

Organization of Psychological and Psychiatric Assistance to Refugees in a Prolonged Emergency

Организация психолого-психиатрической помощи беженцам в условиях длительной чрезвычайной ситуации

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Short Communication

Kyuri Idrisov

*FSBEI HE Chechen State University named
after A.A. Kadyrov, Grozny, Russia*

Кюри Идрисов

*ФГБОУ ВО «Чеченский государственный университет
имени А.А. Кадырова», Грозный, Россия*

ABSTRACT

The article describes the experience of organizing psychological and psychiatric assistance to refugees in temporary accommodation centers (TACs). From 1999 to 2004, about 200,000 people, fleeing military operations during the counter-terrorist operation in the Chechen Republic, moved to neighboring Ingushetia, where they were placed in TACs. Analysis of the work with refugees shows that during a long stay in the TAC, refugees develop psychopathological and psychological issues including stress disorders, irritability, aggressiveness, disorders of adaptive functions, depression, anxiety, decreased initiative, "victim" complex, and damaged interpersonal relationships that significantly reduce their adaptive capabilities. Organizing comprehensive medical, social, psychological, and psychiatric care based on existing disorders can significantly improve the psycho-emotional state of refugees in a short time and prevent the aggravation and chronicity of these disorders.

АННОТАЦИЯ

В статье описан опыт организации психолого-психиатрической помощи беженцам в центрах временного размещения (ЦВР). С 1999 г по 2004 г. около 200 тысяч человек, спасаясь от военных действий в период контртеррористической операции в Чеченской Республике переехали в соседнюю Ингушетию, где были размещены в ЦВР. Анализ работы с беженцами показывает, что в период длительного проживания в ЦВР у беженцев формируются психопатологические и психологические изменения, такие как раздражительность, агрессивность, расстройства приспособительных функций, депрессия, тревожность, снижение инициативы, формирование комплекса «жертвы», нарушение межличностных отношений, которые существенно снижают их адаптивные возможности. Организация комплексной медико-социальной и психолого-психиатрической помощи с учетом имеющихся нарушений способна за короткий срок существенно улучшить психоэмоциональное состояние беженцев и предотвратить утяжеление и хронификацию этих расстройств.

Keywords: *refugees; temporary accommodation centers; psychological and psychiatric assistance; Chechen Republic*

Ключевые слова: *беженцы; центры временного размещения; психолого-психиатрическая помощь; Чеченская Республика*

RELEVANCE OF MEDICAL AND PSYCHOLOGICAL ASSISTANCE TO REFUGEES

Emergencies of any origin, whether technology-related, natural, or anthropogenic, are characterized by a high intensity of psycho-traumatic events, and if an emergency is also long-term and large-scale, then a complex of social, economic, and psychological negative factors affects people living in the emergency zone, significantly worsening their quality of life and ultimately resulting in mental and somatic disorders of varying severity [2, 5, 7]. As noted by many specialists and people directly affected by emergencies, anthropogenic emergencies (wars, terrorist acts, torture) are the most severe in terms of perception, the severity of the trauma, and the consequences [1, 3, 6]. Studies of the mental consequences of hostilities among civilian populations are mainly focused on refugees. According to the majority of researchers, the most common diagnoses among refugees are PTSD, and depressive and somatoform disorders. Long-term overstrain, psychosomatic disorders, and physical illnesses lead to abuse of psychoactive substances and suicidal tendencies and actions [9–11].

Studies investigating the mental state of internally displaced persons emerged as a result of local armed conflicts in the South and North Caucasus.

Analysis of the changes over time in neurotic disorders in internally displaced persons in the Caucasian Mineralnye Vody region revealed a significant increase in syndromic neurotic conditions after a year or more, which was the result of deepening and structuring neurotic symptoms under the influence of adverse social factors. Neurotic reactions were rediagnosed a year later in 43.6% of the refugees, while in 20% of cases there was a worsening of the condition manifested by the complication and deepening of psychopathological symptoms, reaching the severity of syndromic conditions combined with pronounced social maladaptation amongst the refugees. Neurosis itself was diagnosed in 22.9% of the refugees a year later during re-examination. At the same time, a deterioration in the health of refugees was reported in 27.6% of cases, including deepening affective disorders, and stabilization and development of personality changes with pronounced social maladaptation. In general, neurotic disorders amongst refugees during the follow-up examination were distributed as follows: dysthymic disorder (67.4%), obsessive-compulsive disorder (16.3%), neurasthenia (11.6%), and hysterical neurosis (4.6%) [10].

As noted by V.P. Kokhanov, V.N. Krasnov, “Practically all forced migrants and residents of Chechnya (82.4%) had non-psychotic forms of mental disorders of varying severity, manifested by neurotic disorders, characterological and behavioral deviations” [8]. The counter-terrorist operation carried out in the territory of the Chechen Republic (ChR) from 1999 to 2004 was associated with hostilities of varying intensity, which led to the displacement of a significant number of the population outside the Chechen Republic. People left the dangerous region because of a well-founded fear for their lives and a sharp deterioration in their quality of life: lack of social infrastructure, quality food, clean water, and medical care. Some of these people were placed in the territory of neighboring Ingushetia in temporary accommodation centers. According to various estimates, the number of temporarily displaced people ranged from 150,000 to 200,000. People were accommodated in Temporary Accommodation Centers (TACs) in the form of tent camps in an organized manner. Naturally, people were not left without help. Since the establishment of the TACs, people have received assistance from the EMERCOM of Russia, the World Health Organization (WHO), the Office of the United Nations High Commissioner for Refugees (UNHCR), and Russian and foreign non-governmental humanitarian organizations.

The purpose of this article is to describe the work of a team of specialists of FSBEI HE Chechen State University n.a. A.A. Kadyrov as part of the non-governmental humanitarian organization “Medecins du Monde” with refugees during the counter-terrorist operation in the territory of the Chechen Republic in 1999–2004. The article provides an organizational model for the provision of psychological and psychiatric assistance to refugees in temporary accommodation centers.

ORGANIZING MEDICAL AND PSYCHOLOGICAL ASSISTANCE IN REFUGEE ACCOMMODATION CENTERS

Our experience of working with refugees was gained in the Centers for Medical and Psychological Assistance (CMPAs) deployed in the two largest TACs in Karabulak (5,000 people) and Sleptsovskaya (12,000 people) in the Republic of Ingushetia. Each CMPA had a team of specialists consisting of psychologists, a psychiatrist, a general practitioner, a pediatrician, nurses, and volunteers involved in this work as social workers. The CMPAs were in operation from November 1999 to March 2004.

Each CMPA had three large tents that housed a medical station for medical care, a psychological care center, and a separate tent for a psychiatrist. Medical workers, psychologists, and volunteers provided help to refugees at the level of their competence, and if the refugees showed severe psychopathological symptoms, including delirium, hallucinations, PTSD, depression, panic attacks, or if the patient's condition required clarification in terms of diagnosis, such patients were referred for a consultation with a psychiatrist.

PSYCHOLOGICAL REACTIONS AND THEIR CHANGES IN TACS

The experience of working with people living in TACS showed that in the process of adaptation to a new place, people experienced a number of psychological states that changed during their stay in the TAC and consisted of the following stages of psychological reactions:

1) State of fear, despair, and helplessness

People are scared, they are still under the impression of there being extant enduring threats to their lives. For the most part, people who left the danger zone had only personal belongings and documents with them, so they were concerned about the state of the property that had to be left in their homes, their loved ones who, for whatever reason, were unable to leave the danger zone, and because they could not understand the reasons for the hostilities;

2) State of doubt, suspicion, and mistrust

With high emotional stress, people constantly form doubts and suspicions about other refugees, government officials, and even people and organizations trying to help them. Various rumors are constantly circulating among the refugees that "cleansing" will be carried out among them, that refugees are "abducted" at night, that they are "purposefully" gathered in one place. Although these rumors are not confirmed, most refugees believe them, and often such rumors are deliberately spread by provocateurs;

3) State of stabilization and productive activity

At this stage, people's emotional state evens out, aggression and suspicion decrease, people begin to rally, establish interpersonal relationships, are busy arranging their lives, receiving humanitarian assistance, finding employment, and educating their children.

4) State of feeling of personal infringement and sacrifice

This is perhaps the most difficult state that refugees begin to experience. Long-term residence in poor conditions: lack of money, living in a tent, high density of people living in one tent, lack of personal space, lack of household amenities, and dependence on humanitarian aid makes people feel inferior and unable to solve their problems on their own. This leads to the formation of the "victim complex" as a form of compensation, when refugees begin to demand additional conditions and material benefits for themselves, referring to the fact that they are victims, and "everyone is obliged" to them;

5) State of nostalgia for home and formation of a desire to return home

At this stage, refugees get tired of living in the TAC and keep feeling like returning home, which leads to a significant decrease in the interest in productive activities, a decrease in the emotional state, and sleep disturbance.

The duration of the states described above amongst the refugees with whom we worked varied, and often the psychological reactions overlapped during the transition from one stage to another.

ORGANIZATION OF REFUGEES SEEKING PSYCHOLOGICAL AND PSYCHIATRIC ASSISTANCE

Psychological and psychiatric assistance must be organized from the very first days of a TAC's creation and the resettlement of refugees, taking the particularities of their current mental states into account. During the first stage, an active form of identification of refugees with mental disorders is appropriate, and even necessary. We used the following method for these purposes. Our specialists split into pairs, if possible a man and a woman, and went to the TAC. Seeing a group of refugees, they approached them and struck up a conversation. Soon, other refugees would begin to approach them, and a group of 8–10 people formed. Refugees talked about their problems, needs, and our specialists assessed the mental status of the refugees during the conversation: their reactions, tonality, emotionality of statements, level of aggression, and if any of the refugees showed pronounced emotional reactions such as emotional lability, verbal aggression, verbal expression, crying, despair. If so, a separate conversation was held with

these refugees and they were invited to our CMPA, where an in-depth examination was carried out and necessary assistance was provided [4].

The second way to identify refugees with mental health problems was through our health center. People sought medical help, and in the process of examination and provision of medical care, employees of the medical center revealed signs of mental disorders such as fear, anxiety, low mood, sleep disturbance, irritability, aggressiveness, and persistent memories of previously experienced traumatic events. Refugees were referred to a psychologist or psychiatrist for consultation if such symptoms were detected. To improve the professional competencies of medical workers in diagnosing the symptoms of mental disorders, we developed and conducted brief educational seminars on recognizing mental disorders and provided methodological recommendations for diagnosing the common mental disorders that develop in emergencies.

The third way of referring for psychological and psychiatric help was self-referral, when, being aware of their own need for psychological and psychiatric help, refugees turned to our CMPA on their own initiative.

The fourth way of referring was by recommendation from other refugees who had already been referred to our CMPA and received effective assistance.

GENERAL PRINCIPLES FOR THE PROVISION OF PSYCHOTHERAPEUTIC ASSISTANCE IN TACS

It turned out to be important, when organizing psychological and psychiatric care, to divide the flow of those seeking help by sex and age in accordance with the ethno-cultural and religious characteristics of the population living in the Chechen Republic. This division necessitated the formation of permanent open therapeutic groups for children, adolescents, youths, and adults, where the latter two groups were also divided by sex.

Therapeutic approaches were selected in accordance with age characteristics. A playground was created for children and adolescents, where games were used for both diagnostic and therapeutic purposes. Various group trainings were used for boys and girls, such as confident behavior training, perspective formation training, interpersonal relations training, and aggression management training. Meetings with various famous and popular people who have achieved success in sports, art, and culture turned out to be very

impressive to young men and women, since it was very important to give the young men practical examples that there are many ways to achieve success, realize their personal potential, and effectively serve their people, not through participation in the hostilities but in a peaceful way. For adult patients, individual and group cognitive-behavioral psychotherapy was carried out with the purpose of working out mental trauma and forming an awareness of the connection of their neurotic condition and a number of physical illnesses with past traumatic events. Jacobson progressive muscle relaxation was used to relieve feelings of tension, irritability, and sleep disturbances. This work was carried out in therapeutic groups. Open male and female groups were formed. A group consisted of 6–8 people (the size of the tent did not allow larger groups). Psychotherapy sessions were held twice a week for each group. Taking the gender characteristics of patients into account, a female psychologist worked with the female group, and a male psychiatrist worked with the male group. The presence of different specialists in the team allowed us to implement a team-based approach in helping refugees, when a team of specialists (psychiatrist, psychologist, social worker) formed a therapeutic route for patients and controlled its implementation. The compact accommodation of refugees in the TAC allowed our volunteers to observe our patients at the place of residence and register the changes in their condition. The listed organizational and therapeutic approaches contributed to the maximum coverage of people in need of psychological and psychiatric assistance and the timely processing of experienced traumatic events.

Organizing assistance for refugees is complex in nature, and we can expect the best positive effect only when we organize comprehensive psychosocial assistance for refugees, when, simultaneous to organizing the lives of refugees, providing them with food, clothing, and hygiene products, we also provide the psychological, psychiatric, and medical assistance that can contribute to the rapid improvement of their conditions and the prevention of chronic mental and psychosomatic disorders.

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Information about the authors

***Kyuri Arbievich Idrisov**, M.D, Professor, Department of Hospital therapy with a course of psychiatry, medical psychology, FSBEI HE Chechen State University named after A.A. Kadyrov, ORCID: <https://orcid.org/0000-0002-5178-1519>
E-mail: kyuri.idrisov@yandex.ru

*corresponding author

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