## Participant Information Leaflet

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| **Project title** | The Mental Health of the Population of Ukraine |
| **Principal Investigator** | Dr. Dmytro Martsenkovskyi, Department of Psychiatry, Bohomolets National Medical University, Ukraine. |
| **Research Team:** | Professor Menachem Ben-Ezra (Ariel University, Israel), Professor Philip Hyland (Maynooth University, Ireland), Professor Thanos Karatzias (Edinburgh Napier University, Scotland), Dr. Elisa Pfeiffer (Ulm University, Germany), Dr. Cedric Sachser (Ulm University, Germany), and Professor Mark Shevlin (Ulster University, Northern Ireland), Dr. Lucy Berliner (Harborview Abuse & Trauma Center, USA), Professor Svitlana Paschenko (Taras Shevchenko National University of Kyiv, Ukraine), Dr. Igor Martsenkovsky (SI Institute of Psychiatry, Forensic Psychiatric Examination and Drug Monitoring of Ministry of Health of Ukraine, Ukraine), Dr. Inna Martsenkovska (SI Institute of Psychiatry, Forensic Psychiatric Examination and Drug Monitoring of Ministry of Health of Ukraine, Ukraine), Professor Olena Venger (I. Horbachevsky Ternopil National Medical University, Ukraine), Professor Yuryi Mysula (I. Horbachevsky Ternopil National Medical University, Ukraine). |

**Research purpose and procedures**:

We are carrying out this study to understand people’s mental health in the context of the ongoing war. We are looking to recruit 2,000 people currently living throughout Ukraine. You are under no obligation to participate but if you choose to do so, the survey will take approximately 30 minutes to complete, and we will ask you questions about:

* Who you are (e.g., your age, where in Ukraine you live, your occupation),
* Stressful experiences you may have experienced during your life, and your mental health experiences related to these events,
* If anyone close to you has died, and your mental health experiences related to this event, and
* If you have children, your children’s mental health.

**Risks and discomforts**:

The questions we will ask you will be of a sensitive nature and may relate to experiences that have been difficult for you, or for your children. If you believe that answering these types of questions will cause you to feel emotionally distressed or upset, please think carefully as to whether or not you would like to participate.

If you participate and find yourself becoming distressed, you may stop and withdraw from the study at any time. We believe, based on years of scientific research in this area, that the risk of becoming distressed is very low. However, at the end of the survey we will provide you with contact details of several charities that provide free mental health services.

**Potential benefits**:

By participating in this study, you will provide very valuable information that will allow us to understand the mental health of Ukrainian people at this time. This will help to plan for mental health care into the future. This information will be published worldwide in reputable scientific journals.

**Provisions for confidentiality and data storage:**

Your responses will be treated with complete confidentiality and all information you provide will be completely anonymous. The research team will never have access to any information that could be used to determine your identity. All your responses will be collected, stored, and used in full compliance with the Law of Ukraine about personal data protection, and the European Commission’s General Data Protection Regulations. All data collected will be stored on password-protected, secured, and networked computers. Following principles of open science, we will share all data collected with researchers across the world so that its value can be maximized. As the data is completely anonymous, there is no chance that the data you provide can ever be linked back to you.

**Voluntary participation and informed consent:**

Participation in this study is voluntary. You can refuse to take part if you want to. If you begin to answer the questions and wish to stop, you may do so at any time. If you decide that you would like to participate in this study, you will be asked to provide informed consent by checking a box. By doing so, you will be provided with access to the survey questions.

**Ethical Approval for this Study:**

Ethical approval for this survey has been provided by SI Institute of Psychiatry, Forensic Psychiatric Examination and Drug Monitoring of Ministry of Health of Ukraine, Kyiv, Ukraine.

**Contact Details of Research Team:**

Should you have any questions prior to, during, or after the research, you may contact the Principal Investigator of the project:

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| Dr. Dmytro Martsenkovskyi, MD., Ph.D, Assistant Professor Department of Psychiatry  Bohomolets National Medical University Email: d.martsenkovskyi@gmail.com |  |
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**Section 1: Demographic information**

1. Were you born in Ukraine? (Including the USSR)

* Yes
* No

1. Where in Ukraine do you currently live?

* Western Ukraine (Lvivska oblast, Ivano-Frankivska oblast, Zakarpatska oblast, Rivnenska oblast, Ternopilska oblast, Volynska oblast, Chernivetska oblast, Khmelnytska oblast)
* North Ukraine (Zhytomyrska oblast, Kyivska oblast, Chernihivska oblast, Sumska oblast)
* Central Ukraine (Vinnytska oblast, Kirovohradska oblast, Poltavska oblast, Cherkaska oblast)
* Eastern Ukraine (Donetska oblast, Kharkivska oblast, Luhanska oblast)
* South Ukraine (Zaporizka oblast, Dnipropetrovska oblast, Khersonska oblast, Odeska oblast, Mykolaivska oblast, Crimea)

1. At any point since February 24th 2022, were you forced to move to another part of Ukraine?

* Yes
* No

1. At any point since February 24th 2022, were you forced to move to another country?

* Yes
* No

1. Has your life been seriously disrupted in any way since the Russian invasion of Ukraine in 2014? (e.g., forced to move, lost property, became disabled, lost loved ones as a result of military actions, etc.)?

* Yes
* No

1. What best describes the area where you currently live?

* Urban area
* Rural area

1. What type of property do you currently live in?

* Apartment
* House
* Hostel
* Collective accommodation center
* Hotel
* Other forms of emergency accommodation

1. What is your sex?

* Male
* Female

1. What is your age? \_\_\_\_\_\_\_\_ years
2. What is your legal marital status?

* Single
* In a relationship but not living with my partner
* In a relationship and living with my partner
* Married
* Separated, but still legally married
* Divorced
* Widowed

1. How many children do you have? \_\_\_\_\_\_\_
2. Do you have a child aged 7 to 17 years?

* Yes
* No

1. What is your highest level of educational attainment?

* Completed mandatory schooling
* Completed general/secondary school
* Completed vocational school
* Completed university

1. What is your current employment status?
   * + - Full-time employed
       - Part-time employed
       - Temporarily unemployed due to the ongoing war
       - Unemployed
       - Student
       - Retired
       - Disability (temporary or permanent)
2. Are you or any of your close relatives currently employed in one of the following occupations?

* Health worker (e.g., doctor, nurse, physiotherapist etc.)
* Emergency and rescue service worker
* Aid worker
* Social services
* Police officer
* Firefighter
* Armed Forces (including Territorial Defense Forces)

1. Thinking about your current financial circumstances, how worried are you about your financial security?

* Not worried at all
* A little worried
* Moderately worried
* Very worried
* Extremely worried

**Section 2: Experiences of trauma and trauma Reactions:** In this section, we will ask you questions about stressful events you may have encountered during your life, and your mental health reactions to these events.

Please indicate if you have experienced any of the following events at any point in your life.

|  |  |  |  |
| --- | --- | --- | --- |
|  | No | Yes -  Once | Yes -  More than Once |
| 1. You were diagnosed with a life-threatening illness. |  |  |  |
| 1. Someone close to you died in an awful manner. |  |  |  |
| 1. Someone close to you was diagnosed with a life-threatening illness or experienced a life-threatening accident. |  |  |  |
| 1. Someone threatened your life with a weapon (knife, gun, bomb etc.) |  |  |  |
| 1. You were physically assaulted (punched, kicked, slapped, mugged, robbed etc.) **by a parent or guardian**. |  |  |  |
| 1. You were physically assaulted (punched, kicked, slapped, mugged, robbed etc.) **by someone other than a parent or guardian**. |  |  |  |
| 1. You were sexually assaulted **by a parent or guardian**. |  |  |  |
| 1. You were sexually assaulted **by someone other than a parent or guardian**. |  |  |  |
| 1. You were sexually harassed (unwanted sexualized comments or behaviours). |  |  |  |
| 1. You were exposed to war or combat (as a soldier or as a civilian). |  |  |  |
| 1. You were held captive and/or tortured. |  |  |  |
| 1. You caused extreme suffering or death to another person. |  |  |  |
| 1. You witnessed another person experiencing extreme suffering or death. |  |  |  |
| 1. You were involved in an accident (e.g., transportation, work, home, leisure) where your life was in danger. |  |  |  |
| 1. You were exposed to a natural disaster (e.g., hurricane, tsunami, earthquake) where your life was in danger. |  |  |  |
| 1. You were exposed to a human-made disaster (e.g., terrorist attack, chemical spill, public shooting) where your life was in danger. |  |  |  |
| 1. Another person stalked you. |  |  |  |
| 1. You were repeatedly bullied (online or offline). |  |  |  |
| 1. You were humiliated, put down, or insulted by another person. |  |  |  |
| 1. You were made to feel unloved, unwelcome, or worthless. |  |  |  |
| 1. You were neglected, ignored, rejected, or isolated. |  |  |  |

1. Please tell us which event you found the most distressing by entering the number that corresponds to that event from the list above: \_\_\_\_\_\_\_
2. How long ago did this event occur (if more than once, please think about the first instance)?

* Less than one month ago
* 1-6 months ago
* 6-12 months ago
* 1-5 years ago
* 6-10 years ago
* More than 10 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. **Please respond to these questions thinking about the stressful event you identified as most distressing**.

Please read each item carefully, then indicate how much you have been bothered by that problem in the past month.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ***Not at all*** | ***A little bit*** | ***Moderately*** | ***Quite a bit*** | ***Extremely*** |
| 1. Having upsetting dreams that replay part of the experience or are clearly related to the experience? | 0 | 1 | 2 | 3 | 4 |
| 2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now? | 0 | 1 | 2 | 3 | 4 |
| 3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)? | 0 | 1 | 2 | 3 | 4 |
| 4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)? | 0 | 1 | 2 | 3 | 4 |
| 5. Being “super-alert”, watchful, or on guard? | 0 | 1 | 2 | 3 | 4 |
| 6. Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 | 4 |
| ***In the past month have the above problems:*** | | | | | |
| 7. Affected your relationships or social life? | 0 | 1 | 2 | 3 | 4 |
| 8. Affected your work or ability to work? | 0 | 1 | 2 | 3 | 4 |
| 9. Affected any other important part of your life such as parenting, or school or college work, or other important activities? | 0 | 1 | 2 | 3 | 4 |

Below is another set of problems that people sometimes experience after very stressful experiences. The questions refer to ways you typically feel, ways you typically think about yourself, and ways you typically relate to others. Please answer these questions continuing to think about the same stressful event.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ***Not at all*** | ***A little bit*** | ***Moderately*** | ***Quite a bit*** | ***Extremely*** |
| 10. When I am upset, it takes me a long time to calm down. | 0 | 1 | 2 | 3 | 4 |
| 11. I feel numb or emotionally shut down. | 0 | 1 | 2 | 3 | 4 |
| 12. I feel like a failure | 0 | 1 | 2 | 3 | 4 |
| 13. I feel worthless. | 0 | 1 | 2 | 3 | 4 |
| 14. I feel distant or cut off from people. | 0 | 1 | 2 | 3 | 4 |
| 15. I find it hard to stay emotionally close to people. | 0 | 1 | 2 | 3 | 4 |
| ***In the past month, have the above problems in emotions, in beliefs about yourself, and in relationships:*** | | | | | |
| 16. Created concern or distress about your relationships or social life? | 0 | 1 | 2 | 3 | 4 |
| 17. Affected your work or ability to work? | 0 | 1 | 2 | 3 | 4 |
| 18. Affected any other important part of your life such as parenting, or school or college work, or other important activities? | 0 | 1 | 2 | 3 | 4 |

**Instructions**: In the previous section you indicated *having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now*? Please take a moment to think of the **most prominent** image or memory that you re-experience as happening again in the present.

1. **Does this image or memory:**
2. Only consist of the same one moment during the same single incident.

Or

1. Sometimes get linked to other moments during the same single incident.

Or

1. Sometimes get linked to moments from other traumatic events or the same event happening on another occasion.
2. **Does this image or memory:**
3. Clearly belong to a specific occasion.

Or

1. Reflect what usually happened across multiple occasions.

Thinking about the most prominent image or memory, please read each statement below and indicate **how true each is for you**?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Almost never true | Rarely true | Occasionally true | Often true | Almost always true |
| 1 | 2 | 3 | 4 | 5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **When this image or memory of the traumatic event (or events) reoccurs…** | | | | | |
| 1. It seems to come out of nowhere. | 1 | 2 | 3 | 4 | 5 |
| 1. I feel it vividly in my body. | 1 | 2 | 3 | 4 | 5 |
| 1. It seems like time stops. | 1 | 2 | 3 | 4 | 5 |
| 1. I feel like I have travelled back in time to when the event (or events) occurred. | 1 | 2 | 3 | 4 | 5 |
| 1. I feel disconnected from the world around me. | 1 | 2 | 3 | 4 | 5 |
| 1. I feel that I am completely unable to control what is happening to me. | 1 | 2 | 3 | 4 | 5 |
| 1. It replays in my mind like a film or movie. | 1 | 2 | 3 | 4 | 5 |
| 1. I see it happening again but I’m watching myself from the outside. | 1 | 2 | 3 | 4 | 5 |

**Instructions**: We want to know how you typicallyfeel about yourself. Please read each statement and indicate how strongly you agree or disagree with each.

|  |  |
| --- | --- |
| 1. **I can’t stop bad things from happening.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I’m a weak person.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I’m powerless to change anything in the world.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **People can easily take advantage of me.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I always feel that something bad is about to happen.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I feel vulnerable in many situations.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I don’t deserve good things to happen to me.**    1. Disagree very strongly    2. Disagree strongly    3. Disagree    4. Agree    5. Agree strongly    6. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **Other people are better and more deserving than me.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I feel like there is something wrong with me as a person.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **Other people will betray me.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I have been left alone in the world.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **Other people will let me down sooner or later.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I feel like I don’t belong.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **It’s difficult to trust other people.**    1. Disagree very strongly    2. Disagree strongly    3. Disagree    4. Agree    5. Agree strongly    6. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **Other people don’t understand me.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **Sometimes I don’t even know who I am.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I feel like a different person from one day to the next.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I often feel like I am broken in some important way.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **Sometimes I don’t even feel like I exist anymore.**    1. Disagree very strongly    2. Disagree strongly    3. Disagree    4. Agree    5. Agree strongly    6. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **I don’t feel like a whole person.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |
| 1. **Sometimes I feel like I’m not even really alive.** 2. Disagree very strongly 3. Disagree strongly 4. Disagree 5. Agree 6. Agree strongly 7. Agree very strongly | Which of the following statements is most appropriate for you?   1. I did not use to feel this way before the traumatic event but I do now. 2. I have always felt this way. |

Below are some experiences people report about themselves. Please read each one and tick the box if it applies to you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Never | Once | Occasionally | Frequently |
| 1. I sometimes feel unusual sensations in my body that I cannot account for. |  |  |  |  |
| 1. I sometimes see or feel myself to be smaller, weaker, younger, or more vulnerable than I really am. |  |  |  |  |
| 1. I sometimes hear one or more voices in my head talking to me, or about me. |  |  |  |  |
| 1. I sometimes experience sudden abrupt changes in mood for no apparent reason. |  |  |  |  |
| 1. I sometimes feel as though I am out of control. |  |  |  |  |
| 1. Sometimes I don’t feel as though I am real or as though I am living in a dream. |  |  |  |  |
| 1. Sometimes I feel detached from my own body. |  |  |  |  |
| 1. I sometimes fail to recognize my own reflection in a mirror. |  |  |  |  |
| 1. Sometimes I feel much lighter or heavier than usual. |  |  |  |  |

**Section 3: Experiences of grief and general mental health:** In this section, we will ask you questions about whether anyone close to you has died, your reactions to this loss, and your mental health in general.

* + - 1. During your life has someone close to you died (e.g., a partner, parent, child, close friend)?
* No
* Yes
  + - 1. People often experience multiple bereavements during their lifetime. Please indicate if you have lost any of the following people:

|  |  |  |  |
| --- | --- | --- | --- |
|  | No | Yes | Yes -  More than One |
| Child |  |  |  |
| Partner or spouse |  |  |  |
| Parent |  |  |  |
| Brother or sister |  |  |  |
| Grandparent |  |  |  |
| Uncle or aunt |  |  |  |
| Cousin |  |  |  |
| Niece or nephew |  |  |  |
| Close friend |  |  |  |
| Colleague |  |  |  |
| Acquaintance |  |  |  |

* + - 1. Which of these affected you the most?
* Child
* Partner or spouse
* Parent
* Brother or sister
* Grandparent
* Uncle or aunt
* Cousin
* Niece or nephew
* Close friend
* Colleague
* Acquaintance
  + - 1. How long ago did this person die?
* Within the last 6 months
* 6 months to a year ago
* 1-2 years ago
* 2-3 years ago
* 3-5 years ago
* 6-10 years ago
* More than 10 years ago
  + - 1. **In the year before their death**, on average how often were you in contact with them? This would include meeting in person as well as telephone calls, video calls, text messages, emails, cards, letters, and contact via social networking sites.
* Every day
* Almost every day
* Several times a week
* Several times a month
* A few times in the year
* Not at all during that year
  + - 1. Can you indicate the nature of the death?
         1. Anticipated natural death (e.g., death after a period of terminal illness)
         2. Unexpected natural death (e.g., cardiac arrest, epileptic seizure, stroke, stillbirth)
         3. Sudden unnatural death (e.g., road traffic accident, murder or manslaughter, work accident)
         4. Suicide
         5. Died in the war (Death directly as a result of military operations (during combat clashes as part of military formations, as a result of shelling of civilian and military infrastructure, etc.)
         6. Other

Below are a number of problems that people sometimes report following the death of a person close to them. Please answer in relation to the bereavement that causes you the most distress.

Using the scale below, please choose the answer that best describes how **bothered** you have been by each of these problems in the past week.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all (1) | A little bit (2) | Moderately (3) | Quite a bit (4) | Extremely (5) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * + - 1. Yearning for the deceased almost every day? | 1 | 2 | 3 | 4 | 5 |
| * This is more than just missing your loved one. It is an intense and painful desire to be with the deceased again. Is this what you felt almost every day over the past week? | Yes | |  | No | |
| * + - 1. Thinking too much about the deceased almost every day? | 1 | 2 | 3 | 4 | 5 |
| * This means thinking so much about your lost loved one that it causes you pain and it interferes with you doing other things. Is this what you experienced almost every day in the past week? | Yes | |  | No | |
| * + - 1. Feeling guilty or angry about my loss. | 1 | 2 | 3 | 4 | 5 |
| * Do you feel like this frequently and does it cause you distress? | Yes | |  | No | |
| * + - 1. Having trouble accepting the death of my loved one. | 1 | 2 | 3 | 4 | 5 |
| * This means that you sometimes find it difficult to come to terms with the fact that your loved one has died, and you wish it were not the case. Is this what you have been experiencing? | Yes | |  | No | |
| * + - 1. Feeling sad or emotionally numb. | 1 | 2 | 3 | 4 | 5 |
| * Are these feelings related to your loss? | Yes | |  | No | |

* + - 1. Would you say these problems have been going on for longer than most people in your social, cultural, or religious context would expect?
* No
* Yes
* I don’t know

6a. Have you heard from friends or loved ones that you had to come to terms with the loss, move on, or *that you have grieved too much or for too long?*

* No
* Yes
  + - 1. Have these experiences caused problems in personal, family, social, educational, occupational, or other important areas of your life?
* No
* Yes

**Over the last several months**, how frequently have you had the following feelings, thoughts, and behaviours? Please circle the appropriate number to indicate your response.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Never | Only a few days | Half the days | Most days | Every day |
| 0 | 1 | 2 | 3 | 4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Felt nervous or anxious? | 0 | 1 | 2 | 3 | 4 |
| 1. Worried a lot about different things? | 0 | 1 | 2 | 3 | 4 |
| 1. Felt physically tense or agitated? | 0 | 1 | 2 | 3 | 4 |
| 1. Felt your heart racing, difficulty breathing, stomach discomfort, or dry mouth? | 0 | 1 | 2 | 3 | 4 |
| 1. Felt ‘on edge’? | 0 | 1 | 2 | 3 | 4 |
| 1. Had difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 1. Been easily annoyed by different things? | 0 | 1 | 2 | 3 | 4 |
| 1. Experienced sleep disturbances? | 0 | 1 | 2 | 3 | 4 |

Have these experiences caused problems in personal, family, social, educational, occupational, or other important areas of your life? Yes No

**Over the last two weeks**, how frequently have you had the following feelings, thoughts, and behaviours? Please circle the appropriate number to indicate your response.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Never | Only a few days | Half the days | Most days | Every day |
| 0 | 1 | 2 | 3 | 4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Felt down or depressed *for most of the day*? | 0 | 1 | 2 | 3 | 4 |
| 1. Experienced less interest or pleasure from normal activities *for most of the day*? | 0 | 1 | 2 | 3 | 4 |
| 1. Have had difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 1. Had feelings of worthlessness or guilt? | 0 | 1 | 2 | 3 | 4 |
| 1. Felt hopeless? | 0 | 1 | 2 | 3 | 4 |
| 1. Had recurrent thoughts of death or suicide? | 0 | 1 | 2 | 3 | 4 |
| 1. Have had changes in appetite or sleep? | 0 | 1 | 2 | 3 | 4 |
| 1. Moved slower or felt more restless? | 0 | 1 | 2 | 3 | 4 |
| 1. Experienced reduced energy or fatigue? | 0 | 1 | 2 | 3 | 4 |

Have these experiences caused problems in personal, family, social, educational, occupational,

Or other important areas of your life? Yes No

1. How often do you have a drink containing alcohol?
   * Never
   * Monthly or less
   * 2-4 times a month
   * 2-3 times a week
   * 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   * 0-2
   * 3 or 4
   * 5 or 6
   * 7 to 9
   * 10 or more
3. How often do you have six or more drinks on one occasion?
   * Never
   * Less than monthly
   * Monthly
   * Weekly
   * Daily or almost daily
4. Have you used any cannabis over the past six months?
   * Yes
   * No
5. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?
   * Never
   * Less than monthly
   * Monthly
   * Weekly
   * Daily or almost daily
6. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?
   * Never
   * Less than monthly
   * Monthly
   * Weekly
   * Daily or almost daily
7. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?
   * Never
   * Less than monthly
   * Monthly
   * Weekly
   * Daily or almost daily

The following questions were designed to explore your memories of your childhood at home and with your family. The following questions are about how you recall your early life up to the age of 18 years. Please complete the scale by circling the most appropriate number under each statement. Up to the age of 18 years………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Never | Very Rarely | Sometimes | Frequently | Always |
| 1 | 2 | 3 | 4 | 5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Up to the age of 18 years……… |  | | | | |
| 1. I felt my parents valued me | 1 | 2 | 3 | 4 | 5 |
| 1. I felt appreciated by my family | 1 | 2 | 3 | 4 | 5 |
| 1. My family listened to me | 1 | 2 | 3 | 4 | 5 |
| 1. I felt that I was an important part of my family | 1 | 2 | 3 | 4 | 5 |
| 1. My family were supportive | 1 | 2 | 3 | 4 | 5 |
| 1. The atmosphere at home was encouraging and supportive | 1 | 2 | 3 | 4 | 5 |
| 1. I felt secure at home | 1 | 2 | 3 | 4 | 5 |
| 1. I knew my parents were looking out for me | 1 | 2 | 3 | 4 | 5 |
| 1. I was happy at home | 1 | 2 | 3 | 4 | 5 |
| 1. If times were tough my family helped me feel better | 1 | 2 | 3 | 4 | 5 |
| 1. My home-life allowed me to feel my life was meaningful | 1 | 2 | 3 | 4 | 5 |
| 1. My family supported me in reaching my goals | 1 | 2 | 3 | 4 | 5 |

**Section 4: Questions about your child’s mental health.** Earlier you told us that you have a child between the ages of 7 and 17 years. In this section we will ask you some questions about your child’s mental health.

If you have more than one child aged between 7 and 17 years, please answer the following questions about only one of your children. Please select the child whose birthday will be next.

1. What age is this child? \_\_\_\_\_\_\_\_\_
2. What is this child’s biological sex?

* Male
* Female

1. Is this child currently living with you?
   * Yes
   * No – living with another parent outside of Ukraine
   * No - living with another parent elsewhere in Ukraine
2. Did you or any medical specialist ever have concerns about your child's normal development (for example, delay in speech development or walking without support)?

* Yes
* No

1. Has your child ever received any psychological or pharmacological support because of his or her emotional or behavioural problems?
   * Yes
   * No
2. Does your child currently need mental health care?
   * Yes
   * No

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark No if it didn’t happen to the child.

|  |  |  |
| --- | --- | --- |
| 1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. | Yes | No |
| 1. Serious accident or injury like a car/bike crash, dog bite, or sports injury. | Yes | No |
| 1. Threatened, hit or hurt badly within the family. | Yes | No |
| 1. Threatened, hit or hurt badly in school or the community. | Yes | No |
| 1. Attacked, stabbed, shot at or robbed by threat. | Yes | No |
| 1. Seeing someone in the family threatened, hit or hurt badly. | Yes | No |
| 1. Seeing someone in school or the community threatened, hit or hurt badly. | Yes | No |
| 1. Someone doing sexual things to the child or making the child do sexual things to them when he/she couldn’t say no. Or when the child was forced or pressured. | Yes | No |
| 1. Online or in social media, someone asking or pressuring the child to do something sexual. Like take or send pictures. | Yes | No |
| 1. Someone bullying the child in person. Saying very mean things that scare him/her. | Yes | No |
| 1. Someone bullying the child online. Saying very mean things that scare him/her. | Yes | No |
| 1. Someone close to the child dying suddenly or violently. | Yes | No |
| 1. Stressful or scary medical procedure. | Yes | No |
| 1. Being around war. | Yes | No |
| 1. Other stressful or scary event? | Yes | No |

1. Which of these event(s) are bothering your child the most now? \_\_\_

Please answer the following questions about any frightening or stressful events that have happened to your child.

Mark 0, 1, 2, or 3 to indicate how often the child has had the following thoughts, feelings, or problems during the past four weeks: 0 = Never / 1 = Sometimes / 2 = Half the time / 3 = Almost always

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Upsetting thoughts or memories about what happened pop into the child’s head. Or the child re-enacting what happened in play. | 0 | 1 | 2 | 3 |
| 2. Bad dreams related to what happened. | 0 | 1 | 2 | 3 |
| 3. Acting, playing, or feeling as if what happened is happening right now. | 0 | 1 | 2 | 3 |
| 4. Feeling very upset when reminded of what happened. | 0 | 1 | 2 | 3 |
| 5. Strong physical reactions when reminded of what happened (sweating, heart beating fast, upset stomach). | 0 | 1 | 2 | 3 |
| 6. Trying not to think about or have feelings about what happened. | 0 | 1 | 2 | 3 |
| 7. Avoiding anything that is a reminder of what happened (people, places, things, situations, talks). | 0 | 1 | 2 | 3 |
| 8. Not being able to remember an important part of what happened. | 0 | 1 | 2 | 3 |
| 9. Having negative thoughts, such as: |  |  |  |  |
| * + A. I won’t have a good life. | 0 | 1 | 2 | 3 |
| * + B. I can’t trust other people. | 0 | 1 | 2 | 3 |
| * + C. The world is unsafe. | 0 | 1 | 2 | 3 |
| * + D. I am not good enough. | 0 | 1 | 2 | 3 |
| 10. Blame for the event(s): |  |  |  |  |
| * + A. Blaming self for what happened. | 0 | 1 | 2 | 3 |
| * + B. Blaming others for what happened even though it wasn’t their fault. | 0 | 1 | 2 | 3 |
| 11. Upsetting feelings (afraid, angry, guilty, ashamed) a lot of the time. | 0 | 1 | 2 | 3 |
| 12. Not wanting to do things he/she used to do. Losing interest in activities he/she used to enjoy. | 0 | 1 | 2 | 3 |
| 13. Not feeling close to people. | 0 | 1 | 2 | 3 |
| 14. Showing or having less happy feelings. | 0 | 1 | 2 | 3 |
| 15. Managing strong feelings |  |  |  |  |
| * + A. Having a hard time calming down when upset. | 0 | 1 | 2 | 3 |
| * + B. Being irritable. Or having angry outbursts and taking it out on others. | 0 | 1 | 2 | 3 |
| 16. Risky behavior or behavior that could be harmful. Doing unsafe things. | 0 | 1 | 2 | 3 |
| 17. Being overly alert or on guard. | 0 | 1 | 2 | 3 |
| 18. Being jumpy or easily startled. | 0 | 1 | 2 | 3 |
| 19. Problems with concentration. | 0 | 1 | 2 | 3 |
| 20. Trouble falling or staying asleep. | 0 | 1 | 2 | 3 |

Please mark YES or NO if the problems you marked interfered with:

|  |  |  |  |
| --- | --- | --- | --- |
| Getting along with others | Yes  No  | Family relationships | Yes  No  |
| Hobbies/Fun | Yes  No  | General happiness | Yes  No  |
| School / work | Yes  No  |  |  |

Below is a list of things you may have observed in your child. Please read each and select the answer that best describes your child **during the past month.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Please mark under the heading that best fits your child | | |
| **Never** | **Sometimes** | **Often** |
| 1. | Fidgety, unable to sit still. |  |  |  |
| 2. | Feels sad, unhappy. |  |  |  |
| 3. | Daydreams too much. |  |  |  |
| 4. | Refuses to share. |  |  |  |
| 5. | Does not understand other people’s feelings. |  |  |  |
| 6. | Feels hopeless. |  |  |  |
| 7. | Has trouble concentrating. |  |  |  |
| 8. | Fights with other children. |  |  |  |
| 9. | Is down on him or herself. |  |  |  |
| 10. | Blames others for his or her troubles. |  |  |  |
| 11. | Seems to be having less fun. |  |  |  |
| 12. | Does not listen to rules. |  |  |  |
| 13. | Acts as if driven by a motor. |  |  |  |
| 14. | Teases others. |  |  |  |
| 15. | Worries a lot. |  |  |  |
| 16. | Takes things that do not belong to him or her. |  |  |  |
| 17 | Distracted easily. |  |  |  |

**Over the last two weeks**, how often did your child have these feelings, thoughts or behaviours?

|  |  |  |  |
| --- | --- | --- | --- |
| Never | Sometimes | Often | Almost always |
| 0 | 1 | 2 | 3 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. My child felt nervous or anxious. | 0 | 1 | 2 | 3 |
| 2. My child worried a lot about different things. | 0 | 1 | 2 | 3 |
| 3. My child felt stressed or upset. | 0 | 1 | 2 | 3 |
| 4. My child felt strong feelings in her/his body (heart beating, difficulty breathing, upset stomach, sweating or dry mouth). | 0 | 1 | 2 | 3 |
| 5. My child felt restless or jumpy. | 0 | 1 | 2 | 3 |
| 6. My child had problems paying attention. | 0 | 1 | 2 | 3 |
| 7. My child felt easily annoyed, grumpy or mad. | 0 | 1 | 2 | 3 |
| 8. My child had trouble falling or staying asleep. | 0 | 1 | 2 | 3 |

Have these feelings, thoughts or behaviours caused problems with:

Getting along with others: Yes No

Hobbies / Fun: Yes No

School or work: Yes No

Family relationships: Yes No

**Over the last two weeks**, how often did your child have these feelings, thoughts or behaviours?

|  |  |  |  |
| --- | --- | --- | --- |
| Never | Sometimes | Often | Almost always |
| 0 | 1 | 2 | 3 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. My child felt sad or unhappy. | 0 | 1 | 2 | 3 |
| 2. My child was bored or didn’t have fun anymore. | 0 | 1 | 2 | 3 |
| 3. My child had problems paying attention. | 0 | 1 | 2 | 3 |
| 4. My child felt worthless or blamed himself/herself. | 0 | 1 | 2 | 3 |
| 5. My child felt hopeless. | 0 | 1 | 2 | 3 |
| 6. My child thought about death or killing himself/herself. | 0 | 1 | 2 | 3 |
| 7. My child had problems with his/her appetite or sleep. | 0 | 1 | 2 | 3 |
| 8. My child was moving slower or felt more restless. | 0 | 1 | 2 | 3 |
| 9. My child had no energy or felt tired (just sat around or did nothing). | 0 | 1 | 2 | 3 |

Have these feelings, thoughts or behaviours caused problems with:

Getting along with others: Yes No

Hobbies / Fun: Yes No

School or work: Yes No

Family relationships: Yes No

* + - 1. Has anyone close to the child you care for ever died (e.g., a parent, grandparent, sibling, close friend)?
* No
* Yes
  + - 1. What was the child’s relationship to the person who died? (Tick any that apply)

|  |  |  |
| --- | --- | --- |
|  | No | Yes |
| Parent |  |  |
| Brother or sister |  |  |
| Grandparent |  |  |
| Uncle or aunt |  |  |
| Cousin |  |  |
| Close friend |  |  |
| Other |  |  |

* + - 1. Which of these affected the child you care for the most?
* Parent
* Brother or sister
* Grandparent
* Uncle or aunt
* Cousin
* Close friend
* Other
  + - 1. How long ago did this person die?
* Within the last 6 months
* 6 months to a year ago
* 1-2 years ago
* 2-3 years ago
* 3-5 years ago
* 6-10 years ago
* More than 10 years ago
  + - 1. **In the year before their death**, on average how often was the child you care for in contact with this person?
* Every day
* Almost every day
* Several times a week
* Several times a month
* A few times in the year
* Not at all during that year

Below are a number of problems that people sometimes report following the death of a person close to them. Please answer in relation to the bereavement that **causes the child you care for the most distress**.

Using the scale below, please choose the answer that best describes how **bothered the child you care for has been by each of these problems in the past week.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all (1) | A little bit (2) | Moderately (3) | Quite a bit (4) | Extremely (5) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * + - 1. They yearn for the deceased almost every day. | 1 | 2 | 3 | 4 | 5 |
| * + - 1. They think too much about the deceased almost every day. | 1 | 2 | 3 | 4 | 5 |
| * + - 1. They feel guilty or angry about their loss. | 1 | 2 | 3 | 4 | 5 |
| * + - 1. They have trouble accepting the death of their loved one. | 1 | 2 | 3 | 4 | 5 |
| * + - 1. They feel sad or emotionally numb. | 1 | 2 | 3 | 4 | 5 |

* + - 1. Would you say these problems have been going on for longer than most people in your social, cultural, or religious context would expect?
* No
* Yes
* I don’t know
  + - 1. Have these experiences caused problems in the child’s life?
* No
* Yes

Below are a number of things that may be observed in your child. Please read each item and choose the answer that best describes your child.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Definitely Agree | Slightly Agree | Slightly Disagree | Definitely Disagree |
| 1. S/he notices patterns in things all the time. |  |  |  |  |
| 2. S/he usually concentrates more on the whole picture, rather than the small details. |  |  |  |  |
| 3. In a social group, s/he can easily keep track of several different people’s conversations. |  |  |  |  |
| 4. If there is an interruption, s/he can switch back to what s/he was doing very quickly. |  |  |  |  |
| 5. S/he frequently finds that s/he doesn’t know how to keep a conversation going. |  |  |  |  |
| 6. S/he is good at social chit-chat. |  |  |  |  |
| 7. When s/he was younger, s/he used to enjoy playing games involving pretending with other children. |  |  |  |  |
| 8. S/he finds it difficult to imagine what it would be like to be someone else. |  |  |  |  |
| 9. S/he finds social situations easy. |  |  |  |  |
| 10. S/he finds it hard to make new friends. |  |  |  |  |

## Participant Debriefing Sheet

Dear Participant,

Thank you for taking the time to complete this survey. The information that you have provided will help us to understand the nature of mental health in Ukraine. If completing this survey caused you to feel upset, you may contact any of the following charitable organisations in Ukraine who provide free telephone or for individuals experiencing mental health distress, or the consequences of trauma:

* LifeLine Ukraine [7333](tel:7333)
* Free Psychological support +380800211444
* Worth to live (VARTOZHYTY) 5522
* Tell me https://tellme.com.ua/
* https://t.me/friend\_first\_aid\_bot

Thank you again for your participation.

Kind regards,

Dmytro

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