REVIEW

The Mental Health of Refugees and Forcibly Displaced People: A Narrative Review

Психическое здоровье беженцев и насильно перемещенных лиц: нарративный обзор литературы

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Review

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ABSTRACT

BACKGROUND: One of the pressing global issues today is the matter of refugees and forcibly displaced people migration. Refugee or forcibly displaced status has a significant impact on a person's mental health, with a high risk of developing depression, anxiety, post-traumatic stress disorder and psychotic disorders.

AIM: To conduct a literature review and evaluate the mental health status of refugees and forcibly displaced people due to military action

METHODS: The search of literature was conducted without any restrictions on the publication date, with a focus on articles from the past two decades. The search was conducted in the Google Scholar and PubMed databases using the following keywords and phrases: “migration”, “migrants”, “refugees”, “forcibly displaced people”, “mental health”, “mental disorder”, “psychiatric disorders”. This analysis included studies that discussed and evaluated the social, psychological, and clinical aspects of migration. The review included original research and meta-analyses published in English, Russian, and Spanish. Descriptive analysis was applied to summarize the results.

RESULTS: The literature review showed that global migration levels have reached a high point, and this trend continues due to the existing geopolitical conditions. Even limited and difficult-to-compare epidemiological data demonstrate that more than a quarter of migrants suffer from mental disorders. These primarily include depression, anxiety, and post-traumatic stress disorders. Apart from creating and exacerbating problems for the refugees and forcibly displaced people themselves, they also pose serious challenges to the social services and healthcare systems of refugee-hosting countries. The literature review demonstrated that forced displacement plays a role in the development of mental disorders, and also emphasizes the significance of several associated factors.

CONCLUSION: This review emphasizes the urgent need for standardizing screening methods for refugees and forcibly displaced people, creating unified approaches to diagnostic evaluation, as well as specialized training for mental health professionals. Large-scale programs are needed to support and implement sustainable global mental health measures in the countries affected by hostilities.

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АННОТАЦИЯ

ВВЕДЕНИЕ: Одной из глобальных проблем современности является вопрос миграции беженцев и насильно перемещенных лиц. Статус беженца или насильно перемещенного лица оказывает значительное влияние на психическое здоровье человека, что сопровождается высоким риском развития депрессий, тревоги, посттравматических стрессовых и психотических расстройств.

ЦЕЛЬ: Провести обзор имеющейся литературы и изучить состояние психического здоровья беженцев и насильно перемещенных лиц в результате боевых действий.

МЕТОДЫ: Проведен поиск литературы без ограничения по дате публикации с акцентом на работы последних двух десятилетий. Поиск осуществлялся в базе данных Google Scholar и PubMed, по ключевым словам и словосочетаниям «миграция» (migration), «мигранты» (migrants), «беженцы» (refugees), «насильно перемещенные лица» (forcibly displaced persons), «психическое здоровье» (mental health), «психическое расстройство» (mental disorder), «психиатрические расстройства» (psychiatric disorders). Исследования включались в анализ, если в них обсуждались и оценивались социальные, психологические и клинические аспекты миграции. В обзор включались оригинальные исследования и мета-аналитические обзорные статьи на английском, русском и испанском языках. Для обобщения результатов применялся метод описательного анализа.

РЕЗУЛЬТАТЫ: Обзор литературы показал, что уровень миграции по всему миру достиг высокой планки, и тенденция к росту сохраняется из-за сложившихся геополитических условий. Даже фрагментарные и трудно сопоставимые эпидемиологические данные показывают, что более четверти мигрантов имеют психические расстройства. Прежде всего, это депрессивные, тревожные и посттравматические стрессовые расстройства. Они создают и усугубляют проблемы не только у самих беженцев и насильно перемещенных лиц, но ставят серьезные задачи перед социальными службами и системой здравоохранения принимающих сторон. Анализ литературы демонстрирует, что вынужденное переселение является патогенетическим фактором в развитии психической патологии, а также подчеркивает значимость ряда сопутствующих факторов.

ЗАКЛЮЧЕНИЕ: Настоящий обзор подчеркивает насущную необходимость унификации методов обследования беженцев и насильно перемещенных лиц, создания единых подходов к обследованию и специальной подготовке специалистов сферы психического здоровья. Необходимы масштабные программы для поддержки и внедрения устойчивых глобальных мер в области психического здоровья в странах, пострадавших от военных действий.

Keywords: *refugees; forcibly displaced people; migrants; social and psychological issues; mental disorders*
Ключевые слова: *беженцы; насильно перемещенные лица; мигранты; социально-психологические проблемы; психические расстройства*

INTRODUCTION

Migration of refugees and forced displacement are among the most pressing issues faced by the international community at the beginning of this third millennium. In light of the destructive trends in the modern world, including political instability, economic crises, numerous local wars and hostilities, climate change, and natural disasters, the issue of migration is moving increasingly to the foreground. The history of humankind is marked by tragic events involving refugees. They emerged on the tail of small and large-scale wars, epidemics, and invasions by nomadic and barbarian tribes. The First and Second World Wars alone led to the displacement of vast numbers of people. Ongoing military conflicts and climatic cataclysms continue to drive mass migration, subjecting people to profound trauma and stress as they relocate to host countries.

Mass population movements in the post-Soviet space began as a result of the collapse of the Soviet Union in 1991, which was characterized by complex interconnections between migration and forced displacement. Interethnic conflicts and national liberation movements in Central

Asia and the South Caucasus in the first half of the 1990s triggered massive flows of refugees and displaced people (in Sumgait, Baku, Nagorno-Karabakh, Abkhazia, South Ossetia, Chechnya, Tajikistan, and Transnistria) [1]. As a result of these processes, a new category of refugees emerged, called forcibly displaced people (FDPs). This category of people was particularly evident when the mass, forced displacement of Armenians from Nagorno-Karabakh, following a prolonged blockade and military aggression by Azerbaijan, put significant pressure on the country's mental health infrastructure which was tasked with providing specialized care for displaced people in need and assessing their mental health status. However, the very phenomenon of such mass displacement highlighted the need to study the psychological and psychiatric impact of migration on a more global scale.

There are two aspects in studying the phenomenon of migration. The first aspect is migration as a distinct process (studied by sociology, history, economics, demography, etc.). The second aspect is migration as one of the factors affecting people's physical and mental health, which falls within the competence of social and health care services, including psychology and psychiatry.

There is still no consensus on the definition of "migration". Russian researchers, for example, have proposed over 30 definitions of this concept. While retaining the generally accepted meaning of this phenomenon, each author offers their own interpretation of the concept of "migration". Some researchers broaden the concept, while others narrow it.

Perevedentsev defines the migration of large numbers of people in a broad sense as "a set of various movements of citizens across space" [2]. In a narrower sense, he views the phenomenon as "a set of relocations of citizens within a territory directly associated with a change of permanent residence for a relatively long period". Barikhin defines migration in a similarly narrow sense: "the movement of people primarily associated with a change of residence and workplace" [3].

Vorobyova offers a rather broad interpretation of migration. She defines the phenomenon as "any territorial movement of populations involving the crossing of both the external and internal borders of administrative-territorial entities with the purpose of changing permanent residence or temporary stay in a territory for study or employment, regardless of whether it occurs under the predominant influence of push or pull factors" [4].

Trifonov defines migration as "a complex process characterized by its uniqueness and dependence on various determinants (social, political, economic, cultural, ideological, and others) and associated with voluntary or forced movement, regardless of whether internal or external administrative-territorial borders are crossed, the length of stay, or the means of transportation used, and carried out for various purposes" [5].

Slobodchikova et al. define migration as "a socio-economic process in which the subject of migration moves with a specific purpose across the borders of territorial entities, regardless of duration and regularity, driven by the interplay of various conditions and factors, typically religious, economic, political, social, or military in nature" [6].

The definition offered by Yudina is the most accurate. She believes that "Migration is the process of population movement across domestic administrative-territorial borders and state borders, driven by changes in residence, employment, education, citizenship, or other reasons" [7].

The International Organization for Migration provides the following definition: "Migration is the process of moving across an international border or within a state. Migration encompasses any kind of movement, regardless of its duration, reasons, or composition"[1]. Pokhlebaeva defines international migration as the movement of individuals, regardless of its form, motives, or duration, from the territory of one state to another, resulting in a change in their legal status, with its regulation, from the moment these individuals cross the border, being governed by the legislation of the hosting state, as well as by international legal documents developed by international organizations focused on addressing migration issues [8].

Understanding the essence of this phenomenon, the complexity involved in defining it, and its multifaceted nature can be made easy by classifying all types of migration. Pokhlebaeva suggests relying on the following criteria: legal (lawful and unlawful), territorial (international and internal), motivational (voluntary [labor: economic, family reunification, professional] and forced [refugees and displaced persons]), duration (permanent and seasonal), and purpose (seeking asylum, obtaining refugee status,

[1] Promotion and protection of human rights, including ways and means of promoting the human rights of migrants: report of the UN General Secretary August 9, 2013. Available from: https://documents.un.org/doc/undoc/gen/n13/422/65/pdf/n1342265.pdf

family reunification, "brain drain", educational, and labor migration) [8].

In the context of this study, international and forced migration are of particular relevance. The first is defined by the act of crossing a state border and the regulation of movement across the border and subsequent stay in the country under the legislation of the host country and international legal norms. Forced migration is caused by various stress factors: civil wars, interethnic conflicts, persecution based on political or ethnic grounds, the threat of physical annihilation, natural disasters, etc. Forced migrants include such categories as refugees and displaced persons [8]. Displaced people are typically classified into two categories: internally displaced and externally displaced. The first category includes individuals who have been displaced within their own country as a result of emergencies or armed conflicts; they are sometimes referred to as internal refugees. The second category includes individuals who have been expelled from their country of citizenship for specific reasons — these are *de facto* refugees [9].

The United Nations defines a refugee as a person who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of their nationality and is unable or, owing to such fear, is unwilling to avail themselves of the protection of that country.[2]

According to Article 1 of the 1951 Convention, a refugee is a person who, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it"[3].

As a result of modern geopolitical trends, the issue is becoming increasingly pressing, creating serious social, humanitarian, health, and other challenges. A person leaves their permanent place of residence when their personal safety is threatened and flees to a place where they expect conditions to be better [10]. However, for many displaced people, displacement simply means moving from one impoverished and vulnerable situation to other similarly taxing circumstances.

Forcibly displaced people flee to escape violence. Such a population group is at particularly high risk of mental health challenges [11–13]. The mental health of refugees is challenging for modern psychiatry [14], and as noted at the 25th European Congress of Psychiatry, this challenge will contribute to an increased demand for mental health care among those fleeing wars and persecution [15].

In the study by León-Giraldo et al. [16], conducted in Colombia (one of the countries with the highest number of internally displaced people due to armed conflicts), populations from areas experiencing active armed conflicts were deemed the most vulnerable to mental disorders, particularly individuals aged 18–44 years, women, urban residents, and people with a preschool or primary education. Such populations are only exposed to threats and aggression that violate their fundamental rights; they often face stigma because of their location, which acts as an additional stress factor, further exacerbating their mental health state [17]. Kuwert et al. [18], when evaluating the displacement factor of refugees in conflict zones (in Europe), note that the very act of forced displacement significantly contributes to a decreased overall quality of life and the potential onset of anxiety and depressive disorders. This is also exacerbated by the forced separation from "primary support networks", such as friends and family [19]. Furthermore, these individuals generally have limited access to medical services. All of these limitations hinder recovery from trauma and create a vicious cycle that further violates their rights and impairs their physical and mental health [19]. The displacement of large populations creates significant social and economic challenges and disruptions for host communities. However, a positive contribution of refugees in the long term can also never be excluded [20].

Every day, nearly 34,000 people become forcibly displaced due to wars, conflicts, and natural disasters [21]. More

[2] Statute of the Office of the United Nations High Commissioner for Refugees: Adopted by General Assembly Resolution 428 (V) of 14 December 1950. Available from: https://www.unhcr.org/publications/statute-office-united-nations-high-commissioner-refugees

[3] Convention relating to the Status of Refugees: adopted on 28 July 1951 by the Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, convened in accordance with General Assembly Statute of the Office of the United Nations High Commissioner for Refugees: Adopted by General Assembly Resolution 429 (V) of 14 December 1950. Available from: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-relating-status-refugees

than half of them are younger than 18 years of age [21]. According to the World Health Organization (WHO), in 2022, one in eight people globally were displaced.[4] This amounts to nearly one billion people. Of these, 281 million are international migrants and 84 million are FDPs.[4] Among FDPs, there are 35 million children and 1 million children born during the period when their parents were refugees.[4] Factors driving migration (such as poverty, insecurity, lack of access to basic services, armed conflicts, environmental issues, and natural disasters) persist and are even intensifying, suggesting a further increase in the number of displaced individuals.

The status of a refugee or a forcibly displaced people significantly impacts the person's mental health, leading to a high risk of mental disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), and psychotic disorders [22, 23]. And these disorders are more common among refugees, both adults and children, than in the general population [24].

The study aimed to conduct a comprehensive review of the existing literature and to evaluate the mental health implications for refugees and forcibly displaced people as a consequence of hostilities.

METHODS

Eligibility criteria

To study the mental health of refugees and FDPs, we conducted a literature search without any publication date restrictions, focusing on articles from the first quarter of the 21st century.

Information sources

The search was conducted in the Google Scholar and PubMed databases.

Search strategy

The search included various combinations of terms: "refugees", "forcibly displaced persons", "migrants", "mental health", "mental disorder", "psychiatric disorders".

Selection process

Studies were included into the analysis if they discussed and evaluated the social, psychological, and clinical aspects of migration. This review included original research and meta-analyses published in English, Russian, and Spanish, that addressed the mental health issues of refugees. In addition, several articles published before 2000, along with certain official documents from the World Health Organization and the United Nation, and a number of legal and sociological studies were analyzed and referenced for a better understanding the phenomenon of migration.

Data analysys

A descriptive analysis was applied to summarize the results.

RESULTS

When investigating the phenomenon of migration, we identified several key aspects highlighted by the literature review. We analyzed the risk factors for migration, the clinical features of mental disorders in migrants, and the socio-psychological consequences of migration. The results for each aspect are presented below.

Risk factors

Armed conflicts have the most negative impact on people's mental health, regardless of whether individuals are victims of conflicts and military action, members of illegal armed groups, military personnel, or civilians [25]. Such conflicts contribute to mental health disorders in civilians, primarily due to the experience of traumatic events and the fear of their recurrence [17, 26–28], which in turn drive them to migrate. The mental health issues of migrants are numerous, diverse, and complex: the traumatic experiences of displaced people can lead to PTSD, anxiety, depression and somatoform disorders, chronic pain sensations, suicidal tendencies, sleep disruption, and a variety of mental disorders with somatic manifestations (weakness, issues with the cardiovascular, respiratory, gastrointestinal, endocrine, and other systems) [29–32]. The prevalence of mental disorders among displaced people is higher than in the population of the country or region to which they migrate [33], and their health profile differs significantly from that of the host country population [32].

The development of mental disorders can be caused by pre-, intra-, and post-migration events. Silove et al. [34] report that post-migration stress can exacerbate the effects of previous trauma, creating an additional risk to mental health. In particular, it is noted that the prevalence

[4] Refugee and migrant health. World Health Organization; 2022. Available from: https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health

of PTSD is approximately ten times higher among refugees and FDPs than it is among the general population in the host country overall [35].

Refugees and FDPs are more likely to develop depression (e.g., as a reaction to loss), anxiety disorders (as a reaction to uncertainty), and, especially, PTSD (as a reaction to violence and/or torture) compared to the population of the host country [24].

This comes with a high risk of somatic-like responses and existential dilemmas (when beliefs are challenged) [36, 37]. Differences between the migrant's culture and the immigration circumstances (language proficiency, cultural beliefs, disease-related behavior) affect the presentation of mental disorders [38].

For migrants, there are two periods of utmost risk: shortly after migration and after a longer stay in the host country. Some meta-analyses highlight factors that contribute to the prevalence of mental disorders [39]. In particular, the factor of motivation behind a refugee or a FDP phenomenon is discussed. For example, individuals who become refugees for purely economic reasons show twice as low a rate of mental disorders compared to those who migrated due to violence in their country of origin (21% vs 40%) [29].

Many researchers indicate two stable and significant risk factors for the development of mental disorders: past traumatic experiences, and socio-economic conditions after migration [16, 39, 40]. Close et al. consider the low gross national product in the host country, downward social mobility, the country of origin, and the host country as risk factors of mental disorders [41]. The authors believe that the impact of combat-related trauma itself on the current state of mental health is predominant and more significant than post-migration factors.

However, it is also clear that adverse socio-economic post-migration factors also play a role, including unemployment, financial stress, limited language proficiency in the host country, and lack of social support, which more often contribute to the development of depression [42]. However, this data concerning the incidence and prevalence of mental disorders among migrants is contradictory: the role of adverse socioeconomic factors in the development of mental disorders among refugees and FDPs is assessed differently [38]. The WHO report "Mental health of refugees and migrants: risk and protective factors and access to care" specifies that poor socioeconomic conditions following migration can be a contributing factor to the development of mental disorders. Furthermore, the report also suggests that migration can be beneficial to the mental health and well-being of some refugees and migrant groups. It is argued that adverse socioeconomic conditions can exacerbate a pre-existing mental disorder.[5]

Beiser and Hou suggest that persistent and long-term socioeconomic problem can be a predictor of depression even a decade after resettlement [43]. However, according to a longitudinal study by Westermeyer [44] conducted among refugees over a 10-year resettlement period, the level of depression, on the contrary, significantly improved over that period.

The socio-political aspect of life is another adverse factor affecting the mental health of refugees and FDPs according to the literature. This conclusion is based on a large-scale meta-analysis conducted by Porter and Haslam [45]. The authors sought to explore potential factors influencing the mental health status of refugees (internally displaced persons, asylum seekers, and stateless persons), including enduring contextual variables (post-resettlement residence and economic opportunities) and refugee characteristics. They conducted 59 independent comparisons that included 67,294 participants (22,221 refugees and 45,073 nonrefugees). The study demonstrated that refugees had moderately worse outcomes. Post-displacement conditions were found to moderate mental health outcomes. The worse outcomes were observed amongst refugees: 1) living in institutional accommodation, experiencing restricted economic opportunities; 2) displaced internally within their own country; 3) repatriated to a country they had previously fled; or 4) with unresolved conflict in their own country.

Older refugees with higher levels of education, women with higher socio-economic status prior to resettlement and those living in rural areas also performed worse.

The clinical manifestations and dynamics of disorders caused by displacement can be complicated not only by wars and conflicts, which in themselves increase vulnerability to mental disorders, but also by migration and post-migration processes [46]. Such factors include life-threatening displacement, drawn-out asylum procedures,

[5] Mental health of refugees and migrants: risk and protective factors and access to care. Geneva: World Health Organization; 2023. Available from: https://www.who.int/publications/i/item/9789240081840

family separation, unemployment, and discrimination [43, 45, 47–49].

From a clinical perspective, it is extremely important to investigate in greater detail which pre-, intra-, and post-migration factors specifically contribute to the development of symptoms of depression, anxiety, and PTSD [50]. This triad of mental disorders is prevalent among both adult men and women, as well as among pediatric and adolescent refugees and FDPs [51]. However, there are differences in the prevalence rates depending on age [45, 47]. Adolescents and young people have been shown to be more likely to develop PTSD compared to adults [52].

The clinical features of mental disorders in migrants

A person who has left their "past" in their country of residence arrives in a country where they is trying to find their "present" while remaining completely uncertain about the "future". In their "present" life, they faces numerous obstacles, which can be described as "a search for a place in the sun". The multitude of problems make them one of the most vulnerable members of society. The need to go through the circumstances of the move and arrival in a new country, adapt to living conditions in the host country, accept the "rules of the game" in the new community, change established relationships, and accept new life and work conditions. All of this creates new needs and issues that refugees and FDPs have to confront, ranging from household to medical. Their experience of trauma (migration) can increase their susceptibility to various disorders — physical illness, mental, and infectious diseases with varying degrees of severity[6].

The severity of clinical symptoms depends on traumatic life events in their country of origin and is determined by the trauma and deprivation experienced during resettlement. It is also important to consider the role of factors in the host country. Among these are the isolation of migrants, discrimination, wanting social support infrastructure [33], difficulties with social integration and language proficiency, changes in beliefs and worldview, psychological issues, internal diseases, etc. [21, 32, 33]. Refugees and FDPs themselves are a vulnerable group, often exposed to various risk factors related to poverty and lack of access to health and social and social services that could address their health problems. They face a higher risk of developing mental disorders that is the result of the psychological trauma they have experienced. For many of them, diseases occur after migration to the "destination country"[7]. Many of them experience feelings of anxiety and hopelessness, exhaustion, irritability, anger, and they suffer from insomnia and various pain sensations[7].

According to Henkelmann et al. [51], despite the diversity of psychopathological reactions, the majority of refugees and FDPs have a trinity of disorders: anxiety, depression and post-traumatic stress disorder (PTSD). The authors conducted a meta-analysis and systematic review that included 14,882 respondents. They found that the prevalence of diagnosed anxiety and self-report was 13% and 42%, for diagnosed depression and self-report was 30% and 40%, and for diagnosed PTSD and self-report was 29% and 37%. These rates were significantly higher than those observed in the general population, non-refugees, both globally and among populations living in armed conflicts or war zones. These parameters were similar for children, adolescents, as well as adult refugees and were not dependent on the duration of life in a particular region. According to the authors, one in three refugees has diagnosable depression and/or PTSD, and diagnosable anxiety disorders are seen in 1–2 out of 10 refugees. The prevalence of these disorders, based on self-reports, is even higher.

Migrants' health is worse than that of the host population. Close et al. [41] note that first-generation migrants are at a higher risk of mental disorders compared to the local population. Among the most vulnerable individuals are women, especially in matriarchal families; adolescents; elderly people; those who have lost their individual documentation; people with disabilities or with a previously diagnosed mental disorders; victims of violence; and those living in extreme poverty [14]. They often experience xenophobia, discrimination, and stigmatization in the host country, live in substandard housing, are involved in unskilled work and have limited access to medical

[6] Refugee and migrant health. World Health Organization; 2022. Available from: https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health

[7] For the first time, WHO has investigated the health of migrants and dispelled some myths. In Russian. Available from: https://news.un.org/ru/story/2019/01/1347312

care, face difficult life situations, as well as language and cultural barriers[8].

Close et al. [41] provided quantitative data on mental disorders in first generation migrants and the indigenous population based on an analysis of 1,820 reviews. The authors demonstrated that there was a wide variation in prevalence rates in both groups, ranging from 5% to 44%, compared with prevalence rates of 8–12% in the general population.

The prevalence of PTSD was higher among first-generation migrants compared to the local population, ranging from 9% to 36%, compared to a prevalence rate of 1–2% in the general population. The prevalence of anxiety disorders in first-generation migrants demonstrated similar tendencies. The prevalence ranged from 4% to 40% compared with a reported prevalence of 5% in the general population.

The mental health of refugees and FDPs has been extensively researched. Nonetheless, assessing the prevalence of mental disorders among this population has proven to be a challenge dependent on a variety of factors (the country of origin, the country of resettlement, pre-migration traumatic events and experiences, post-migration stress, and post-migration socio-economic status). As noted by Bogic et al. [47], significant discrepancies were observed in the prevalence rates of mental disorders between studies, depending on clinical characteristics and research methodology. For example, the prevalence of depression ranged from 2.3% [43] to 80% [39], PTSD from 4.4% [40] to 86% [39], and anxiety disorders from 20.3% [53] to 88% [39]. Several reviews on this issue also highlight significant discrepancies in the prevalence rates of mental disorders, ranging from 5% to 80% for depression and from 3% to 88% for PTSD [47, 54]. Fazel et al. [52] report a prevalence of 4–6% for depression and 8–10% for PTSD in adult refugees. Lindert et al. [29] and Steel et al. [55] report a significantly higher prevalence of depression (25–45%), anxiety disorders (21–35%), and PTSD (31–63%) among this group of refugees compared to economic migrants.

Mental health disorders may not manifest themselves immediately during the migration process, but days, weeks, months or even years later. Even five or more years after resettlement, high prevalence rates ranging from 20% or higher have been reported in war refugees [16]. Based on a study conducted by Sabin et al. [56], two decades after the conflict, 12% of the people examined showed symptoms that fit the diagnostic criteria for PTSD. More than half of them (54%) had symptoms of anxiety; and more than a third (39%), symptoms of depression. A similar trend was reported by Steel et al. [40]. Another study [57] found that refugees exhibit pronounced somatic symptoms when seeking medical care for their mental health issues. Refugees and FDPs are approximately 14 times more likely to develop depression and 15 times more likely to develop PTSD [58–60].

PTSD is considered a common manifestation of mental disorder among refugees and FDPs. However, this disorder is rarely diagnosed as a standalone condition. It is usually accompanied by psychopathological symptoms. For example, Belz et al. [61], confirming the high prevalence of PTSD among refugees with symptoms of intrusion, hyperarousal, avoidance, and dissociation associated with pre-, intra-, and post-migration events, also reported a high level (94%) of comorbid depression in PTSD patients. This pattern of mental disorders creates additional challenges for mental health professionals and the health care system, as such cases are associated with reduced cognitive abilities, energy levels, motivation, learning capacity, and decision-making ability [62], which further complicates PTSD therapy [63]. In general, these studies showed a clear (40-fold) difference in prevalence rates, indicating a high degree of statistical heterogeneity. Such a high level of heterogeneity was also reported in other systematic reviews and meta-analyses [45, 55].

On the path to social integration, refugees and FDPs face serious hurdles related to employment, xenophobia, racism, mental health, physical safety, accommodation, health care, and quality of life.

Traumatic experiences can also lead to the development of specific phobias, personality disorders, and dissociative disorders [64]. Significant differences in the prevalence of alcohol abuse and psychotic disorders among refugees and internally displaced people were noted by Morina et al. [65]. Suicidal tendencies and thoughts are common among refugees and FDPs [16].The authors attribute their occurrence more to depression than to anxiety,

[8] Convention relating to the Status of Refugees: adopted on 28 July 1951 by the Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, convened in accordance with General Assembly Resolution 429 (V) of 14 December 1950. Available from: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-relating-status-refugees

even though anxiety is more pronounced than depression [66]. One of the most common symptoms experienced by refugees and FDPs is sleep deprivation, which can exacerbate other disorders and interfere with the ability to function daily [67, 68].

Researchers pay special attention to people over 60, whose needs are often ignored and who do not have access to special support programmes. This exacerbates the vulnerability of the elderly affected by natural disasters, catastrophes and wars.[9] According to Singh [69] pronounced depressive and anxiety syndromes were noted among temporarily displaced elderly people as part of general distress. The authors also described such psychosocial issues as feelings of abandonment, isolation, and passivity, as well as conflicts in the family.

The analysis of the mental disorders identified in refugees and FDPs reveals a number of gender-specific characteristics. It has been found that the prevalence rates of depression and anxiety are typically higher in women than in men [58, 70, 71]. Researchers have different opinions on PTSD. It has been found that both men and women are equally likely to be at a high risk of PTSD. However, this contradicts previous findings in the general population, which suggest that women are more likely to develop PTSD [72, 73]. However, this finding is consistent with the results of a previous meta-analysis of a population affected by war [55]. In the general population, men and women typically differ in their types of traumatic experiences: the most common PTSD-related traumatic events for men are combat experiences, while for women they are rape and sexual harassment [73, 74]. Both the civilian male population and women can be exposed to similar traumatic events during war [75].

As well as mental health issues, somatic mordibilities are often prevalent during humanitarian crises in low- and middle-income countries. However, the prevalence of these mordibilities is significantly underestimated in the current health services research [76]. As noted by Cheung et al. [76], over half of examined migrants (55%) were identified as being at moderate (18%) or high (13%) risk of somatic distress. The authors also reported that there were significant associations (p <0.05) between somatic distress and age, female sex, economic status, depression and post-traumatic stress, and multiple trauma exposures. It is worth noting that high detectability of internal diseases is a reliable predictor of care-seeking behavior [76].

The socio-psychological consequences of migration

In addition to specific disorders and syndromes, the deterioration of physical and mental well-being, wars, mass forced displacement, and human rights violations can have a profound impact on the worldview of refugees and FDPs. In a study investigating cognitive representations of the world globally, Ter Heide et al. [77] found that refugees exhibited a relatively low level of perceived benevolence of the world and people's kindness, and a relatively good sense of their own self-worth. The authors highlight the need to take into account refugees' attitude towards society, particularly the loss of trust, when communicating with them and assessing their condition. Addressing these issues may help ease the adaptation of vulnerable individuals. Bäärnhielm et al. [21] emphasize the need to promote a positive public image of refugees in host countries, alongside addressing their trauma and mental health needs, to support their well-being and social integration. They also stressed the importance of involving refugees in elaborating policy, planning, development, and the delivery of services that cater to them [78].

Most research on refugees and FDPs is conducted in countries with developed economies that can provide relatively high levels of support and opportunities for integration. However, for the sake of objectivity, it is also worth noting that most of these migrants had lived in low-income countries. Their struggles to survive and make plans for the future make their mental health situation particularly difficult. The granting of asylum should be accompanied by the provision of health care, including mental health support, to help mitigate the negative impact of migration.

DISCUSSION

This literature review included original research and meta-analyses. As a result of recent geopolitical trends, migration is becoming an increasingly critical issue, creating serious humanitarian, social, health, and other challenges. It has become increasingly dangerous and problematic to live in the place of one's birth, as due to various reasons, threats

[9] World Development Indicators/databank. Available from: https://databank.worldbank.org/reports.aspx?source=2&series=sp.pop.65up.to.zs&country=

to personal security arise and a person flees to a place where they expect conditions to be better [10]. Factors contributing to mass displacement (such as poverty, insecurity, lack of access to basic services, armed conflicts, environmental issues, and natural disasters) are increasing and even intensifying, suggesting further increase in the number of displaced people and the growing relevance of this issue in the global community.

The resettlement of large groups of people can occur within their own country (internal displacement) or across national borders into neighboring or other countries (as asylum seekers) [12]. However, we could not find any article on refugees that had looked into a situation similar to the one that occurred in Nagorno-Karabakh. The peculiarity of this resettlement was that the people who were fleeing from violence and aggression in their ethnic territory [79] did not move to a third country. Instead, they resettled in their historic homeland, which they were forced to leave by political decisions. They were settled not in refugee camps (as is the case almost everywhere), but in the apartments and houses of their fellow citizens. On the one hand, this is a flight across national borders to an adjacent country, and on the other hand, it is a resettlement in a country that is their historic homeland with a shared history, culture, language, and religion. This peculiarity, from our point of view, requires special attention.

The fact that people who have been exposed to extreme stressors such as wars, natural disasters, social catastrophes, and others, are resettled, puts the problem of health, including mental health, in the forefront [29, 30]. Regardless of whether these disorders are transient, acute, or situationally determined, they tend to chronicle and inhibit the full development of a person's potential [26, 27].[10]

In addressing mental health issues caused by migration, priority must be given to understanding the processes underlying the phenomenon of migration and the factors contributing to the development of mental disorders. The literature highlights a range of factors, including armed conflicts and social upheaval (or past-traumatic experiences), socio-economic and socio-political conditions, the motivational factors of refugees [29], migration and post-migration processes (life-threatening movements, long asylum procedures, family separation, unemployment, discrimination [39, 80],conditions in the host country, problems with social integration, insufficient social support, worldview and psychological problems, internal diseases, etc. [21, 32, 33]). Factors such as low gross national product in the host country, downward social mobility, the country of origin, and the host country are considered risk factors for mental disorders [16, 39–41]. At the same time, while highlighting numerous risk factors, the impact of the trauma on the current state of mental health is not denied; moreover, its leading significance compared to post-migration factors is emphasized.

There is a lack of consensus on the impact of adverse factors on the emergence of mental health issues among refugees and FDPs. A comprehensive meta-analysis conducted by Porter and Haslam [45] demonstrated that post-displacement conditions had a significant impact on the mental health of refugees and FDPs. These conditions include living in institutional accommodation, experiencing restricted economic opportunities, repatriation to the home country, or unresolved conflict. Undoubtedly, the lack of social support plays a negative role in the development of mental disorders, particularly depression [64]. Certain demographic factors also negatively affect the development of mental disorders. These factors include age >60 years, high education level, and being female.

The nature, intensity, and duration of exposure to risk factors, as well as a specific psycho-emotional background before, during, and after migration, can explain the high prevalence of mental disorders. Many researchers highlight two stable and significant risk factors behind the development of mental disorders: past traumatic experiences and socio-economic conditions after migration (unemployment, financial stress, poor language skills in the host country, and lack of social support) [16, 39, 40, 42].

However, these results regarding the incidence and prevalence of mental disorders among migrants are contradictory [38].

For migrants, there are two periods of elevated risk: shortly after migration and after a longer stay in the host country. Differences between the migrant's culture and the immigration circumstances (language proficiency, culture, disease-related behaviors) affect the character of mental disorders [38]. However, among all the events contributing to the forced displacement of people, military actions play a special role, as they cause widespread mental

[10] Galderisi S. Opening ceremony. Flolence: Programme of the 25th EPA Congress, 2017.

disorders even many years after the end of the war and resettlement.

Health issues among refugees and FDPs have been shown to be diverse, numerous, and complex. The traumatic experiences of displaced people can lead to PTSD, anxiety, depressive, and somatoform disorders, chronic pain sensations, sleep deprivation [67], various mental health issues, suicidal tendencies [16, 66], and somatic symptoms affecting multiple organs and systems (cardiovascular, respiratory, musculoskeletal, gastrointestinal, immune, endocrine, and other systems) [29–31, 76]. There is a high risk of somatised reactions and existential problems (when stereotypical beliefs are challenged) [36, 37] personality and dissociative disorders [64], alcohol abuse and psychotic disorders [65].

Moreover, these mental disorders may be the result of experiences related to pre-, intra-, and post-migration events. It is noted that post-migration stress can exacerbate the effects of prior trauma, creating an additional risk to mental health [34]. In particular, it is noted that the prevalence of PTSD is approximately ten times higher among refugees and asylum-seekers than among the population in the host country [81, 32, 35].

Despite the diversity of psychopathological responses among refugees and FDPs, the most common clinical manifestations are anxiety (13%), depression (30%), and PTSD (29%) [51]. According to self-reports, the prevalence of these disorders is much higher: anxiety was reported by 42%, depression by 40%, and PTSD by 37% of refugees and FDPs. Moreover, the indicators did not depend on the duration of residence in a particular neighbourhood according to Henkelmann et al. [51].

Data from various authors on the prevalence rates of anxiety, depression, and PTSD among refugees and FDPs show a significant variation, which complicates an accurate, reality-based assessment of the prevalence of these disorders [29, 39, 43, 47, 52–55]. This also indicates a high degree of statistical heterogeneity [45, 55, 64].

The integration process of refugees and FDPs is complicated by serious challenges related to employment, xenophobia, racism, physical safety, accommodation, and overall quality of life. All these problems are accompanied by mental pathology, unless they are followed by psychological phenomena: anxiety, fear, emotional tension, anger, powerlessness, hopelessness, worthlessness of one's own existence, passivity and despair suicidal thoughts [68].

The lack of special programmes for persons over 60 years of age exacerbates the vulnerability of older persons [70] in displacement following natural disasters, catastrophes and war[11]. This social group has been found to display significant symptoms of distress in the context of depressive and anxiety syndromes, as well as psychosocial problems such as feelings of abandonment, isolation and passivity, and suffering from intra-family conflicts [69].

Women are a particularly vulnerable group among refugees and FDPs, as they are more prone to depression and anxiety [60, 72, 73]. In relation to PTSD, differences between the sexes have been noted in the types of traumatic experiences: in women, it is rape and sexual harassment [74–76].

In addition to psychosocial and mental problems during humanitarian crises in low- and middle-income countries, a high prevalence of internal diseases is also observed [77]. However, significant correlations are noted between internal diseases, age, female gender, and mental disorders, a high level of each being a reliable predictor of care-seeking behavior [77].

In addition to specific disorders and syndromes, the deterioration of physical and mental well-being, wars, and mass forced displacement can have a profound impact on the worldview of refugees and FDPs. They exhibit a relatively low level of perceived benevolence of the world and the warmth of people, loss of trust. This should be taken into account in the process of communication, development of rehabilitation programmes, formation of positive public attitudes towards refugees [21, 46, 79].

There is no doubt that the resettlement of large numbers of people and migration policies raise many ethical, political and organisational issues, in addition to health issues. These issues need to be constantly discussed and resolved [78, 82, 83]. The key to effective intervention and its implementation is the involvement of a wide range of local and global actors [84].

Limitations

The primary limitation of this article is its narrative, rather than systematic, review format, which may have resulted in the omission of relevant studies on this topic.

[11] Mental health of refugees and migrants: risk and protective factors and access to care. Geneva: World Health Organization; 2023. Available from: https://www.who.int/publications/i/item/9789240081840

A non-systematic search for information was conducted, and articles of any type that evaluated the social, psychological, and clinical aspects of displacement were included in the study; the quality of the included studies was not assessed. Many of the included studies had a low level of evidence. These limitations may cloud a more complete understanding of the issue. Therefore, the conclusions drawn in this article may be preliminary.

A key strength of the present study is the identification of the role of various factors contributing to the development of mental disorders among refugees and FDPs.

CONCLUSION

The data presented in this review highlight the importance and relevance of the issue of refugees and FDPs for any society, as well as for specific services that aim to realistically assess the problem in each individual case and respond appropriately to the needs of migrants. Available limited and difficult-to-compare epidemiological data demonstrate that more than a quarter of migrants suffer from mental disorders requiring therapy, although access to such treatment is often difficult to achieve.

The data obtained clearly demonstrate that forced displacement plays a role in the development of mental disorders. The importance of other accompanying and contributing factors is emphasized — the role of factors in the host country, such as the isolation of migrants, discrimination, stigmatization, insufficient social support, changes in beliefs and worldview, psychological issues and internal diseases, language and cultural barriers, etc. Medical and social support for refugees and FDPs should be based on a clinical assessment of their mental health, the factors that led to their displacement, the cultural characteristics of the migrants, and the socio-economic and socio-political conditions in their home country. It should also be guided by the principles of humanism and tailored to each individual. In this process, it is crucial to rely on both governmental and community organizations, which should complement each other. To address the problem of mental health and implement social programs, an open dialogue is necessary between displaced people and the host communities at all levels (municipal, state, economic, and political, as well as business entities and public organizations).

This review emphasizes the urgent need to standardize screening methods for refugees and forcibly displaced people and create consolidated approaches to diagnostic evaluation, as well as specialized training for mental health professionals.

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