ORIGINAL ARTICLE

CONTENTS

Structure and features of psychopathological symptoms in forced migrants and internally displaced persons

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ABSTRACT

Aim: To study the structure and characteristics of psychopathological symptoms in FM who left Ukraine as a result of the full-scale armed aggression of the Russian Federation against Ukraine, and internally displaced persons, in a comparative aspect.

Materials and Methods: Examination was performed in compliance with the principles of biomedical ethics, based on informed consent. Research was provided on the basis of the Ternopil Regional Clinical Psychoneurological Hospital. Inclusion criteria were women who were forced to leave the territory of Ukraine as a result of hostilities after February 24, 2022, and who left for temporary residence in the territory of the Republic of Poland (Poland) (FM), and women who were temporarily relocated within Ukraine in connection with connection with hostilities (IDP). Exclusion criteria from the study were presence of language disorders, pronounced cognitive disorders, severe somatic condition. The examination was organized by the method of a semi-structured clinical interview according to the developed by us protocol and was conducted remotely. During the examination, depressive, anxiety-phobic, asthenic and dyssomnic disorders, addictive behavior and symptoms of PTSDwere identified and verified. Statistical and mathematical processing a was carried out using Fisher's exact test.

Results: The data we obtained indicate a significant spread of psychopathological symptoms in FM and IDP.

Conclusions: FM and IDP are characterized by a high incidence of psychopathological symptoms. The most frequent were: depressed mood (FM – 67.2%, IDP – 58.5%), feelings of anxiety and fear (FM –52.5%, IDP – 43.6%), obsessive thoughts (FM – 58.9 %, IDP – 49.5%).

KEY WORDS: treatment, psychopathological symptoms, internally displaced persons, forced migrants

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INTRODUCTION

The full-scale invasion of the Russian Federation into Ukraine led to radical societal, social and psychological transformations in Ukrainian society. One of the most important public, social and psychological phenomena associated with war is forced migration. According to UN data in the end of May 2022, more than 6.5 million Ukrainians temporarily emigrated to neighboring countries, and more than 8 million people became internally displaced persons (IDP) [1].

Emigration is a serious psychological stress that carries risks for a person's mental health. In previous studies, we established the presence of pronounced psychopathological changes in emigrants, which primarily related to the affective sphere, in particular, depressive and anxiety disorders [2-6].

At the same time, the socio-psychological situation of emigration before and after the start of the full-scale invasion of the Russian Federation into Ukraine differs significantly. Pre-war migration was planned: the recipient country was carefully chosen by the potential migrant, the possibilities and prospects of migration, the situation on the labor market were analyzed, employment, provision of housing, food, medical, legal assistance, etc. was planned, certain preparatory actions were carried out; quite often, such migration had a group character (family or as a part of professional groups), which significantly reduced the stress of adaptation, provided the migrant with the necessary level of psychological and social support and contributed to better integration into the social environment of the recipient country. The main motive for pre-war migration was economic – the desire to improve one's financial situation or move to a country with a higher standard of living. Migration caused by hostilities is forced, usually spontaneous, is carried out under the influence of an immediate threat to life and health, is not planned in advance, the choice of the recipient country is often random, and the place of stay and the conditions of stay are determined not by the migrant, but by the side that accepts. The stress of adaptation in such migrants is exacerbated

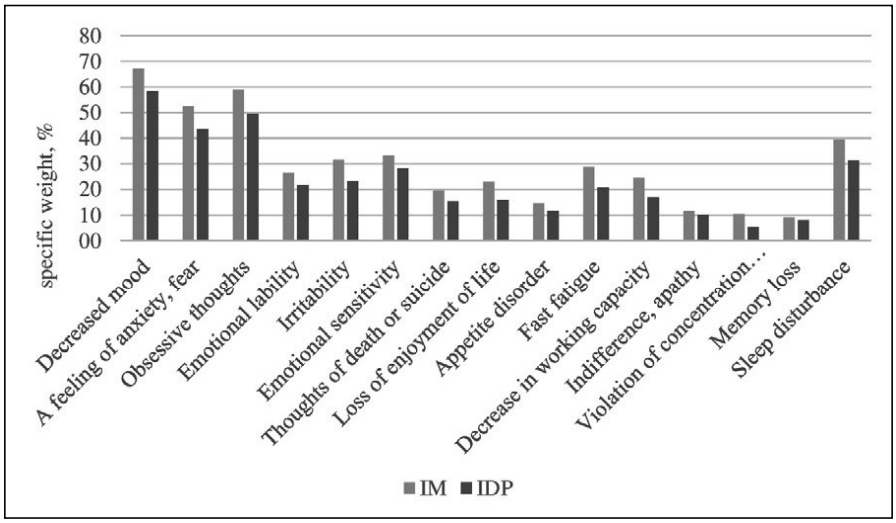

Fig. 1. The structure and prevalence of complaints from the psycho-emotional sphere among forced migrants and internally displaced persons.

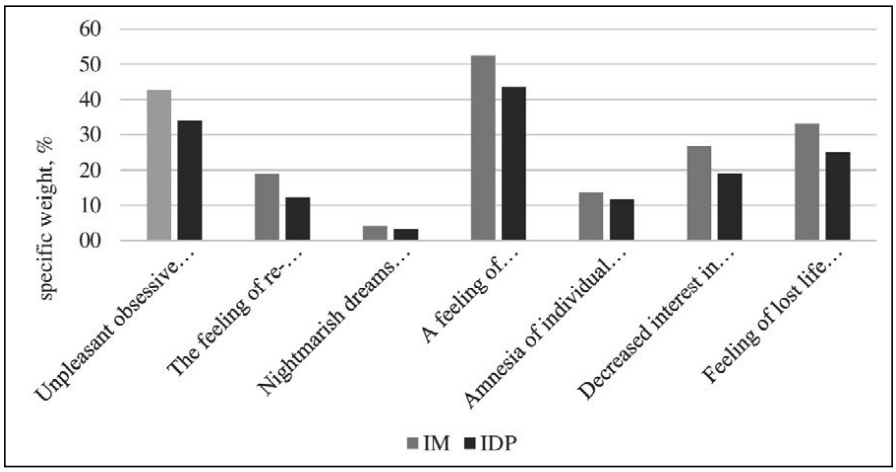

Fig. 2. Structure and prevalence of symptoms of post-traumatic stress disorder in forced migrants and internally displaced persons.

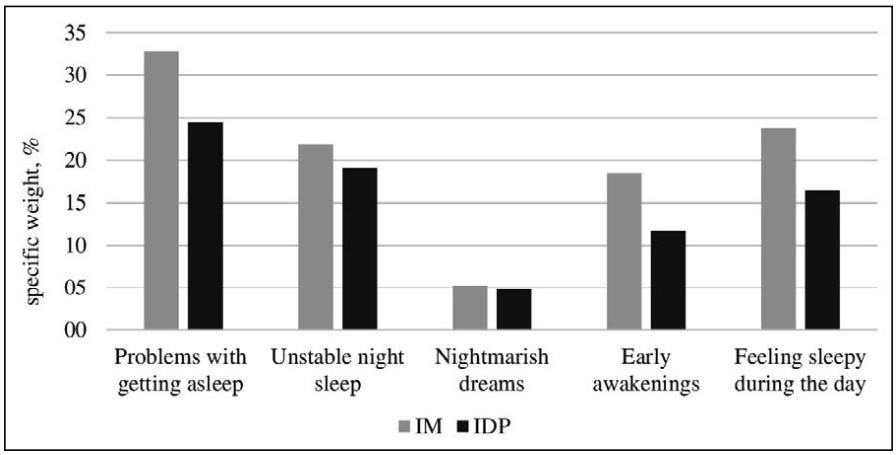

Fig. 3. The structure and prevalence of sleep disorders in forced migrants and internally displaced persons.

by unpreparedness for a new linguistic and social environment, financial problems, difficulties in employment and housing, ignorance of local legislation and related legal insecurity, insufficient medical and psychological support, uncertainty about the future, worries about the fate of relatives and ones who left in the war zone, etc.

In this regard, the study of the peculiarities of the structure and nature of psychopathological symptoms in forced migrants (FM) becomes especially relevant. The data of such a study can form the basis for the development of targeted treatment and rehabilitation and psychocorrective measures for this category of persons.

AIM

The aim of this study was to study the structure and characteristics of psychopathological symptoms in FM who left Ukraine as a result of the full-scale armed aggression of the Russian Federation against Ukraine, and internally displaced persons, in a comparative aspect.

Table 1. The subjective structure of complaints from the psycho-emotional sphere in FM and IDP

Complaint	FM		IDP		p
	abs.	%	abs.	%	
Low mood	178	67.2	110	58.5	< 0.05
A feeling of anxiety, fear	139	52.5	82	43.6	< 0.05
Obsessive thoughts	156	58.9	93	49.5	< 0.05
Emotional lability	70	26.4	41	21.8	> 0.05
Irritability	84	31.7	44	23.4	< 0.05
Emotional sensitivity	88	33.2	53	28.2	> 0.05
Thoughts of death or suicide	52	19.6	29	15.4	> 0.05
Loss of enjoyment of life	61	23.0	30	16.0	< 0.05
Appetite disorder	39	14.7	22	11.7	> 0.05
Fast fatigue	76	28.7	39	20.7	< 0.05
Decrease in working capacity	65	24.5	32	17.0	< 0.05
Indifference, apathy	31	11.7	19	10.1	> 0.05
Violation of concentration of attention	28	10.6	10	5.3	< 0.05
Memory loss	24	9.1	15	8.0	> 0.05
Sleep disturbance	105	39.6	59	31.4	< 0.05

Table 2. The structure of symptoms of post-traumatic stress disorder in FM and IDP

Symptom	FM		IDP		p
	abs.	%	abs	%	
Unpleasant obsessive memories of a traumatic event	113	42.6	64	34.0	< 0.05
The feeling of re-experiencing the traumatic event	50	18.9	23	12.2	< 0.05
Nightmarish dreams with the content of a psychotraumatic event	11	4.2	6	3.2	>0.05
A feeling of psychological distress	139	52.5	82	43.6	< 0.05
Amnesia of individual elements of the experienced event	36	13.6	22	11.7	>0.05
Decreased interest in everyday life	71	26.8	36	19.1	< 0.05
Feeling of lost life (pessimistic assessment of perspectives)	88	33.2	47	25.0	< 0.05

Table 3. The structure of sleep disorders in FM and IDP

Symptom	FM		IDP		p
	abs.	%	abs.	%	
Problems with getting asleep	87	32.8	46	24.5	< 0.05
Unstable night sleep	58	21.9	36	19.1	>0.05
Nightmarish dreams	14	5.3	9	4.8	>0.05
Early awakenings	49	18.5	22	11.7	< 0.05
Feeling sleepy during the day	63	23.8	31	16.5	< 0.05

MATERIALS AND METHODS

We clinically examined 265 women who were forced to leave the territory of Ukraine as a result of hostilities after February 24, 2022, and who left for temporary residence in the territory of the Republic of Poland (Poland) (FM), and 188 women who were temporarily relocated within Ukraine in connection with connection with hostilities (IDP). The average age of the examined FM was 31.8 ± 9.4 years, IDP – 33.1 ± 8.7 years (p>0.05). The examination was organized by the method of a semi-structured clinical interview and was conducted remotely in the mode of an online video conference using technical tools and computer platforms that provided constant two-way video and audio communication. During the examination, elucidation and detailing of complaints from the psycho-emotional sphere was carried out, the psychopathological manifestations present in the examinees, the peculiarities of their occurrence and

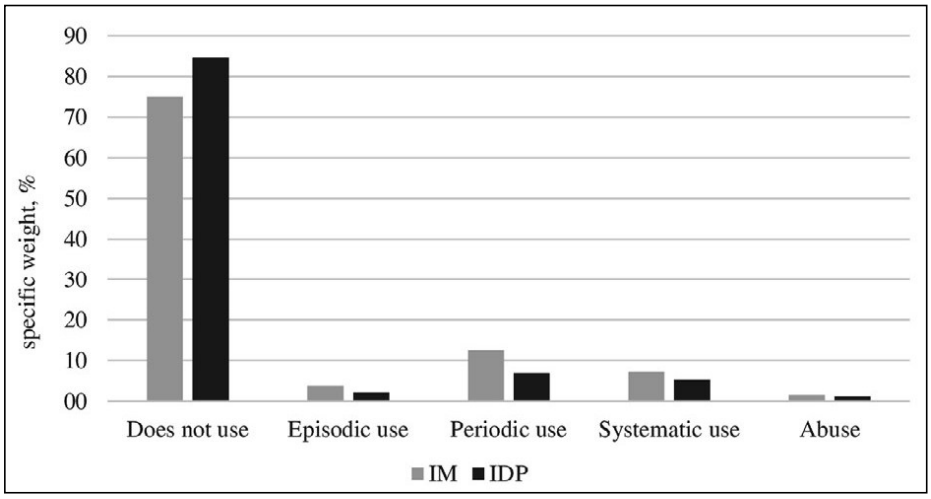

Fig. 4. Prevalence of various forms of smoking among forced migrants and internally displaced persons.

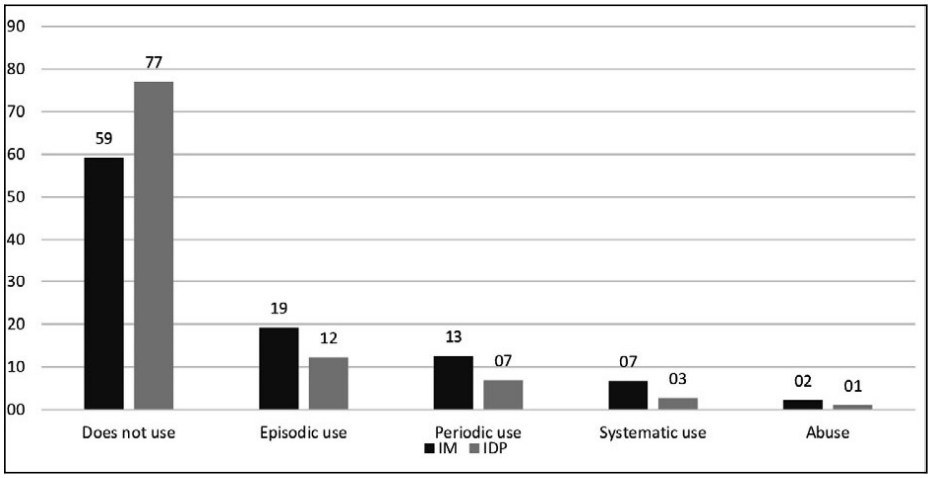

Fig. 5. Prevalence of various forms of alcohol consumption among forced migrants and internally displaced persons.

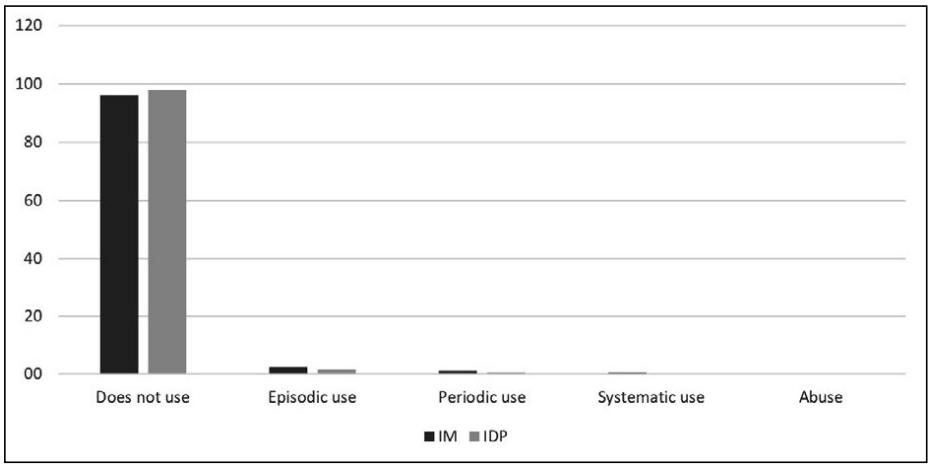

Fig. 6. Prevalence of various forms of drug use among forced migrants and internally displaced persons.

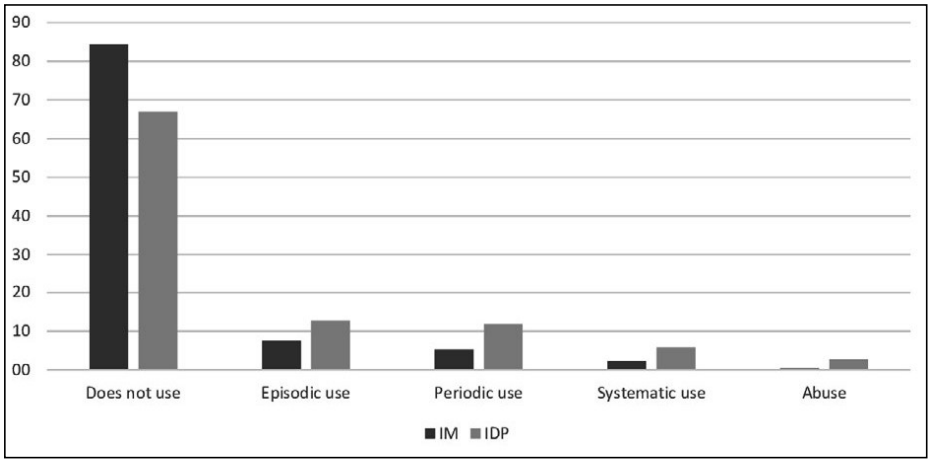

Fig. 7. Prevalence of various forms of drug addiction among forced migrants and internally displaced persons.

Table 4. The structure of addictive disorders in FM and IDP

Types of dependencies	FM		IDP		p
	abs.	%	abs.	%	
Smoking and tobacco substitutes (vapes)					
Does not use	199	75.0	159	84.6	< 0.01
Episodic use	10	3.8	4	2.1	> 0.05
Periodic use	33	12.5	13	6.9	< 0.05
Systematic use	19	7.2	10	5.3	> 0.05
Abuse	4	1.5	2	1.1	> 0.05
Alcohol					
Does not use	157	59.2	145	77.1	< 0.01
Episodic use	51	19.2	23	12.2	< 0.05
Periodic use	33	12.5	13	6.9	< 0.05
Systematic use	18	6.8	5	2.7	< 0.05
Abuse	6	2,3	2	1.1	> 0.05
Narcotics (cannabis, psychostimulants)					
Does not use	255	96.2	184	97.9	> 0.05
Episodic use	6	2,3	3	1.6	> 0.05
Periodic use	3	1.1	1	0.5	> 0.05
Systematic use	1	0.4	0	0.0	> 0.05
Abuse	0	0.0	0	0.0	> 0.05
Medicines and medicinal products					
Does not use	224	84.5	126	66.9	< 0.01
Episodic use	20	7.5	24	12.8	< 0.05
Periodic use	14	5.3	22	11.7	< 0.01
Systematic use	6	2,3	11	5.9	< 0.05
Abuse	1	0.4	5	2.7	< 0.05

pathodynamics were identified and verified. Statistical and mathematical processing of the obtained data was carried out using Fisher's exact test.

RESULTS

A wide range of complaints from the psycho-emotional sphere was found in the FM and IDP (Table 1, Fig. 1).

The most common complaints in FM and IDP were complaints of low mood, obsessive thoughts and feelings of anxiety or fear, somewhat less common – various forms of dyssomnia, irritability, anhedonia (loss of pleasure from life and activities that were previously interesting and enjoyable), rapid fatigue and reduced work capacity; these symptoms were significantly more common in FM. An important place in the structure of complaints was also belongs to emotional lability and sensitivity; these complaints were also found more often in FM, however, the differences compared to IDP are not statistically significant. Complaints about suicidal thoughts, loss of appetite, apathy, memory loss and impaired concentration turned out to be less frequent; the last complaint was significantly more frequent in the FM, for the rest of the complaints, the differences are not statistically significant with a higher specific weight of complaints in the FM compared to the IDP.

The most common post-traumatic symptoms of post-traumatic stress disorder in FM and IDP were the feeling of psychological distress , unpleasant memories of the experienced stress that had an obsessive nature, a pessimistic assessment of perspectives, a decrease in interest in everyday life, as well as a feeling of re-experiencing a traumatic event (flashbacks); all these symptoms were significantly more common in FM. Amnesia of certain elements of the experienced event and nightmare dreams with the content of psychotrauma were less common, which were more often found in FM, however, the differences with IDP were not statistically significant (Table 2, Fig. 2).

The structure of dyssomnic symptoms in FM and IDP was dominated by disturbances in falling asleep and unstable night sleep, as well as a feeling of sleepiness during the day and early awakenings; these symptoms were more often found in FM, and the differences with

IDP were statistically significant (with the exception of unstable night sleep) (Table 3, Fig. 3).

Nightmares were the rarest dyssomnic symptom in FM and IDP; they were found insignificantly more often in FM.

Forced migration and internal displacement are associated with an increased risk of addictive behavior (Table 4).

The prevalence of tobacco smoking (including the use of tobacco substitutes) was higher in FM, and the most significant differences were regarding the periodic use of tobacco and its substitutes (Fig. 4).

Differences in alcohol consumption turned out to be more significant (Fig. 5). FM significantly more often used alcohol episodically, periodically and systematically compared to IDP.

The prevalence of narcotization (cannabis derivatives and psychostimulants) among the studied persons was insignificant, and did not differ significantly in FM and IDP (Fig. 6, Fig. 7).

The only exception was the use of medications and drugs (mainly anxiolytic, antidepressant, sedative, as well as sleeping pills), which was significantly more common among IDP. To our opinion, the explanation of this phenomenon lies in the much greater availability of psychotropic drugs for the population in Ukraine compared to the countries of the European Union, the need to comply with complex and lengthy procedures for obtaining prescriptions for psychotropic drugs in EU countries, which make it impossible for migrants to freely purchase such drugs. On the other hand, in Ukraine, it is easier to buy a wide range of psychotropic drugs in pharmacies, as well as to order them via the Internet, bypassing formal procedures, which leads to a much greater prevalence of this type of addiction among IDP.

The data we obtained indicate a significant spread of psychopathological symptoms in FM and IDP. At the same time, a clear tendency was revealed to be more affected by psychopathological manifestations of FM compared to IDP. To our opinion, this may be due to the influence of the language barrier, the difficulties of acculturation in a new social, cultural and religious environment, the absence or insufficiency of social support groups, separation from family members and loved ones, and significantly fewer opportunities for direct communication with them. In addition, FM face significantly greater difficulties in finding employment, housing, medical care, legal support, etc. Also important is the psychologically difficult feeling of being a foreigner in another country, awareness of one's own vulnerability and dependence on the actions of the authorities and the local population. All these factors have a complex synergistic negative impact on the psyche of forced migrants, leading to a higher prevalence of various forms of psychopathological symptoms.

DISCUSSION

In the literature there are results that are similar to ours:

- Prevalence of depression and anxiety may be higher among forced migrants and internal migrants at different stages of displacement and migration experience.
- Forced migrants and internal migrants affected by conflict and war show higher rates of PTSD and other mental health problems, especially among younger migrants and adolescents.
- The incidence of psychosis has been shown to be higher among migrants in a number of countries, which is related to the cumulative effect of social disadvantage before, during and after migration.
- Forced migrants and internal migrants, asylum seekers and irregular migrants, in particular, show a higher prevalence of mental health problems compared to the population of receiving countries [7-11].

When a person becomes a forced migrants and internal migrants, it can be associated with a number of stressors that affect their mental health. Migrants and refugees may be exposed to a variety of stressors that affect their mental health and psychosocial well-being before and during the migration journey, as well as during the settlement and integration process. This can lead to a wide range of mental illnesses, including depression, anxiety, PTSD, psychotic disorders, and more. Forced migrants and internal migrants may experience a variety of mental disorders, which vary depending on social and environmental factors such as lack of family or social support, discrimination, age, ethnicity, and length of time spent in the host country. The results indicate that the prevalence of mental health problems may be quite high. Many internal migrants and forced migrants do not have access to, or face barriers to, mental health services. There may also be a disruption in the continuity of medical care [7, 10].

Recent prevalence have shown that the burden of mental disorders in conflict-affected populations is as high as 22.1% [12]. Certain populations exposed to conflict and war, such as young migrants and adolescents, are more likely to be characterized by poor mental health. Groups such as forced migrants and internal migrants tend to have a higher prevalence of depression; however, this largely depends on their living conditions and the presence of injuries received during the relocation. It is necessary to approach the mental health of forced migrants and internal migrants comprehensively, providing them with treatment while considering the determinants of health, including migration status.

Some studies in groups of forced migrants resettled in high-income countries have shown an increased risk of suicidal behavior, likely resulting from a combination of adverse socioeconomic conditions, exposure to potentially traumatic events, the burden of mental disorders, and the lack of adequate and accessible health care.

The high prevalence of depression among forced migrants and internally displaced persons in WHO regions is widely documented. It can develop at different points along the path of movement and migration. For example, depression may begin in the home country as a result of traumatic events, after experiencing violence during displacement and migration, or while living in host countries due to discrimination, marginalization, and loss of resources. A global meta-analysis found that forced migrants, internal migrants and asylum seekers were characterized by high and persistent rates of PTSD and depression [8]. However, the prevalence of depression and anxiety among forced migrants and internal migrants varies considerably across different regions, due to a number of regional and contextual factors. In the European region, it is noted a similar prevalence of anxiety both among forced migrants (13%) and among the general population (9%), but a significantly higher frequency of depressive disorders in the first category (32% vs. 4%). It should be noted that regarding the influence of length of stay in the destination country on the prevalence of depression and anxiety, the data differ [13]. The results of a study among young forced migrants (aged 19–25) in Canada showed that the prevalence of mental disorders decreased with increasing educational attainment, and PTSD rates decreased with increasing length of stay in the country. Isolation has been shown to be significantly associated with depression and anxiety among migrants [10]. Therefore, the formation of deep social ties with the host country community, as well as the provision of social integration services, are considered valuable in promoting the mental well-being of migrants [13].

Events involving interpersonal violence are associated with the highest risk of developing PTSD. Long-term effects of violence or other traumatic events can include severe anxiety, stress, or fear; alcohol or drug use; depression; eating disorders; self-harm or suicide. Studies have shown relatively high rates of PTSD among forced migrants and internal migrants: a prevalence of 24.3% was found among forced migrants in Berlin and 35.7% among asylum seekers living in three collective accommodation centers in Erlangen, Nimes [7].

CONCLUSIONS

1. FM and IDP are characterized by a high incidence of psychopathological symptoms.
2. The leading place in the structure of psychopathological symptoms in FM and IPD belongs to depressive symptoms, post-traumatic symptoms and anxiety symptoms, as well as various forms of dyssomnias.
3. The prevalence of the majority of psychopathological symptoms in FM is higher compared to IDP, which can be explained by the difficulties of social and psychological adaptation and acculturation in a cultural, social, foreign language and religious environment.
4. Forced migration and internal displacement is a factor that contributes to the activation of addictive behavior; at the same time, the prevalence of smoking and alcoholism is higher among forced migrants, and the use of psychotropic medications and medicinal products is higher among internally displaced persons.
5. The revealed regularities should be taken into account when developing treatment and rehabilitation and preventive measures for forced migrants and internally displaced persons.

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CONFLICT OF INTEREST

The Authors declare no conflict of interest

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