Asociación Colombiana de Psiquiatría ACP

Revista Colombiana de Psiquiatría

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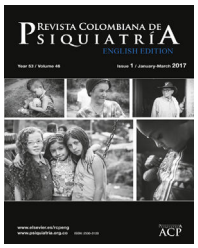

Original article

Social determinants, symptoms and mental problems in adults internally displaced by armed conflict. Soacha, Colombia, 2019

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ARTICLE INFO

Article history:
Received 18 May 2022
Accepted 8 August 2022
Available online 26 April 2024

Keywords:
Human migrations
Armed conflicts
Mental health
Mental disorders
Social determinants of health

ABSTRACT

Objective: To characterise social determinants of health, mental health problems and potentially problematic symptoms in the adult population displaced by internal armed conflict in Colombia.

Methods: Cross-sectional descriptive study with a random sample of 98 adults forcefully displaced to Soacha, Colombia, due to internal armed conflict. The Self Report Questionnaire to detect potentially problematic mental health problems and symptoms, and a structured questionnaire on social determinants of health were applied.

Results: The median age was 38 [interquartile range, 28–46] years, and women predominated (69.39%). The median time since displacement was 36 [16–48] months, and time since settlement in Soacha, 48 [5–48] months. 86.32% survived on less than the minimum wage per month and 93.87% did not have an employment contract. 42.86% and 7.14% reported being owners of their homes before and after displacement, respectively. Upon arriving in Soacha, 79.60% went to primary support networks and 3% to institutions. Before displacement, 16.33% lacked health insurance and 27.55% afterwards. Regarding mental health problems; there were possible depressive or anxious disorders in 57.29%; possible psychosis in 36.73%; and potentially problematic symptoms in 91.66%, being more prevalent and serious in women ($p = 0.0025$).

Conclusions: A deterioration in living conditions and a higher prevalence of potentially problematic mental health problems and symptoms was reported in displaced adult populations settled in Soacha compared to other regions of the country. Analyses with complementary perspectives are required to evaluate these differences.

DOI of original article: https://doi.org/10.1016/j.rcp.2022.08.001.

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Determinantes sociales, síntomas y problemas mentales en población adulta víctima de desplazamiento forzado por conflicto armado interno. Soacha, Colombia, 2019

Palabras clave:
Migrantes
Conflictos armados
Salud mental
Trastornos mentales
Determinantes sociales de la salud

RESUMEN

Objetivo: Caracterizar determinantes sociales en salud, problemas y síntomas mentales potencialmente problemáticos en adultos desplazados por conflicto armado interno en Colombia, asentados en Soacha.

Métodos: Estudio descriptivo de corte transversal con tamaño muestral de 98 adultos desplazados por conflicto armado. Se aplicó el *Self Report Questionnaire* para detección de problemas y síntomas mentales potencialmente problemáticos y un cuestionario estructurado sobre determinantes sociales en salud.

Resultados: La mediana de edad fue 38 [intervalo intercuartílico, 28–46] años y predominaron las mujeres (69,39%). La mediana de tiempo desde que fueron desplazados fue 36 [16–48] meses y asentados en Soacha, 24 [5–48] meses. El 86,32% sobrevivía con menos de un salario mínimo mensual y el 93,87% no tenía contrato laboral. Un 42,86% y un 7,14% manifestaron ser propietarios de las viviendas que habitaban antes y después del desplazamiento respectivamente. Al llegar a Soacha, el 79,60% acudió a redes primarias y el 3%, a instituciones. El 16,33% carecían de aseguramiento en salud antes del desplazamiento y el 27,55%, después. Resultaron positivos en problemas mentales por posible trastorno depresivo o ansioso el 57,29%; en posible psicosis, el 36,73% y en síntomas potencialmente problemáticos, el 91,66%, más prevalentes y graves en mujeres (p = 0,0025).

Conclusiones: Se identificaron en la población adulta desplazada y asentada en Soacha deterioro en condiciones de vida y una prevalencia de problemas y síntomas mentales potencialmente problemáticos mayor que la reportada en desplazados ubicados en otras regiones del país. Se requiere análisis con perspectivas complementarias para evaluar estas diferencias.

Introduction

Forced displacement due to persecution and human rights violations threatens individual and collective development. By 2020, there were 26.40 million refugees and 45.90 million internally displaced people worldwide, with Colombia having the largest number of displaced people.[1] The Centro Nacional de Memoria Histórica [National Centre for Historical Memory in Colombia] reported 7,035,936 displaced people between 1970 and 2018, and the 2017 Colombian Single Registry of Victims indicated that victims of forced displacement were predominantly of ethnic origin (88%).[2]

In Cundinamarca, a Colombian department with a large displaced population, Soacha is one of the main municipalities through which displaced populations transit and for permanent settlement.[3] Its urbanised area, close to Bogotá, touches the south-western border of the latter at Bosa and Ciudad Bolívar, forming a corridor for displaced people, with the associated insecurity and crime.[4,5] It has become home to so many people displaced by the internal armed conflict, with changing temporal dynamics.[6]

Mental health outcomes in displacement victims are modulated by sociodemographic characteristics, experience of material and immaterial losses, additional polytrauma before or after displacement, access to basic services, economic and employment opportunities in the new settlement areas, and the welcoming or discriminatory attitudes displayed by the receiving community.[7,8]

There is evidence of mental health problems in migrants displaced due to armed conflicts, with greater psychopathology in all subgroups of refugees compared to the general population, and worse outcomes in internally displaced persons and those repatriated to the countries from which they have fled, where the internal armed conflict is still ongoing.[7] Prevalence varies widely, this being attributed to the heterogeneity of the samples studied and the diversity of the instruments used.[9] One systematic Colombian review of adult victims of displacement due to internal armed conflict found prevalences of mental symptoms ranging between 9.9% and 63% with prevalence of possible cases ranging from 21% to 97.3% and mental disorders ranging from 1.5% to 33.9%.[10]

In Colombia, comprehensive reparation is a legally established right that includes physical, mental and psychosocial healthcare through the "Comprehensive Health and Psychosocial Care Programme for Victims" (Programa de Atención Psicosocial y Salud Integral a Víctimas — PAPSIVI) of the Colombian Ministry of Health and Social Protection (Ministerio de Salud y Protección Social). Victims do not always access the services, due to mistrust and fear of being identified, and due to the persistence of the conflict, among other barriers.[11–13]

For this study, a biomedical model of mental health[14] was applied, and the presence or absence of psychiatric symptoms established, which indicated possible mental problems impacted by social determinants, consisting of social, cultural, biological, behavioural, political, economic and environmental aspects capable of playing a role in expressions of health.[15] Social capital, represented by primary networks (family members and close friends) and by accessible secondary or institutional networks, acts as a social determinant of the health of the victims of violence.[16] The objective of the study is to characterise the social determinants of health (SDH), mental problems (MP) and potentially problematic symptoms (PPS) among the adult population of the municipality of Soacha victim to forced displacement due to the internal armed conflict, in order to guide future clinical and public health interventions on the subject.

Methods

Descriptive cross-sectional study involving forcibly displaced adults located in Soacha, Colombia, between 2013 and 2017. The sample size was estimated based upon an overall displaced population in Soacha comprising a total of 58,471 people, 64% of whom were aged 18–45 years.[17] Based on an expected prevalence of depressive or anxious symptoms among the adult population living in poverty of 9.6%, according to the 2015 Colombian Mental Health Survey, and using the *Self Report Questionnaire* (SRQ),[18] a sample size of 98 adults was calculated ($\alpha = 0.05$; power of 0.9) with a forecast 20% that would be lost to follow-up. People who had been displaced for any reason not related to the internal armed conflict were excluded.

The population was accessed through the Comprehensive Victim Support and Reparation Unit (Unidad de Atención y Reparación Integral para la Víctimas — UARIV) of the municipality of Soacha. Field researchers (duly standardised healthcare professionals) applied the eligibility criteria (adults arriving in Soacha due to displacement associated with the internal armed conflict during the 5 years prior to the start of the project) on a daily basis to all individuals visiting the UARIV during the 3-month information collection period. Those who met these criteria and agreed to participate by giving their informed consent were selected. The instruments were applied in privacy by means of a direct personal survey at the UARIV facilities. The instruments used were the SRQ for detection of MP and PPS, and a structured questionnaire for the SDH information collection project. Information was collected from February to April 2019.

Mental problems and symptoms were analysed using the scores obtained from the 25-question SRQ.[18,19] The SRQ was designed by the World Health Organization (WHO) for Primary Health Care (PHC), which makes it possible to identify adults with symptoms compatible with possible mental disorders.[19] It is not a diagnostic instrument, but rather a screening instrument, as it only indicates the presence of a possible psychopathology in those who test positive, and must always be confirmed by an expert clinical assessment. Introduced to Colombia in 1980,[20,21] sensitivities have been reported for this instrument ranging between 62.9% and 90%, as well as specificities ranging between 44% and 95.2%.[21] It been validated nationally in various populations, including victims, to be used either self- or interviewer-administered.[18,22]

Table 1 shows the categories of the SRQ's 25 question based on the construct reported in the 2015 Colombian National Mental Health Survey.

Surveys with positive anxious or depressive symptoms of any magnitude were considered PPS, as they raise the alert of potential unmet mental health needs.[23] Any case of MP or PPS requires a subsequent clinical interview to ascertain diagnoses.

The SDH questionnaire consists of 24 questions to describe: demographic information, socioeconomic information, level of education, access to improved water and sanitation facilities, the situation with respect to basic needs and social support networks. As secondary social networks, the following were enquired about: religious affiliation, aid institutions for displaced people and affiliation to the social security system through which access to health services is obtained, given that these provide potential support in times of need.

The information was analysed descriptively, with measurements of frequency in the case of categorical variables, using Fisher's exact test to evaluate the differences between men and women. For continuous variables, the information was reported as medians [interquartile range], since the data did not have a normal distribution, and using the Shapiro–Wilks test. In addition, the Mann–Whitney U test *(Wilcoxon rank sum test)* was used to evaluate differences in medians between two groups. Data were processed using the R.v3.4 statistical software.

This project was initially approved and then renewed by the Ethics Committee of the Faculty of Medicine, Universidad Nacional de Colombia, in Minutes 007-054-17 of 11-May-2017 and 008-109-19 of 10-May-2019, including its informed consent. The information was collected on paper and transcribed into RedCap, thus guaranteeing its confidentiality. Psychological first aid and referral to healthcare services was provided whenever MP and PPS warranting this were identified.

Results

Social determinants of health

The characteristics of the 98 people included in the study, with their most outstanding SDH features, are presented in Table 2. The median age of the respondents was 38 [28–46] years; 38.5 [27–48] years for women and 37.5 [29.5–43.5] for men.

According to exposure to violence, all were survivors of forced displacement due to the internal armed conflict, with possible concomitant victimisations. Geographically, they were displaced from 23 of the 32 departments of Colombia, with the highest frequencies being from Tolima (19.4%), Cauca (8.2%) and Chocó (7.1%). The other 20 departments were, in descending order of frequency: Huila, Cundinamarca, Arauca, Caquetá, Nariño, Meta, Boyacá, Antioquia, Bolívar, Casanare, Norte de Santander, Santander, Putumayo, Cesar, Atlántico, Caldas, Córdoba, Guajira, Guaviare and Magdalena. The median time that had passed since displacement was 36

Table 1 – Categories for assessing possible mental problems (MP) or potentially problematic symptoms (PPS).

Category	Construct
SRQ possible anxious or depressive mental disorder: anxious or depressive mental problem	Eight or more positive answers to the first 20 questions indicate a high probability of mental disorder (depression, anxiety or both), which is compatible with having at least one problem[18]
SRQ possible anxiety (anxiety PPS)	Categorised as none, few, moderate and many anxious symptoms, according to the number of positive answers to questions 1, 2, 3, 4, 5, 6, 7, 8, 19 and 20[18]
SRQ possible depression (depression PPS)	Categorised as none, few, moderate and many depressive symptoms, according to the number of positive symptoms (yes answers) to questions 2, 3, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 and 20[18]
SRQ possible psychotic disorder (psychosis MP)	One of two positive psychosis indicator symptoms with questions 23 and 24[18]
SRQ possible epilepsy (convulsive MP)[18]	One symptom that is a positive indicator of convulsions (question 25)[18]

Source: modified from the 2015 National Mental Health Survey and the 1983 Manual of Psychiatry for Primary Care Workers.

[16–48] months, having been settled in Soacha for 24 [5–48] months.

According to gender-based SDH, there were more women than men (69.39%) (Table 2). Socioeconomic position, indicated by level of income, occupation and level of education, showed that 86.32% survived on less than 1 minimum monthly salary; 66.33% reported having no income-generating activity; and only 6 of the 98 people interviewed had some type of active employment contract, this being related to the evinced low level of education, since only 7 people had vocational or professional qualifications (Table 2).

Economic vulnerability was also evinced in the 62.24% (n = 61) of those surveyed who had gone at least 1 day without eating since their arrival in Soacha, due to a lack of money, and 63.3% (n = 62) who had not received any support or subsidy from aid institutions, and this in households with a high economic dependence, denoted by the presence of a median of 4 people in the household, with an interquartile range of 0–3 minors. In addition, 19.39% reported having people in their homes with physical or mental limitations that prevented them from performing autonomous activities (Table 2).

Living conditions, indicated by the ownership and classification of the dwelling place, changed as a result of the displacement compared to their previous dwellings in their place of origin. It is important to note that, in their urban dwelling place in Soacha, 13.27% had no drinking water at home and 16.33% had no sewage system (Table 2).

Regarding primary networks, it stands out that, upon arriving in Soacha, displaced people mostly resorted to help from their family or friends (79.6%; n = 78). Once settled, 42.9% lived in nuclear family households (n = 42) and 20.4% (n = 20) lived in extended or compound family households. The rest lacked this primary support.

Regarding secondary networks, only 1% visited the Victims Unit in Soacha to ask for help. After displacement, only 72.45% (n = 71) were affiliated with an EAPB (Benefits Plan Administrator, Third-Party Payer), while 27.55% (n = 27) were not affiliated to such a plan. This represented a negative change compared to conditions prior to displacement (Table 2). In relation to religious affiliation, 41.9% (n = 41) declared themselves to be catholic, 9.2% (n = 9) expressed that they were evangelical or pentecostal, and 6.1% reported being protestant (traditional or non-evangelical; n = 6). A total of 10.2% (n = 10) reported no religious affiliation, while 32.7% (n = 32) stated that they did not know their religious affiliation or preferred to not report this.

Mental problems and potentially problematic symptoms

Regarding MP, more than half of the those surveyed were identified as having a possible anxious, depressive or mixed disorder (Table 3). 36.73% had a score indicative of a possible psychotic disorder and only 5.1% showed symptoms indicating a possible convulsive disorder. For all of the MPs examined, women predominated (Table 3). Regarding PPS, those related to the anxiety and depression spectrum were taken into account, regardless of whether the PPS met the MP thresholds, since there are vital situations that do not have the character of possible disorders, but may require mental health support in order to cope properly (Table 3).

In decreasing order of frequency, many anxious PPS predominated (58.33%; n = 56), followed by many depressive PPS (35.71%; n = 35) or moderate depressive PPS (32.65%; n = 32). Women consistently were consistently the most highly represented among people with few, moderate or many depressive symptoms, and also among those with many anxious symptoms. Men only had higher prevalences for mild or moderate anxious symptoms. A total of 8.33% of the people had no anxious symptoms and 7.14% had no depressive symptoms, with a constant predominance of men in both cases.

Discussion

Three years after the signing of the peace agreements in Colombia,[24] socioeconomic vulnerability, deficiencies in living conditions, and a high frequency of MP and PPS, were found in a representative sample of the adult population settled in the municipality of Soacha, after having been displaced due to the internal armed conflict between 2013 and 2017.

Monthly income, which was mostly lower than one minimum wage, and the predominance of informal employment and unemployment among the respondents, revealed their disadvantage compared to that described for the general Colombian population in the 2015 National Mental Health Survey (Encuesta Nacional de Salud Mental ENSM).[18] Unemployed people and informal workers affected by the internal armed conflict are more likely to suffer from mental disorders.[25] The

Table 2 – SDH results in men and women from the study.

	Total, n = 98	Women, n = 68 (69.39%)	Men, n = 30 (30.61%)	p Value
Age (years)	38 [28–46]	38.5 [27–48]	37.5 [29.5–43.5]	0.9692[a]
Marital status				
Married/cohabiting	46 (46.94)	26 (38.24)	20 (66.67)	0.0133[b]
Single	42 (42.86)	33 (48.53)	9 (30.00)	
Separated/divorced	8 (8.16)	8 (11.76)	0	
Widowed	2 (2.04)	1 (1.47)	1 (3.33)	
Self-reported ethnicity				
Indigenous	9 (9.18)	5 (7.35)	4 (13.33)	0.795[b]
Black, mixed, Afro-Colombian or of African descent	12 (12.24)	7 (10.29)	5 (16.67)	
None	46 (46.94)	30 (44.12)	16 (53.33)	
Did not respond	31 (31.63)	26 (38.24)	5 (16.67)	
Average income (Legal Minimum Wage in 2019: $828.116)				
Less than 1 legal minimum wage	82 (86.32)	59 (89.39)	23 (79.31)	0.277[b]
1 legal minimum wage	12 (12.63)	6 (9.09)	6 (20.69)	
2 legal minimum wages	1 (1.05)	1 (1.52)	0	
Level of education (last grade passed)				
None	4 (4.08)	2 (2.94)	2 (6.67)	0.757[b]
Preschool	0	–	–	
Primary school (grade 1–5)	41 (41.84)	30 (44.12)	11 (36.67)	
Secondary school (grade 6–9)	22 (22.45)	15 (22.06)	7 (23.33)	
College (grade 10–11)	21 (21.43)	15 (22.06)	6 (20.00)	
Vocational without qualification	2 (2.04)	1 (1.47)	1 (3.33)	
Vocational with qualification	6 (6.12)	4 (5.88)	2 (6.67)	
Technological without qualification	0	–	–	
Technological with qualification	1 (1.02)	0	1 (3.33)	
University without certificate	0	–	–	
University with certificate	1 (1.02)	1 (1.47)	0	
Household members dependent due to physical or mental limitations				
Yes	19 (19.39)	14 (20.59)	5 (16.67)	0.2766[b]
No	48 (48.98)	28 (41.18)	20 (66.67)	
Did not respond	31 (31.36)	26 (38.24)	5 (16.67)	
First port of call on arrival in Soacha				
House of family member or close friend	78 (79.59)	56 (82.35)	22 (73.33)	0.2926[b]
Foundation	2 (2.04)	2 (2.94)	0	
Victims unit	1 (1.02)	1 (1.47)	0	
Other	17 (17.35)	9 (13.24)	8 (26.67)	
At least one day without eating due to lack of money after displacement				
Yes	61 (62.24)	40 (58.82)	21 (70.00)	0.3681
No	37 (37.76)	28 (41.18)	9 (30.00)	
Type of affiliation with social security system (before displacement)				
Contribution-based	14 (14.29)	6 (8.82)	8 (26.67)	0.0048[b]
Subsidised	68 (69.39)	54 (79.41)	14 (46.67)	
None	16 (16.33)	8 (11.76)	8 (26.67)	
Type of affiliation with social security system after displacement				
Contribution-based	16 (16.33)	10 (14.71)	6 (20.00)	0.5449[b]
Subsidised	66 (67.35)	45 (66.18)	21 (70.00)	
None	16 (16.33)	13 (19.12)	3 (10.00)	
Registered with an EPS (Entidad Promotora de Salud, public health insurance plan) after displacement				
Yes	71 (72.45)	48 (70.59)	23 (76.67)	0.6283[b]
No	27 (27.55)	20 (29.41)	7 (23.33)	
Type of housing (before displacement)				
House	72 (74.23)	51 (76.12)	21 (70.00)	0.8089[b]
Apartment	6 (6.19)	4 (5.97)	2 (6.67)	
Room(s)	2 (2.06)	1 (1.49)	1 (3.33)	
Other	17 (17.53)	11 (16.42)	6 (20.00)	

Table 2 (Continued)

	Total, n = 98	Women, n = 68 (69.39%)	Men, n = 30 (30.61%)	p Value
Ownership of home (before displacement)				
Own property	42 (42.86)	29 (42.65)	13 (43.33)	0.0612[b]
Rental property	30 (30.61)	25 (36.76)	5 (16.67)	
Other	26 (26.53)	14 (20.59)	12 (40.00)	
Type of housing (current)				
House	42 (42.86)	30 (44.12)	12 (40.00)	0.6749[b]
Apartment	38 (38.78)	14 (35.29)	14 (46.67)	
Room(s)	15 (15.31)	12 (17.65)	3 (10.00)	
Other	3 (3.06)	2 (2.94)	1 (3.33)	
Ownership of home (current)				
Own property	7 (7.14)	3 (4.41)	4 (13.33)	0.269[b]
Rental property	82 (83.67)	59 (86.76)	23 (76.67)	
Other	9 (9.18)	6 (8.82)	3 (10.00)	
Public services (current)				
Sewage system	82 (83.67)	57 (83.82)	25 (83.33)	1[b]
Electricity	94 (95.92)	66 (97.06)	28 (93.33)	0.5838[b]
Drinking water	85 (86.73)	58 (85.29)	27 (90.00)	0.7487[b]
Gas	74 (75.51)	53 (77.94)	21 (70.00)	0.4489[b]
Rubbish collection	85 (86.73)	58 (85.29)	27 (90.00)	0.7487[b]
Internet	13 (13.27)	6 (8.82)	7 (23.33)	0.1018[b]
Cable TV	42 (42.86)	26 (38.24)	16 (53.33)	0.1886[b]
Details of household				
Household members	4 [3–6]	4 [3–6]	4 [3–6]	0.823[a]
Dependants of the respondent	3 [2–4]	3 [2–4]	3 [2–4]	0.727[a]
Minors	1 [0–3]	1 [1–3]	1 [0–3]	0.364[a]
Has income-generating activity				
Yes	33 (33.67)	23 (33.82)	10 (33.33)	1[b]
No	65 (66.33)	45 (66.18)	20 (66.67)	
Type of employment contract (if respondent has active productive activity)				
Fixed term	3 (10.00)	2 (10.00)	1 (10.00)	0.0892[b]
Indefinite term	1 (3.33)	0	1 (10.00)	
Casual worker	1 (3.33)	0	1 (10.00)	
Service provision	1 (3.33)	0	1 (10.00)	
Other	4 (13.33)	4 (20.00)	0	
None	20 (66.67)	14 (70.00)	6 (60.00)	

Source: created by the authors. Values are expressed as n (%) or median [interquartile range].

[a] Mann–Whitney U test.

[b] Fisher's exact test.

low level of education and the low income found correlate with other studies conducted on the displaced population residing in Soacha.[26] Worse living conditions were observed due to variations in housing characteristics, access to public services, and health insurance before and after displacement.

Regarding MP and PPS, it is important to recognise that it is difficult to compare our results with other samples, due to differences in the design and instruments used between studies. However, the total prevalence of anxious-depressive MP in our sample (57.29%) is 3.8 times higher than that found in the 2015 National Mental Health Survey among the Colombian population displaced by the internal armed conflict at some point in their lives (15%), using the same version and same cut-off point of the SRQ.[25] The higher prevalence of anxious-depressive problems in those women surveyed coincides with global scientific evidence on their greater vulnerability in terms of health during the internal armed conflict.[27,28]

Possible psychotic disorders among the displaced population studied showed a much higher figure (36.73%) than that found in the total national population of adults evaluated using the same methodology in the 2015 National Mental Health Survey (14.8%),[18] i.e. using questions 23 (have you noticed any interference or anything else unusual in your thinking?) and 24 (do you ever hear voices without knowing where they come from or that other people cannot hear?) of the instrument. There are very few studies on psychotic symptoms in the displaced Colombian population. Among the existing studies that use the SRQ, 85% of possible psychoticism has been reported after taking into account the four questions, numbers 21, 22, 23 and 24, of the SRQ instrument.[29] Since the 1993 Colombian National Mental Health Survey, it has been argued that questions 21 (do you feel that someone has been trying to harm you in any way?) and 22 (are you a much more important person than others think?) could overlap with experiences other than psychoticism, such as normal

Table 3 – SRQ results in displaced men and women from Soacha.

	Total (n = 96[a]), n (%)	Women (n = 67), n (%)	Men (n = 29), n (%)	p[b]
SRQ: some anxious-depressive MP	55 (57.29)	44 (65.67)	11 (37.93)	0.01432
SRQ symptoms (PPS), depression				0.0914
None	7 (7.14)	3 (4.41)	4 (13.33)	0.1959
Few	24 (24.49)	15 (22.06)	9 (30.00)	0.4489
Moderate	32 (32.65)	21 (30.88)	11 (36.67)	0.6426
Many	35 (35.71)	29 (42.65)	6 (20.00)	0.0398
SRQ symptoms (PPS), anxiety				0.0025
None	8 (8.33)	2 (2.99)	6 (20.69)	0.0087
Few	12 (12.50)	6 (8.96)	6 (20.69)	0.1754
Moderate	20 (20.83)	13 (19.40)	7 (24.14)	0.595
Many	56 (58.33)	46 (68.66)	10 (34.48)	0.003
SRQ: some psychotic MP	36 (36.73)	24 (35.29)	12 (40.00)	0.0025
SRQ: some convulsive MP	5 (5.10)	4 (5.88)	1 (3.33)	0.0025

MP: mental problem; PPS: potentially problematic symptoms; SRQ: *Self Report Questionnaire*.
Source: created by the authors.
[a] Of the 98, only 96 individuals answered all 25 questions.
[b] Fisher's exact test.

extreme experiences during the internal armed conflict, or narcissistic traits, which is why these were not included in the 2015 National Mental Health Survey or in this study, which could explain the lower results obtained.[18]

In the international literature there is also little information on the presence of psychotic disorders among displaced populations. In one systematic review that included studies of internally displaced people (IDP) and refugees in low- and middle-income countries with high rates of political instability, a prevalence of 1%–12% of psychotic disorders was found, assessed in two different samples of IDP and refugees from Africa, while a prevalence of 13%–21% of psychotic symptoms, such as visual and auditory hallucinations, was found. Depression, anxiety and post-traumatic stress are the most commonly researched MP, with variations from 5.1% to 81% in depression and from 1% to 90% in anxiety disorders.[9]

Given these variations, it is advisable to consider the characteristics of the settlement places after displacement, in terms of active internal armed conflict or other types of violence, and rural or urban location. In the department of Meta-Colombia, a 21.8% prevalence of MP was found, assessed using the SRQ. This figure is higher than that reported by the 2015 National Mental Health Survey, and is closer to the findings reported in Soacha, although higher.[30] The harmful influence of urbanisation phenomena on mental health may also negatively impact the population of Soacha.[31]

Other differences in the frequency of MP and PPS between populations can be explained by the time passed since displacement, polytrauma or previous psychopathology,[10,16] as well as uprooting, discrimination and acculturation,[32] or continued exposure to violence due to persistent internal armed conflict.[33] In addition, poor living conditions and high levels of responsibility of caring for others in the middle of a precarious setting could influence the high rates of MP and PPS found in Soacha.

Regional differences in MP and PPS and their possible contributing factors must be taken into account in mental health programmes for populations displaced by internal armed conflict, who, like external migrants, do not represent a homogeneous category. Likewise, reductionist biomedical models are inadequate for understanding suffering and addressing all the mental health needs of these populations. Although they help to measure the possible unmet demand for healthcare services, it is appropriate to complement them with psychosocial assessments and interventions,[34] as these approaches do not substitute one another.

The main strength of this study lies in the use of an instrument for assessing any changes in mental health that is easy to use and has a wide history of use among various populations in our country. This makes comparisons easier and, in this case, it was applied to a random sample of adults displaced by the internal armed conflict. Furthermore, one of the limitations observed in this and in other studies on the subject is the low participation of the male population, which could influence the results. The main difficulty was in recruiting participants, due to the survivors' resistance to being identified as victims given the persistence of the Colombian internal armed conflict.

The central weakness of the study is based on the fact that psychosocial well-being assessments were not used concomitantly to comprehensively measure the needs of people affected by internal armed conflict, which would have been complementary to the variables that were considered.

Conclusions

The characterisation of SDH in the adult population of Soacha displaced by the internal armed conflict revealed a precarious group that lacks the minimum conditions adequate for living with dignity. Using the SRQ, MP and PPS values were found that were well above the average shown in other Colombian displaced populations assessed in the same way for possible anxiety, depression and psychosis. There were statistically significant differences between men and women in such conditions, within the context of a low participation of the male population in the study. New studies with analytical methods

incorporating psychosocial well-being are required in order to improve our understanding of the problem addressed.

Funding

150th National Meeting in 2018, at Universidad Nacional de Colombia; "Community-based intersectoral network for the management of mental problems and disorders associated with forced displacement due to armed conflict in the municipality of Soacha – Cundinamarca (pilot)" project.

Conflicts of interest

The authors have no conflicts of interest to declare.

Acknowledgements

We would like to thank the participating victims. We would also like to thank the field research team: Laura Rodríguez, Daniel Samacá, Luisa Bautista, Angie Vargas, Ana Herrera, Teresa Vanegas, Jaime Moreno and Andrés Chala.

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