		
Anger	New	12.23	4.84	2.076	.127
	Old	13.27	4.79		
	Host	12.21	4.59		
Hostility	New	15.38	6.69	6.932	.001*
	Old	16.77	6.71		
	Host	16.86	6.00		
Total	New	44.60	16.97	2.263	.105
	Old	48.06	14.92		
	Host	44.15	15.42		

*p< 0.001

The findings suggest that the Old Rohingyas showed significantly more VERBAL AGGRESSION than the New Rohingyas. The New Rohingyas showed significantly more VERBAL AGGRESSION than the Host community. Interestingly, the Old Rohingyas and Hosts showed significantly more HOSTILITY than the New Rohingyas. However, total scores (i.e., considering Physical Aggression, Verbal Aggression, Anger & Hostility) among the three groups showed no significant differences.

Table 5: Differences in aggression scores according to sex

Sub -scale of aggression	Sex	Mean	SD	t	Sig.
PA	Male	10.61	5.30	8.788	.000**
	Female	8.11	4.71		
VA	Male	6.74	3.73	-2.543	.011*
	Female	7.31	4.06		
Anger	Male	12.36	4.32	-.582	.561
	Female	12.63	5.13		
Hostility	Male	15.14	6.00	-6.471	.000**
	Female	17.49	6.786		
Total	Male	45.99	15.22	.709	.479
	Female	44.89	16.68		

*p< 0.01 p<0.0001

Results indicate that the males are significantly more PHYSICALLY AGGRESSIVE than the females. Interestingly, the females are significantly more VERBALLY AGGRESSIVE and HOSTILE than the males.

Table 6: The violent ideation scores among the three groups of ample

Scale	Categories of sample	Mean	sd	F
VIS	New	24.52	9.73	2.90*
	Old	25.42	9.92	
	Host	23.83	8.66	

*P<0.05

The Old Rohingyas have more VIOLENT THOUGHTS compared to the New Rohingyas and the Host community. Results show that significant differences exist among these three groups.

Table 7: Differences in violent ideation score according to sex

Scale	Sex	Mean	sd	t	Sig.
VIS	Male	21.92	7.83	10.32	0.00*
	Female	27.25	10.20		

*p<.001

The result shows that the females have significantly more VIOLENT THOUGHTS than the males.

A positive correlation exists between VIOLENT THOUGHTS & AGGRESSIVE BEHAVIOR. Old Rohingyas have a higher correlation compared to the Host and New Rohingyas.

Table 8: Correlation between violent ideation and aggressive behaviour scores for new Rohingyas, old Rohingyas, and host community

Category	New Rohingya	Old Rohingya	Host community	
r value	.40	.50	.463	p<.01

3.2 Exposure to violence on psychological state

The 2nd objective was to investigate whether there is an exposure to violence on psychological states (such as stress, anxiety, depression and aggression). To achieve this objective, the mean, standard deviation and t values were calculated for different psychological states (violent ideation, anxiety, depression and stress) presented in tables 9 to 12.

Table 9: Mean difference between violation ideation, anxiety, depression and stress according to being a victim of violence

Psychological state	Victim of viole nce (n)	Mean	SD	t	Sig.
Violent ideation	Yes (192)	26.79	10.62	3.505	000*
	No(1052)	24.19	9.20		
Anxiety	Yes (192)	2.23	1.52	4.697	.000*
	No(1052)	1.69	1.45		
Depression	Yes (192)	2.34	1.53	3.123	.002**
	No(1052)	1.94	1.65		
Total PHQ4	Yes (192)	3.26	2.16	3.756	.000*
	No(1052)	2.63	2.12		
Stress	Yes (192)	4.42	2.17	5.244	.000*
	No(1052)	3.52	2.20		

*p<0.0001 **p<0.002

In every measure of Violent Ideation, anxiety, depression and stress, it is found that there is a significant difference between YES and NO respondents. In every measure, those who have been victims of violence scored higher compared to those who have not been victims of violence. Victims have more violent ideations and suffer from anxiety, depression, and stress.

Table 10: Difference between three groups regarding anxiety, depression, stress, and violent ideation according to being victim of violence

Category	Response (n)	Anxiety	Depression	Total PHQ	Stress	Violent Ideation
New	YES 70					
	NO 360	*			*	*
Old	YES 70					
	NO 339	*		*	*	*
Host	YES 52					
	NO 353	*	*	*	*	*

Significant differences between YES and NO respondents are presented in the table with an asterisk (*) mark. Regarding anxiety, significant differences exist between YES and NO respondents among all three groups. Victims are more anxious than non-victims among all three groups. A significant difference exists regarding the stress of the New Rohingyas. Victims are more stressed than non-victims. The Old Rohingya victims scored higher on total anxiety and depression (PHQ4) and stress. Victims of Host communities also scored higher on depression, Total PHQ4, stress and anxiety than the non-victims. Significant differences were found among New, Old Rohingyas and Host communities regarding violent ideation.

It was found that those who witnessed violence have significantly higher violent ideation, anxiety and depression compared to those who have not witnessed violence. However, in the case of stress, no significant difference was found

Significant differences between YES and NO responses are presented in the above table with an asterisk (*) mark. A significant difference exists between witnessing violence and not witnessing in the areas of depression and total PHQ4 scores of New Rohingyas. That is, among New Rohingya, those exposed to violence/witnessed violence have higher depression and total PHQ4 scores than those who did not witness such violence.

Table11: Mean difference of violent ideation, anxiety, depression and stress as a result of being exposed to/witnessing violence

Psychological state	Exposed to violence (n)	Mean	SD	t	Sig.
Violent ideation	Yes (528)	26.20	10.33	5.197	.000*
	No (716)	23.40	8.61		
Anxiety	Yes (528)	1.90	1.47	2.604	.009*
	No (716)	1.68	1.47		
Depression	Yes (528)	2.13	1.63	2.376	.018*
	No (716)	1.91	1.64		
Total PHQ4	Yes (528)	2.94	2.10	2.924	.004*
	No (716)	2.58	2.15		
Stress	Yes (528)	3.74	2.19	1.118	.264
	No (716)	3.60	2.24		

*p<0.01

Table 12: Comparison among three groups regarding anxiety, depression and stress according to witnessing violence

Category	Response (n)	Anxiety	Depression	Total PHQ	Stress
New Rohingyas	YES (245)				
	NO (185)		*	*	
Old Rohingyas	YES (174)				
	NO (235)				
Hosts	YES (109)				
	NO (296)				

3.3 Psychological support for emotional healing and behavioural changes

The third objective was to look into whether psychosocial support affects the young Rohingya adults' emotional healing and behavioural adaptations.

The table shows that violent ideation, anxiety, depression, stress, and aggression of the young females who received counselling services from the NGOs have a higher score than the males. Females scored higher on all measures of psychological states- violent ideation, anxiety, depression, total PHQ4 and stress. Males are in better psychological states compared to females who took counselling.

Table 13: Mean difference of violation ideation, anxiety, depression, stress and aggression of males and females who have received counselling services

Psychological state	Sex	Mean	SD	t	Sig.
Violent ideation	Male	21.41	7.67	9.82	.000*
	Female	28.36	11.18		
Anxiety	Male	1.72	1.38	3.52	.000*
	Female	2.11	1.57		
Depression	Male	1.85	1.55	4.47	.000*
	Female	2.38	1.68		
Stress	Male	3.61	2.08	1.97	.04**
	Female	3.94	2.38		
Aggression	Male	44.13	14.38	3.03	.04**
	Female	50.05	15.50		

*p<0.001 **p<0.05

3.4 Nature, causes and results of aggressive behaviours

FGDs and IDIs were conducted to answer four aspects: understanding the nature of aggression, causes of aggressive behaviours, results of aggressive behaviours, and ways to mitigate aggression. Both the Rohingyas and the host community contributed to these questions. The findings are provided in the following tables.

Nature of aggression

As the Rohingyas described

- Self-harm: cutting hands, banging heads
- Blaming others
- Quarrelling
- Beating wives, children
- Fighting / hitting others
- Sometimes attacking NGO workers
- Drug dealing/trafficking
- Involvement with religious groups
- Fleeing from home
- Bullying others
- Robbery/unlawful activities

As the hosts described

- Blaming others
- Quarrelling/shouting/name-calling
- Fleeing from home
- Family conflicts/in-laws conflict
- Bullying others
- Displacing on less powerful persons
- Beating younger ones

Causes of aggressive behaviours

As the Rohingyas described

- Pent up anger and despair against Myanmar Army
- Previous history of abuse/sexual exploitation
- Victim of discrimination
- Frustration regarding helplessness and current life situation
- Lack of identity/ lack of opportunities for own cultural practice
- Feeling of insecurity
- Traumatic experiences/rape/assault
- Restriction on mobility
- Helplessness and hopelessness regarding future
- Victims of injustice
- Absence of legal system and protection system within the camps
- Poor livelihood
- Absence of ownership
- Polygamy of husbands
- Power exercise of male family members
- Being verbally/ physically/ emotionally abused

As the hosts described

- Daily life hassle/ stress
- Being surrounded by Rohingyas
- Feeling of being isolated in own country
- Family troubles/ abusive behaviours
- Relationship problems
- Poverty
- Male dominaning society (for women)
- Lack of respect from family members
- Fighting with siblings
- Neglecting behaviuor of others
- Comparison
- Sexual harrassment
- Drug/involvement in unlawful activities
- Power control
- Not being able to meet family's need

Effects of aggressive behaviours

As the Rohingyas described

- Internalisd and externalized reactions
- Increased vulnerability
- More traumatic experiences
- Lack of self respect and respect for others
- Mistrust/doubt
- More aggression/fight
- More psychological distress/ irritable mood/crying/sadness
- Emotional/physical pain
- Food refusal/self-harm/attempt to suicide
- Destroying property
- Sleep disturbance/inattentiveness
- Using drugs
- Children are most affected/ displacement of anger is on them

As the hosts described

- Daily life hassle/ stress
- Being surrounded by Rohingyas
- Feeling of being isolated in own country
- Family troubles/ abusive behaviours
- Relationship problems
- Poverty
- Male dominaning society (for women)
- Lack of respect from family members
- Fighting with siblings
- Neglecting behaviuor of others
- Comparison
- Sexual harrassment
- Drug/involvement in unlawful activities
- Power control
- Not being able to meet family's need

Way to mitigate the aggression

The Rohingyas and host respondents emphasised the repatriation of displaced Rohingyas to Myanmar. They also opined for engaging them in income-generating activities and tasks. They further mentioned that access to mental health/counselling services to manage mental health issues is crucial. Old Rohingyas and hosts emphasised the need for women empowerment and initiating self-development programmes. The host respondents pressed to create a friendly relationship or resolve the local community and Rohingyas conflict. They further opined increasing NGO activities for the local community, especially on education, health facilities and livelihood opportunity.

CHAPTER 4
Discussion

Rohingyas were exposed to more family-related adverse experiences than host communities: The old Rohingya adults affirmatively on family members being addicted to yabba/heroin, punished by law for criminal activities, and mentally sick and family members being exposed to family violence/torture compared to the new Rohingyas and host community. This has been reflected in the qualitative findings:

> "I used to take yabba, but not now... a few of my family members and friends take it…

- Response of a 29-year-old male Rohingya (Old)

On the other hand, the new Rohingyas responded that they were more neglected, physically and emotionally abused by family than the old Rohingyas and the host community.

> "I do not feel like staying at my place... no peace at all... beating, fighting, quarrelling is continuously going on.

- Verbatim of a female New Rohingya

Rohingyas witnessed violence more than the host community: Nearly half of the new Rohingyas reported seeing someone being killed or being a victim of extreme violence compared to the old Rohingyas and the host community. Old Rohingyas reported having addictive items like heroin or yabba (47.4%), much higher than the new Rohingyas and the host community. This is by the self-report stated by the old Rohingyas that more family members of old Rohingyas were addicted to drugs like Yabba or heroin. The host community reported hearing less of such stories. When asked about receiving counselling services for emotional wellbeing, similar responses were obtained from the old and new Rohingyas, whereas host communities have very little access to such services.

No significant difference among the three groups regarding aggressive behaviour: In the total aggressive behaviour score, there was no significant difference among the three groups, though, among the subscales, i.e., Physical Aggression, Verbal Aggression, Anger & Hostility, there are some significant differences. Regarding verbal aggression, a significant difference was found among them. The old Rohingya people use more verbal aggression to express their anger than the host and new Rohingya adults. Also, in the case of showing hostility, the difference among the three groups was found

to be significant. The old Rohingyas and hosts showed significantly more hostility than the new Rohingyas. Hostility charaterises the cognitive component of aggressive behaviour. It does not imply they act out their aggression. It has been found that there were no significant differences among new, old, and host communities regarding physical aggression and anger. Rohingyas or not, all have a similar level of anger in them and, they exhibit physical acts likewise out of aggression. That is to say, only subscales of verbal aggression and hostility make significant differences among these three groups. However, when considering all four types of aggressions, no differences were found among the new and old Rohingyas and the host communities. This is a crucial finding of the study. The qualitative research also revealed that aggression is similar for both Rohingyas and the host community. Therefore, the myth of Rohingya people being more aggressive, uncouth and barbarian might not be true at all. It is only a myth.

- The old Rohingyas showed significantly more VERBAL AGGRESSION than the new Rohingyas.

- The new Rohingyas showed significantly more VERBAL AGGRESSION than the host community.

- Interestingly, the old Rohingyas and hosts showed significantly more HOSTILITY than the new Rohingyas.

- Total scores (i.e., considering Physical Aggression, Verbal Aggression, Anger & Hostility) among the three groups showed no significant differences.

Aggressiveness differs according to sex: Statistically, a significant difference exists between males and females regarding physical aggression, verbal aggression, and hostility but not in anger. Anger is the emotional or affective component that indicates psychological stimulation and grounding for aggression. Males and females have similar feelings of anger. Males were found to be more physically aggressive than females, which matched their societal norm and the biological factors of the male being more physically strong and aggressive. The original questionnaire developers (Buss-Perry) also found men more physically aggressive. The reason behind this could be evolutionary as testosterone hormone plays a vital role (Liu J, 2004).

On the other hand, females were verbally more aggressive, which can also be explained by their societal norms. As expressing physical aggression among women is discouraged in our society, women are more prone to use verbal aggression (quarrelling, using abusive words, cursing, etc.) to vent their anger. Regarding hostility, females were more hostile than males, which can be explained as hostility has been defined as a cognitive component of aggressive behaviour—not acting out aggressively. Instead, hostility is more close to violent ideation/thoughts. The qualitative part of the study examined the nature and effects of aggressive behaviours. It is found that females use verbal aggression and males use physical aggression (fighting, destroying property, beating/hitting dependents etc.).

- Males are significantly more PHYSICALLY AGGRESSIVE than females.

- Females are significantly more VERBALLY AGGRESSIVE and HOSTILE than males.

The verbatim also reflects the findings:

- “When I am angry, I shout at others even without their any faults and beat my children and wife, and sometimes I bang my head on walls.”- A Rohingya married person

- “The other (male) person ‘Matha fatay dise’ (made an injury on the head) while fighting over a silly matter.”- Another Rohingya person reported

- “If I feel angry, I wish to cut my hand. I call bad names/brick-bat to others and engage in quarrelling with others.” – A female Rohingya reported

Male and females differ significantly in violent ideation: Females have significantly higher violent ideation than males in all three groups. Ideation means thoughts. Violent Ideations have been defined as thoughts, daydreams or fantasies of harming another person. This result could be that women are reared up in society so as not to exhibit physical strength. It is also true that biologically they are less powerful in physical strength. Therefore, they might have violent or aggressive thoughts in their mind but seldom exhibit them. This could be their way of coping with the odds of life. This has been going on from generation to generation. This finding agrees with the previous findings that females are more hostile than males. The result is reflected in the verbatim of a young Rohingya mother.

> The tortures/ abuses we faced there and even here when things are against me, I think of doing terrible things, but I am helpless, what can I do?

- A young mother from new Rohingya

Old Rohingyas have more VIOLENT THOUGHTS than the new Rohingyas and the hosts: Violent ideation scores among the three groups revealed significant differences among the respondents (old and new Rohingyas and hosts). The old Rohingya adults have more violent thoughts compared to the new Rohingyas. Host community scored the least. It is understandable that the host community leads a much respectful life, enjoys the utilities and other facilities of the country, has access to almost anything and everything, and does not suffer from identity crises compared to the Rohingya community. These quantitative findings have been reflected in the qualitative results too. Rohingya communities are not considered the citizens of Bangladesh. They are forcefully displaced from their homeland. Insecurity, uncertainty, humiliation are part of their lives now. Respect as a human being is at stake. All these might give rise to violent thoughts. The explanation of the old Rohingya adults having more violent ideation could be due to their extended stay as displaced persons, getting into fights with local people, getting not enough support from NGOs as the new Rohingyas get etc. The following verbatim commensurate with the findings:

> As a Rohingya, I feel angry. Because we do not have our own house, a place to live, and we do not have any identity. I witnessed my uncle being killed in front of my eyes in Myanmar. I feel anger towards Myanmar Army. I wish I could harm to them.

- An old male Rohingya

Positive correlations exist between VIOLENT THOUGHTS & AGGRESSIVE BEHAVIOUR:

Correlation between violent ideation and aggressive behaviour were calculated for the total sample and three different groups. It has been found that a positive correlation ($r=.45$, $p<.01$) exists between violent thoughts and aggressive behaviour for the total sample. The correlation values for the new and old Rohingyas and the host community are 0.40, 0.50, and 0.46, respectively. Though not a high correlation, it indicates violent thoughts and acting out aggressively have a positive relationship. This is an important finding which needs to be addressed. Research has examined the relationship between self-reports of thoughts of harming others and actual aggression among sexual psychopaths (e.g., Malamuth, 1998), as well as nonclinical samples such as school children (e.g., Rosenfeld, Huesmann, Eron, & Torney-Purta, 1982), adolescent delinquents (e.g., Silver, 1996), and college students (e.g., Greenwald & Harder, 1997). They found positive correlations between these two. In another study, reporting violent thoughts was significantly related to a psychopath, anger, and impulsiveness (Grisso et al., 2000). The present finding and the literature review implications for community-based mental health services and social and emotional learning and aggression/violence prevention programmes for adolescents and adults. A comprehensive assessment of mental health, social and emotional learning and aggressive/violent behaviours in fieldwork, research, and programme-evaluation efforts should be considered. In the future, these need to be explored with follow-up studies. Environmental and social changes can be facilitated so that fewer chances of developing violent thoughts can be ensured. The less violent ideation among people, the less the possibility of acting out aggressively. Government and NGOs can take adequate measures to provide conflict resolution and mitigate discrimination and victimisation, creating an amiable atmosphere, healthy communication, and acceptance of others.

Being a victim of violence has a significant negative impact on violent ideation, anxiety, depression, and stress:

- In every measure of violent ideation, anxiety, depression and stress, it is found that there is a significant difference between YES and NO respondents
- Victims have more violent ideations and suffer from anxiety, depression and stress

In every measure of psychological states of the total sample who have been the victim of violence are more stressed, depressed, anxious, and have violent thoughts than those who have not been the victim of violence. Literature supports these findings. Evidence is that violence exposure is associated with several mental health issues such as depression, suicidal ideation, and post-traumatic stress disorder (Fitzpatrick & Boldizar, 1993; Freeman, Martinez &Richters, 1993; DuRant, Cadenhead, Pendergrast, Slavens, & Linder, 1994). Studies on the experience of fleeing and subsequent post-migration ordeals have been found to affect the psychological wellbeing of forcefully displaced populations (Thomas & Thomas, 2004). Sometimes, despite mental health difficulties, severe and lasting psychological effects have been extensively documented (e.g., Barenbaum, Ruchkin, & Schwab-Stone, 2004). A complete range of psychological symptoms have been detected, such as post-traumatic stress disorder (PTSD), depression, anxiety disorders and behavioural problems (e.g., Derluyn, Broekaert, & Schuyten, 2008; Paardekooper, de Jong, & Hermanns, 1999).

A significant difference exists among three groups on violent ideation, anxiety, depression and stress according to the victimisation of violence

- Regarding anxiety significant differences exist between YES and NO responders among all three groups—victims are more anxious than non-victims among all three groups.
- A significant difference exists regarding stress of the new Rohingyas—victims are more stressed than the non-victims of the new Rohingyas.
- Old Rohingya victims scored higher on total anxiety and depression (PHQ4) score and stress.
- Victims of the host communities also scored higher on depression, total PHQ4, stress than the non-victims.
- Violent ideation differs significantly between the victims of violence and non-victims among the new and old Rohingyas and host communities.

Interestingly, in the host community, all measures (i.e., anxiety, depression, total PHQS, stress and violent ideation) significant differences were found between YES and NO respondents. Victims of the host community have negative psychological impacts. They might have distressing issues such as family violence, societal violence, history of abuse/ongoing abuse etc. These might contribute to developing stress, anxiety, depression and violent ideation more than the non-victims.

Old Rohingya adults also indicate significant differences in all measures except depression. Regarding depression, no differences were found among victims and non-victims. At the

same time, the new Rohingya victims differed significantly from the non-victims in all measures except depression and PHQ4 (total depression and anxiety score). As in the present study, only a two-item measure was used to identify depression. It might not yield the actual scenario. As mentioned in earlier researches, it is found that displaced people/refugees/internally displaced persons usually suffer from depression (Thomas & Thomas, 2004; Derluyn, Broekaert, & Schuyten, 2008; Tay et al. 2018).

Therefore, it can be said that considering the total sample, measures of psychological states vary between the victims and non-victims, but there exist some differences in groups.

Differences in violent ideation, anxiety, and depression exist between the respondents having been exposed to violence/witnessing violence and not exposed:

- It was found that those who witnessed violence have significantly higher violent ideation, anxiety and depression compared to those who did not see violence.
- In the case of Stress, no significant difference was found.

These findings are also consistent with other research's findings where it has been proved that witnessing hostility and violence also negatively impacts the

witness's mental wellbeing. A study on a sample of children from South Africa compares the effects of witnessing school violence with those having being victimised. They found that in the context of the school, witnessing violence creates distress among the children, however, the victimisation has a somewhat more substantial effect on distress (Shields, Nadasen, & Pierce, 2008).

New Rohingya those who have been exposed to violence or witnessed violence have higher depression:

- A significant difference exists between those who witnessed and who did not witness violence in terms of depression and total PHQ4 scores among the new Rohingyas.
- No differences were found in any of the measures among the old Rohingyas.
- No differences were found regarding the psychological states of the host community.

Among the new Rohingyas, those exposed to violence or witnessed violence have higher depression and total PHQ4 scores than those who did not witness any violence. As the new Rohingya adults were exposed to violence more than the old Rohingyas, it affected their wellbeing.

Listening to stories of violence and aggression harms developing violent ideation: Only in the case of violent ideation there exists a significant difference between those who listened to stories about violence and those who did not. But no significant differences were found regarding other psychological states. Therefore, it is clear that directly being the victims of violence has the highest negative impact on psychological health. Being exposed to/witnessing violence also has a strong negative impact, and listening to violent stories has affected only developing violent thoughts in mind. As it has been established that violent ideation and aggressive behaviour have a positive correlation, we need to consider this matter.

Males are in better psychological states than females who took counselling: It has been found that the difference between males and females was highly significant for each of the five psychological measures. Interestingly, females scored higher scores than their male counterparts in every measure. In a nutshell, the psychological states of females are poorer compared to males. It means females have more violent ideation (which was found in overall female respondents, see table 7); they suffered more from anxiety, depression, and stress and scored higher in aggression than males who received counselling services. The reason behind this difference might be the living condition of the female group, no matter where they are living (inside or outside the camp). Women, in general, encounter more problems in their lives than their male partners/family members. Findings from qualitative data support the fact that male members highly suppress females. Their emotional needs and opinions are not taken into consideration. Physically, emotionally and socially, they have to go through turmoil.

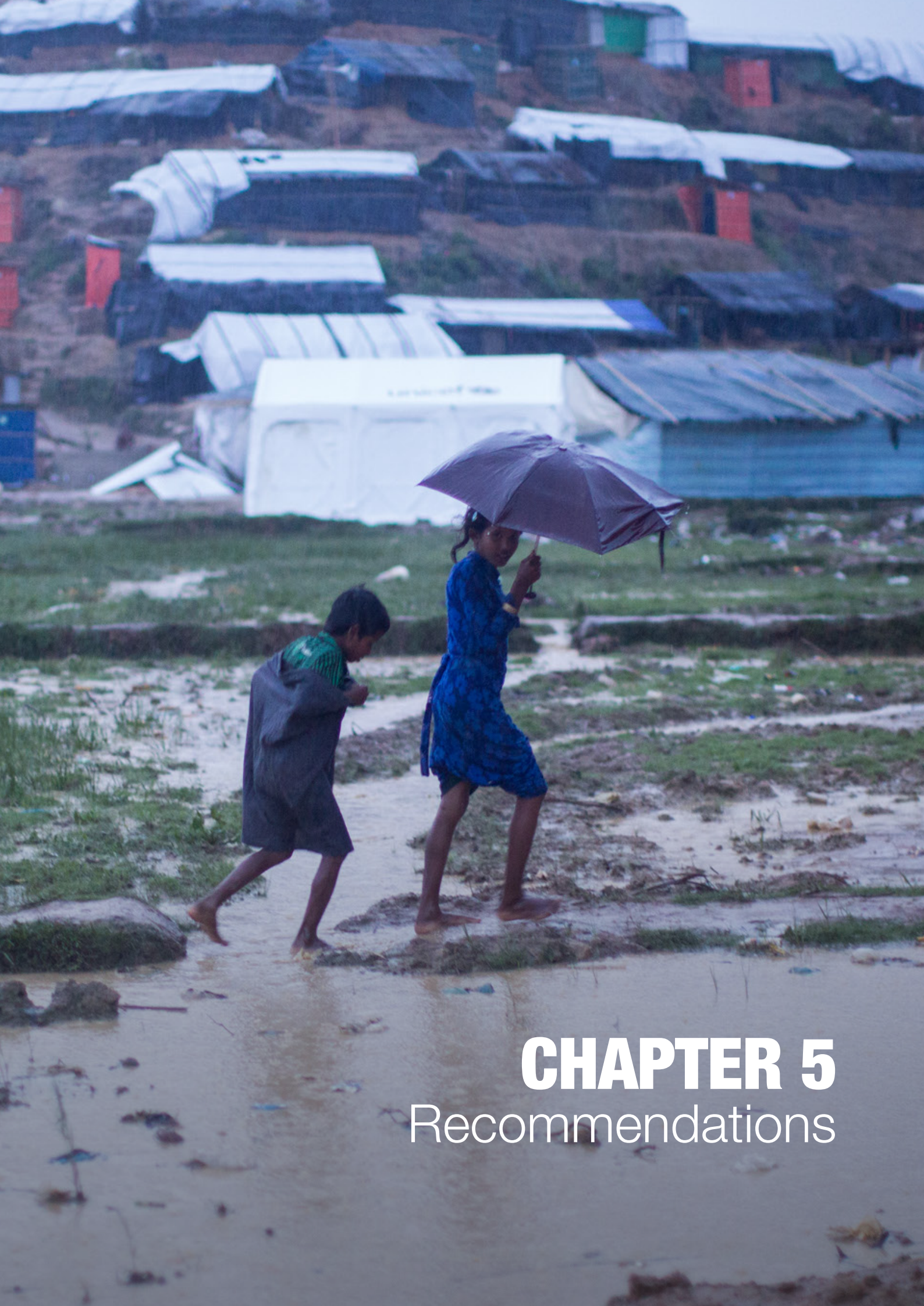
On the other hand, males might have developed different strategies to cope with negative emotions. As mentioned in FGDs and IDIs, male members can go somewhere, sit silently in a quiet place, play with friends, engage in video games, or consult with Majhi and senior members of society when they feel distressed; females cannot avail. Males also fight with others to vent out their anger. From every FGD and IDI, it was found that males express their anger on their wives. In the case of females, they have to stay at home and manage household chores. Either they do not have a support system, or it is not strong enough to help them cope with a negative experience of their lives. They are mostly going through lots of negative experiences (divorce, polygamy, bitter relationship with husband, dissatisfaction with children and life etc.). Ongoing trauma could be another cause for not getting benefits from psychological services. Most Rohingya women have been tortured, assaulted, and raped, contributing to developing PTSD, acute trauma stress, depressive disorders, anxiety disorders, dissociative disorders, and many other forms of mental illness. These traumatic experiences wounded their 'self'. They need long-term specialised trauma-focused psychotherapy for their healing. That is why males have been benefited from counselling services but not the female groups.

- "Now I can manage my anger to some extent. Sometimes, I rely on Allah. I know that BRAC people listen to our 'Moner Kotha'. I have visited once for sharing my pain and anger, and they gave some suggestions."- A new Rohingya female

- "BRAC people are coming to camp to help us. They console us to minimise our anger and also other problems. They also talk to us when we are anxious and in pain. When we go to the 'ShantiKhana', madam listens to us. I can ventilate my worries to her."- A 30-year old Majhi

- ....because of household chores, I can't manage to talk to 'Apa' (NGO workers)."..... A mother

Another point to consider is that the number of sessions, type of sessions, language etc., have not been taken into consideration. It is crucial to remember that psychological services are mainly available to the Rohingya community through MHPSS. The host community cannot avail of this service. Therefore, the participants who have received psychological services are mainly the Rohingyas.



CHAPTER 5
Recommendations

5.1 Recommendations

A. Survival and livelihood options related

Recommendation 1: Ensuring the survival and fundamental biological needs i.e., food, shelter, education and health of Rohingya communities living at different camps in Cox's Bazar. There is an urgent need to ensure educational rights through formal, informal, and non-formal ways. Securing the Rohingya community's education rights might be concerned with the national legitimacy and emphasising their cultural context and native language. However, the right to education through creating access and protecting dropout among host communities should be emphasised.

Recommendation 2: The process of engaging male power to productivity within the camp condition should be explored by adapting the national legitimacy and the rights of Forcibly Displaced Myanmar Nationals (FDMN) under international convention. Creating access to technical and vocational training on different contextualised trades like fishing, processing of ocean wealth and others would be a process to develop the livelihood options for the host communities.

B. Safety and protection

Recommendation 3: Safe and secure repatriation of the Forcibly Displaced Myanmar Nationals (FDMN) to their motherland is needed to be started as an ultimate action. Meanwhile, overall safety and protection mechanism and system within the camp condition has to be improved where each of the members of the Rohingya community feels safe and secure. There is a need to take appropriate measures and strategies to reduce inter- and intra-community conflict through adopting Non-violent Communication (NVC) in the conflict resolution process.

Recommendation 4: Various community-based interventions are needed to address gender-based violence (GVB) in the Rohingya communities and host communities. Physical, mental, sexual violence against children; early marriage; and trafficking must be addressed by taking appropriate awareness raising and youth-led engaging programmes.

Recommendation 5: By creating mass awareness and developing rules and regulations within the community system, social problems like polygamy need to be addressed. Social skills, life skills, stress and anger management in day-to-day life can be focused on developing protection and other programmes for youth and children for both Rohyinga and host communities.

Recommendation 6: Engaging men and boys to address the issues of gender-based violence through various programmes such as the fatherhood programme, gender transforming programme, peer to peer approach etc. Gender mainstreaming in every programme can be considered the cross-cutting issue for implementation in Rohingya humanitarian crisis.

Recommendation 7: Appropriate steps should be taken to protect Forcibly Displaced Myanmar Nationals (FDMN) from drug addiction within the camp condition. Awareness-raising programme on substance abuse in each educational institution, creating a safe space for children and developing youth club for peer to peer approach needs to be focused.

C. Mental health and psychosocial support (MHPSS)

Recommendation 8: It is needed to increase the psychosocial support and care within the camps and host communities. More people can be covered through the MHPSS programme or treated as an integrated part of the programme of protection, education, health, and hygiene to address day-to-day life stressors and traumatic experiences.

Recommendation 9: Individual survivors, family, school, community and society need to be included for ensuing mental health and

psychosocial support (MHPSS). Individual and family counselling services need to be ensured.

- To gain an alternative perspective through group exchange and interaction,

  access to group counselling for women, men, youth and children needs to be ensured. It should be facilitated by non-violence communication (NVC) tools and developing self-confidence essential for managing stress, anger and mental health wellbeing.

- Providing family counselling by professionals would be helpful. It will involve family members to shift the focus from an individual in crisis to a family and help recognise the responsibility of each member of the family to create a friendly space for the person.

- It is needed to shift policies to prioritise the MHPSS issue at organisational service delivery to address psychological distress.

Recommendation 10: To deal with the enormous emotional turmoil of Forcibly Displaced Myanmar Nationals (FDMN), the body-focused, attachment-based and trauma-focused interventions i.e., Eye Movement and Desensitisation and Reprocessing (EMDR) therapy, body-focused Cognitive Behaviour Therapy (CBT) are essential for mental health professionals. Focusing on the body and emotionally focused intervention strategies such as alternative tools and techniques for counselling and psychotherapy should be adopted. Play therapy would be appropriate for children and youth; physical activity-oriented treatment, music and dance therapy-based and trauma-focused intervention tools and techniques would be more appropriate to deal with children, youth and females.

D. Positive parenting and sports and cultural activities

Recommendation 11: Men, boys, girls and women should be engaged in their cultural activities and heritages and indoor and outdoor games to integrate into their cultural belief and cohesion that contribute to sensemaking of worth and connected with their identity as a nation or community. A participatory dialogue process among intergenerational groups considering gender, age, and community within the camp can be organised to reduce anger and aggressiveness. Similarly, inter-community dialogue among Rohingya and host communities may reduce mistrust/differences against each other and facilitate acceptance. Helping them find the purpose of life and develop spirituality might promote healing and decrease their negativity.

Recommendation 12: It is needed to break the cycle of gender-based violence by addressing adverse childhood experiences of the children of the Rohyning and host communities. Various programmes such as enhancing positive parenting skills; promoting healthy recreational facilities to children and youth; adopting stress and anger management tools within schools and education systems; and developing community-based child protection mechanism and systems can be taken.

Recommendation 13: Children need to be protected from abuse by their parents. The negative impact of abuse by the family members has to be informed to parents and other social agents like Majhi, religious leaders, social leaders and so on through contextualised Information Education and Communication (IEC) materials and applied ingenious local methods of public awareness.

E. Further research opportunities:

Recommendation 14: More qualitative studies on a larger scale that includes Forcibly Displaced Myanmar Nationals (FDMN) should be conducted to address their internalised and externalised behaviours to understand and provide efficient services to children, youth, women and men. The risk or protective factors can be included in services and/or policy for developing programme.

Recommendation 15: The researcher recommends more studies to generate more statistical data and specialised findings.

These studies can be conducted with all the professionals working with specialised groups of Forcibly Displaced Myanmar Nationals (FDMN), i.e. children, youth, women, and men, to address their trauma healing process and mental health wellbeing.

Recommendation 16: Longitudinal and case-control research are recommended in the communities to address issues of anger, aggression, stress, anxiety and so on. Also, research may address topics like radicalisation, trauma, addiction and crime in specific camps or communities, which gives rise to violence, hostility and aggression.

- Emotional literacy programme at the community level to foster self-awareness, emotional growth and psychological wellbeing
- Non-violent Communication (NVC) training programme for connecting compassionately with self and others
- Non-violent Communication (NVC) based mediation programme to address the current conflicts among community people and cultivate collaboration as well as mutual wellbeing
- Addressing trauma/PTSD and other trauma-related issues through particular psychotherapy like EMDR, re-establishing a sense of security and self-esteem
- System development to address gender-based violence, power imbalance and sense of safety
- Programmes to develop a sense of self, mitigate identity crisis, build acceptance among and between Rohingya and host communities besides food, shelter, sanitation, education and job opportunity

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