UDC 616.891-054.65-036.86-07-08

POST-TRAUMATIC STRESS DISORDER IN A SERVICEMAN AFTER RETURNING FROM RUSSIAN CAPTIVITY (CLINICAL CASE STUDY)

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Key words:
military serviceman, post-traumatic stress disorder.

Clinical and experimental pathology 2023. Vol.22, № 2 (84). P. 88-91.

DOI:10.24061/1727-4338.XXII.2.84.2023.15

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In order to detect disorders in the emotional and volitional sphere in a serviceman, the chest test (ST), a non-burdensome method for detecting anxiety and depression NADS, the PCL-5 scale were used. The questions on this scale reflect the corresponding clusters of PTSD symptoms according to the DSM-5 classification. Clinical-psychopathological and statistical methods were also used.
Using a screening test, it was established that the serviceman experienced severe psychological trauma related to the war, the memories of which are still «unrelenting». Using the NADS test, the patient was diagnosed with clinically expressed anxiety (14 points) and subclinical depression (10 points). Interpreting the results of the study in terms of clinically significant symptoms, in accordance with the PCL-5 scale, it was concluded that according to the total number of points and the sum of points calculated by clusters of symptoms, the serviceman has post-traumatic stress disorder. The patient was prescribed: psychopharmacotherapy (sedative antidepressant amitriptyline (50 mg), anxiolytic miaser (30 mg), anti-anxiety neuroleptic eglonil (50 mg)) and trauma-focused cognitive-behavioral psychotherapy, which increased the patient's resourcefulness. As a result of the treatment, the patient's condition improved within two weeks.

Ключові слова:
військовослужбовець, посттравматичний стресовий розлад.

Клінічна та експериментальна патологія 2023. Т.22, №2 (84). С. 88-91.

ПОСТТРАВМАТИЧНИЙ СТРЕСОВИЙ РОЗЛАД У ВІЙСЬКОВОСЛУЖБОВЦЯ ПІСЛЯ ПОВЕРНЕННЯ З РОСІЙСЬКОГО ПОЛОНУ (СПОСТЕРЕЖЕННЯ З ПРАКТИКИ)

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Чернівецька обласна психіатрична лікарня, м. Чернівці, Україна

З метою виявлення у військовослужбовця порушень емоційно-вольової сфери застосовували скриніг-тест (СТ), необтяжливий метод на виявлення тривоги і депресії НАДS, шкалу PCL-5. Питання по цій шкалі відображають відповідні кластери симптомів постравматичного стресового розладу згідно з класифікацією DSM-5. Також застосовували клініко-психопатологічний та статистичний методи. Застосовуючи скринінгтест встановили, що військовослужбовець пережив тяжку психотравму, пов'язану з війною, спогади про які на сьогодні «не відпускають». За допомогою тесту НАДS у пацієнта встановлена клінічно виражена тривога (14 балів) та субклінічна депресія (10 балів). Інтерпретуючи результати дослідження за клінічно значущими симптомами згідно шкали PCL-5 дійшли висновку, що за загальною кількістю балів та сумою балів, підрахованих за кластерами симптомів, у військовослужбовця наявний постравматичний стресовий розлад. Пацієнту призначено: психофармакотерапія (для покращення настрою – седативний антидепресант амітриптилін (50 мг), анксіолітик міасер (30 мг), нейролептик з антитривожною дією еглоніл (50 мг)) та травмо-фокусована когнітивно-поведінкова психотерапія, що підвищило його ресурсність. Внаслідок проведеного лікування стан пацієнта покращився протягом двох тижнів.

Introduction

The horrifying face of war with long-lasting, constant threats of death evokes extremely intense emotions in all sane people. The anxiety, anger and sadness that most people experience are healthy and normal reactions to warfare, but some soldiers who take part in combat may experience much deeper reactions triggered by war. The war in Ukraine has fundamentally disrupted the sense of security and led to stress, the psychological consequences of which can be dangerous for the healthy future of both adults and children. Traumatic experiences can lead to the development of post-traumatic stress disorder. Post-traumatic stress disorder (PTSD) is a non-psychotic delayed reaction to traumatic stress that can cause a number of mental and behavioural disorders. For PTSD to occur, a person must have experienced a stressor that goes beyond normal human experience and is capable of causing distress [1].

PTSD is an extreme reaction to a severe life-threatening stressor. The incidence of PTSD at the time of an emergency is low. Typically, PTSD begins to manifest itself about six months after a psychological trauma. However, if the stressor has a powerful and long-lasting effect (e.g., being under occupation, constant situations of shelling and air raids, being in captivity, etc.), the likelihood of rapid development of PTSD increases [2].

The psychological consequences of participation in hostilities lead to the fact that in peacetime, due to the heightened sense of justice, increased anxiety, «explosive» reactions that periodically occur in response to any stimuli and depressive states, veterans have disrupted social interaction, family conflicts and problems with returning to work or employment. Such people lose interest in social life and become less active in solving vital problems. Therefore, the multifactorial model of PTSD is more viable [3].

Symptoms of post-traumatic stress disorder do not develop in all people who have experienced distress, but only in about 12-20 % of servicemen who have suffered combat trauma but did not seek psychological help because they feared contempt for showing weakness, cowardice, or threatening their military career, although everyone has the right to emotional experience. However, it is important to note that participation in hostilities leaves a negative emotional impact on a person's consciousness, subjecting it to serious qualitative changes [4].

The length of time spent in the combat zone creates a greater risk of developing post-traumatic stress disorder, which is more likely to be influenced by captivity. Almost all combatants inevitably experience changes in their physical and mental health to varying degrees

The fighting on the territory of Ukraine, which is now a full-scale war, has provoked a wave of psychosocial adaptation problems, in which post-traumatic stress disorder has acquired new qualitative and quantitative characteristics. At any moment, combat stress can manifest itself in various ways. These disorders occur mainly in those servicemen who were on the battlefield, lived in the trenches, were wounded, maimed, witnessed death of their comrades-in-arms, or were taken prisoner. Very often, combatants themselves do not notice mental disorders. But if they are not helped in time, the war will never end for them [5].

Description of a clinical case

A 53-year-old serviceman who signed a contract with the Armed Forces of Ukraine in 2015 and was on rotation at the front line served as a cook until 2019. Later, after undergoing training, he performed the tasks of a grenade launcher. In 2022, while serving in a military unit stationed in Mariupol, he found himself in the epicentre of the war and became a participant in fierce fighting. He lost his friends in the battles and was injured and severely concussed. While at Azovstal, he did not receive full medical care. Despite his injuries, he continued to fight the occupiers until the decision of the Supreme Commander-in-Chief to withdraw from Azovstal.

Together with his comrades-in-arms, he was held captive first in the occupied Donetsk region (in Olenivka), and then in Russia. While in captivity, he suffered abuse and beatings from Donetsk separatists. The only thing left was to endure and pray. There are no atheists in war. Everyone knew this, so they prayed and waited for the exchange. Despite the unbearable conditions of captivity: psychological terror, being fed sour food that was impossible to eat, physical torture for any reason, everyone tried to stick together, helping each other in difficult times. They were especially afraid of the «special executioners» who were on duty, who targeted officers and soldiers for allegedly behaving defiantly – not humiliating themselves in front of them and not «re-educating» them by not betraying their homeland and not accepting the «Russian world». In captivity, everyone was psychologically strong «as much as possible». No one whined or surrendered. There was little information from «ours», but faith in God and the victory of our armed forces kept us afloat. And so it went on for six months. During the exchange, there was so much joy «that our nerves could not stand it», namely: we cried, hugged, called our families, not fully believing that we were «already home». At first, the prisoners were distributed to the medical institutions according to their medical conditions. The first medical facility of the serviceman under study was a neurosurgical unit in Dnipro, then a neurological unit in Lviv, and then Chernivtsi – a neurological unit at the place of residence.

The serviceman's complaints were neurological, namely headaches, periodic dizziness, sleep disturbances, and lower back pain. During his hospitalisation in the admission department, he was irritable, had an explosive outburst, did not want to give the discharge summary from the neurological department of the Lviv hospital, explaining that all discharges «should remain» in the patient's hands, and the hospital should only have copies. The presence of inadequate impulsive behaviour required an examination by a psychiatrist.

Using the clinical and psychopathological method, it was found that the serviceman had no hereditary mental disorders. The subject was orientated in his own person, time, and space. He was available for productive contact, but answered questions slowly with some pauses (obviously thinking over the answers), focusing on the negative, namely stressful events that worried him the most, namely: the dominant feelings of the serviceman for his loved ones – disturbing thoughts about his parents and two children, who, in his opinion, «could not be completely safe» while staying in Ukraine. Therefore, a high level of mental instability was observed emotionally. During the conversation, the patient was easily exhausted with asthenic irritability and outbursts of anger directed towards the enemy. There was an inability to relax due to the feeling of mental pain, which the patient tried to hide, associating it with a physical headache, which clearly caused great anxiety

When applying ST: Have you had any psychological trauma in your life?

– yes – no

How do you cope with them?

– easily – difficult

It was found that the subject answered «yes» to the first question and «difficult» to the second. This means that the serviceman experienced severe war-related trauma, namely the loss of his comrades-in-arms and his time in Russian captivity, the memories of which are still with him.

In order to determine the impact of psychological stress on the patient's mental health, we used the concise HADS scale, a subjective methodology designed for early screening of affective disorders such as anxiety and depression, which is widely used in general medical

ISSN 1727-4338 https://www.bsmu.edu.ua

practice. The questionnaire is easy to administer, does not take long to complete, does not cause complications, and is therefore not burdensome for the patient, while having high discriminant validity for two disorders: anxiety and depression with minimal error. The test revealed clinically pronounced anxiety (14 points) with the following indicators: frequent feelings of tension – 2 points; a sense of fear of something terrible that may happen – 3 points; restless thoughts that constantly run through the mind – 3 points; loss of vigour – 3 points; difficulty relaxing under any circumstances – 3 points.

The subject was also diagnosed with subclinical depression (10 points) according to the following indicators: a feeling of very frequent internal tension and trembling – 3 points; a feeling of restlessness and the need for constant movement – 3 points; a fairly frequent feeling of panic – 3 points; receiving (sometimes) pleasure from watching TV – 1 point, which indicates a neurotic level of anxiety and depression and requires psychological and psychiatric care.

Taking into account the presence of exposure to a traumatic event, the PCL-5 scale was used to confirm the diagnosis of PTSD (PTSD Symptom Checklist). The subject was asked to mark the symptoms that «bothered you a lot» during the last month. The questions on this scale reflect the corresponding clusters of PTSD symptoms according to the DSM-5 classification.

Given that the presence of exposure to a traumatic event (according to criterion A) is mandatory to confirm the diagnosis of post-traumatic stress disorder, the soldier was asked to describe the moment of injury. According to him, he was wounded and contused while performing a combat mission under massive shelling. For some time, he was under a barrage of shelling, lying on the cold ground, until his comrades managed to pull him to safety. He received only the most necessary medical care, realising that his fellow soldiers also needed it, «it was necessary to share medical care», knowing that the availability of medicines and food was limited. While being «trapped» at Azovstal, he realised that «I was alive and thank God» and that his health «will improve later». However, after leaving Azovstal, he was taken prisoner by the enemy, where he experienced psychological torture that was «endless». Despite frequent back pain, he tried to hold on, realising that some of his comrades were in a more «terrible» physical and psychological state.

Intrusions (Criterion B) included: «significantly» (3 points) recurrent, disturbing and unwanted memories of stressful experiences; intrusive «significantly» (3 points) frightening dreams, dissociative reactions (flashbacks); severe psychological distress with a «moderately» pronounced (2 points) feeling of upset when something reminded of the stressful experience and «significantly» pronounced (3 points) physiological reactions (heart palpitations, shortness of breath) when faced with reminders (triggers) of the traumatic event. Thus, with a maximum score of 11 points for criterion B, which is 55 % at a significant level ($p<0.05$), we can assert the presence of a high level of intrusion.

The serviceman did not avoid memories, thoughts and feelings associated with the stressful experience, trying to recall everything to the smallest detail, especially being in «torture» captivity. However, he avoided external stimuli, namely watching events with Russian soldiers on television, which disturbed him «very» much (4 points), thus reminding him of the stressful experience. Thus, having scored 4 points on the maximum indicator of signs according to criterion C, which amounted to 50 % at a reliability level ($p<0.05$), we can state the presence of avoidance symptoms.

Among the negative thoughts and emotions (Criterion D), the serviceman had «significantly» strong (3 points) negative beliefs that it is «difficult to trust anyone in this world», and «very» strong affective reactions prevailed – low mood with negative emotions (4 points), namely, anger directed at the enemies who brought him, his family and friends, his comrades-in-arms and all Ukrainians so much trouble, and heartache and guilt because of the impossibility of revenge «right now». The fighter spoke of a «moderately» pronounced (2 points) loss of interest in his former favourite occupation, namely furniture making, which used to be his passion and pleasure and provided financial support for his family. The experience of positive emotions of joy, love, and happiness (2 points) was also problematic. Thus, having scored 11 points for the maximum indicator of signs according to criterion D, which was 39 % at a reliability level ($p<0.05$), we can state the presence of negative thoughts and emotions.

The serviceman also had symptoms of overreactivity (Criterion E), namely, «significantly» strong (3 points) irritation with outbursts of anger with a «very» strong (4 points) feeling of constant tension. Being «on edge» is a «natural state» for a serviceman today, with a score of «very» high (3 points), indicating a high level of mental instability. Problematic were the «very» frequent (4 points) night wakings due to disturbing dreams and nightmares, which reflected psychological trauma. It seemed «like you were on the front line», and it was «such a habit» not to sleep there. Thus, with a maximum score of 14 points according to criterion E, which was 58 % at a significant level ($p<0.05$), we can state the presence of symptoms of overreactivity.

Thus, interpreting the results of the study by clinically significant symptoms, in accordance with the PCL-5 scale, we concluded that: the total number of points was 40, as well as the calculation of symptom clusters. The patient answered 2+11 points for four questions from criteria B and one question from criterion C with 4 points and four questions from criteria D and E with a total score of 25, which corresponds to the presence of post-traumatic stress disorder in the serviceman.

Given the presence of PTSD, the soldier was prescribed psychopharmacotherapy, namely: eglonil 50 mg to eliminate anxiety, amitriptyline 50 mg to improve mood, anxiolytic miaser 30 mg and psychotherapy in the form of trauma-focused cognitive-behavioural psychotherapy, which helped to eliminate the painful perception of the «really difficult present» and his future in this «unusual» world, as well as inadequate actions in response to the persistence of vital «unfairly problematic situations», thereby removing the «struggle for justice», which increased the patient's resourcefulness. The treatment process took into account that not all injuries, especially combat injuries, are visible and understandable to both combatants and others, but they

all need healing. As a result of the treatment, the soldier's condition improved within two weeks.

Therefore, the timely provision of psychological and psychiatric care to a patient who was injured, held captive, or subjected to torture allows to preserve his mental health and adequate socialization in a peaceful life.

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Стаття надійшла до редакції 09.06.2023
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