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H.M. Kozhyna, A.M. Skrypnikov[1], O.V. Druz[2], K.O. Zelenska, I.O. Chernenko[2]
Kharkiv National Medical University, Kharkiv
[1]Poltava State Medical University, Poltava
[2]National Military Medical Clinical Centre "Main Military Clinical Hospital", Kyiv

CLINICAL AND PSYCHOPATHOLOGICAL FEATURES OF POST-STRESS DISORDERS IN PERSONS WITH HOSTILITIES EXPERIENCE

e-mail:дамkozhyna888@gmail.com

Hostilities is a major cause of combat mental trauma, the development of acute stress and post-traumatic stress disorder, and has a significant impact on the individual. The continuity of war actions in eastern Ukraine is the reason why servicemen are in a multifactorial state of stress, the extreme forms of which are mental changes and disorders. At the same time, the more soldiers experience intense forms of combat stress, the more psychological losses are suffered by units of the Armed Forces of Ukraine. According to the results of the study, all examined patients have the consequences of combat stress, which determines the specifics of the clinical picture of post-stress disorders. The clinical structure of post-stress disorders in the examined patients was represented by: moderate or severe depressive episode without psychotic symptoms (F 32.1, F 32.2) – 14.5 % of the examined group I and 24.2 % group II; anxiety disorders (F 41.0, F 41.1) – 18.4 % and 26.1 %, respectively; post-traumatic stress disorder (F 43.1) – 32.1 % and 28.8 %, respectively; adjustment disorders (F 43.2) – 35.0 % of patients from group I and 20.9 % – from group II.

Keywords: post-traumatic stress disorder, post-stress disorders, combatants, hostilities, mental disorders, volunteers.

Г.М. Кожина, А.М. Скрипніков, О.В. Друзь, К.О. Зеленська, І.О. Черненко

КЛІНІКО-ПСИХОПАТОЛОГІЧНІ ОСОБЛИВОСТІ ПОСТСТРЕСОВИХ РОЗЛАДІВ У ОСІБ, ЯКІ ПЕРЕЖИЛИ БОЙОВІ ДІЇ

Військові дії чинять значний вплив на особистість та є основною причиною бойових психічних травм, розвитку гострих стресових і посттравматичних стресових розладів. Безперервність бойових дій, що тривають на сході України, стає причиною перебування військовослужбовців у поліфакторному стресорному стані, крайніми формами якого є психічні зміни та розлади. При цьому чим більше бійців відчувають інтенсивні форми бойового стресу, тим більше психологічних втрат зазнають підрозділи Збройних сил України. Як показали результати дослідження усі обстежені хворі мають наслідки бойового стресу, що обумовлює специфіку клінічної картини постстресових розладів. Клінічна структура постстресових розладів у обстежених хворих була представлена: депресивним епізодом помірним або важким без психотичних симптомів (F 32.1, F 32.2) – 14,5 % обстежених I групи та 24,2 % II групи; тривожними розладами (F 41.0, F 41.1) – 18,4 % та 26,1 % відповідно; посттравматичним стресовим розладом (F 43.1) – 32,1 % та 28,8 % відповідно; розладами адаптації (F 43.2) – 35,0 % обстежених I та 20,9 % – II групи.

Ключові слова: посттравматичний стресовий розлад, постстресові розлади, комбатанти, бойові дії, психічні розлади, волонтери.

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Military actions have a significant impact on the individual and are the main cause of combat mental trauma, the development of acute stress and post-traumatic sfitress disorders. According to the World Health Organization, about 16 % of the world's population suffers from the effects of military conflict and war, and about 12 % have war-injured family members. Combat mental trauma becomes a direct cause of post-stress disorders in 80 % of hostilities survivors, and in the long-term period are often observed: self-destructive behavior, depression, alcohol dependence, anxiety disorders and other negative consequences [2, 3].

The continuity of hostilities in eastern Ukraine is the reason why servicemen are in a multifactorial state of stress. Its extreme forms are mental changes and disorders. At the same time, the more soldiers experience intense forms of combat stress, the more psychological losses are suffered by units of the Armed Forces of Ukraine (AFU) [6].

Post-stress mental disorders that occur during hostilities are one of the important internal barriers to combat effectiveness and effective performance of professional duties by combatants, and later – to adapt to normal life through the layering of new stresses on this substrate, associated with social maladaptation [8].

The study of the clinical structure specifics, diagnosis, treatment and prevention of post-stress disorders in survivors of hostilities, certainly, is one of the most important social and medical issues of our society. This need is caused by the fact that post-stress disorders not only lead to the suffering of the patient, but also interfere with his personal and social functioning [7, 8].

The purpose of the work was to study the clinical picture of post-stress disorders in servicemen and those who volunteered in armed conflict.

Material and methods. To achieve this purpose, in accordance with the principles of bioethics and deontology, it a comprehensive clinical, psychopathological and pathopsychological examination was carried out in 156 patients with post-stress disorders, both genders (95 men and 61 women), aged 20–55 years. The group I of examined patients included 87 servicemen who took a direct part in hostilities in the Anti-Terrorist Operation (ATO) zone, the group II included 69 servicemen who were involved in volunteer activities related to supporting the servicemen in the combat zone for at least 1 year.

The following examination methods were used: clinical and psychopathological study, which was based on generally accepted approaches to psychiatric examination by interviewing and observation using diagnostic and research criteria by ICD-10 and "Questionnaire to determine the level of psycho-emotional disturbances in military officers" (Kozhyna H.M., Korostiy V.I., Zelenska K.O., Platyniuk O.B.) [4].

The psychodiagnostic method included use of the "Traumatic Stress Questionnaire" (Kotenev O.I., 1996), "Impact of Event Scale-Revised" (IES-R) (Weiss, Marmar, Metzler, 1996), "Clinical Administered PTSD Scale" (CAPS) (Tarabrina N.V.) [11], Mississippi Scale for Combat-Related PTSD (M-PTSD) (Keane T.M., Caddell J.M., Taylor K.L., 1988), Hamilton Anxiety Rating Scale and Hamilton Depression Rating Scale (HAM-A and HAM-D) (Hamilton M., 1959), method "Diagnosis of the level of social frustration" (Wasserman L.I., modified by Boyko V.V., 2002).

Data processing during statistical analysis was performed with a personal computer using a licensed office suite Microsoft Excel and application package Statistica 6.0 (StatSoft Inc., USA). The results are presented as the mean ± representativeness error at a probability level of $p<0.05$.

Results of the study and their discussion. According to the results of the study, all examined patients have the consequences of combat stress, which determines the specifics of the clinical picture of post-stress disorders. Thus, according to the Impact of Event Scale-Revised, 72.2 % of the examined from group I and 70.8 % of the examined from group II had severe clinical manifestations of PTSD.

At the same time, a high level of impact of the traumatic event was observed by all scales of PTSD: invasion (79.6 % of the surveyed from group I and 75.2 % of the group II), avoidance (49.8 % and 54.6 %, respectively) and physiological excitability (34.2 % of examined from group I and 26.9 % of the group II). According to the "Traumatic Stress Questionnaire", 69.5 % of the subjects from group I and 63.5 % of the group II had a complete manifestation of stress disorder – 29.2 % and 33.2 % of the examined - a clear manifestation of stress disorder.

In general, the role of a traumatic event's impact in patients who were in the combat zone was quite large; characterized by a wide range of clinical manifestations; causes disorders in various organs and systems; necessitates further clinical treatment and diagnostic measures. Subthreshold values of the impact of a traumatic event also caused some clinical manifestations.

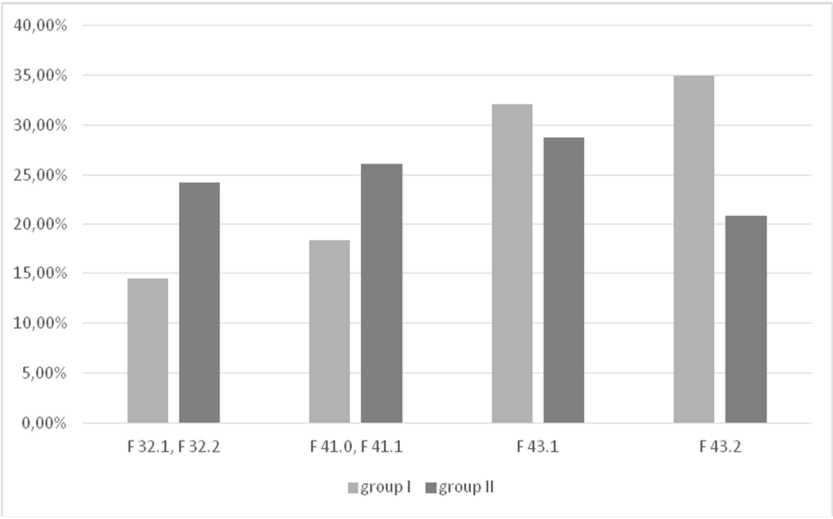

Fig. 1 Structural distribution of the examined patients, (n=156)

For greater information, it was decided to study the presence of clinical symptoms using psychodiagnostic techniques, so in the clinical structure of post-stress disorders in the examined patients was presented: moderate or severe depressive episode without psychotic symptoms (F 32.1, F 32.2) – 14.5 % of examined from group I and 24.2% of patients from group II; anxiety disorders (F 41.0, F 41.1) – 18.4 % and 26.1 %, respectively; post-traumatic stress disorder (F 43.1) – 32.1 % and 28.8 %, respectively; adjustment disorders (F 43.2) – 35.0 % of the examined patients of group I and 20.9% – group II (fig. 1).

In the clinical picture of depressive disorders in the examined patients there is a depressed mood and sadness affect (89.1 % of the group I and 90.2 % of the group II), passive and active suicidal thoughts (56.8 % of subjects from group I and 59.9 % of the group II), feelings of internal tension with inability to

relax, unreasonable anxiety (56.2 % and 61.1 %, respectively), psychomotor retardation (33.5 % of patients from group I and 41.1 % of patients from group II), ideas of self-blame, survivors guilt (35.2 % and 12.6 %, respectively), anhedonia (69.8 % of the group I subjects and 71.1 % of the group II subjects), narrowing of the interests range (82.2 % and 84.5 %, respectively), obsessive memories of combat stress (66.2 % of group I and 70.1 % of group II), asthenic symptoms, feelings of exhaustion (72.2 % and 74.1 %, respectively). According to the Hamilton Depression Rating Scale and Hamilton Anxiety Rating Scale, 69.8 % of patients from group I and 73.5 % of the group II had severe depressive episode, 30.2 % of group I and 26.5 % of the group II with the moderate depressive episode and 55.8 % of the group I subjects and 61.2 % of the group II patients had moderate anxiety episode, 44.2 % and 38.8 % of the examined respectively showed mild anxiety episode.

Anxiety disorders were manifested by unmotivated, persistent, constant anxiety (with generalized anxiety disorder) (54.2 % of group I subjects and 49.8 % of group II) or unpredictable attacks of severe anxiety (panic disorder) (45.8 % and 50.2 % respectively), feelings of danger, threat (45.8 % of the group I and 42.8 % of the group II), unreasonable worried (85.2 % and 83.9 %, respectively), sleep-wake cycle disorders (72.2 % of the surveyed from group I and 79.8 % of group II patients). According to the Hamilton Depression and Anxiety Rating Scales, 43.9 % of the patients from group I and 47.2 % of the patients from group II had a moderate depressive episode, 56.1 % of the examined from group I and 52.8 % of the examined from group II had a mild depressive episode, and 72.1 % of the group I and 77.3 % of the group II had a severe anxiety episode, 27.9 % and 22.7 % of the surveyed had a moderate anxiety episode, respectively.

In post-traumatic stress disorder, there were obsessive memories of combat actions (table 1), which caused depressive feelings, sleep disorders in the form of nightmares, flashbacks, efforts to avoid memories and conversations associated with combat mental trauma, incontinence of affect, dysphoria, apathy, feelings of internal tension with the inability to relax.

Table 1

Clinical symptoms of PTSD in examined patients (%)

Symptom	Group I	Group II
Depressive feelings (experiences)	72.2	76.8
Sleep disorders in the nightmares form	51.1	49.8
Flashbacks	56.2	48.5
Avoiding memories and conversations related to combat mental trauma	42.1	35.6
Incontinence, dysphoria	36.2	25.6
Apathy	29.8	25.6
Feeling of inner tension with the inability to relax	45.3	52.6

According to the Hamilton Depression and Anxiety Rating Scales, 55.2% of the examined patients from group I and 56.9 % of the group II had a severe depressive episode, 44.8 % of the subjects from group I and 43.1 % from the group II had a moderate depressive episode, and 63.2 % of the group I and 65.4 % of the group II had a severe anxiety episode, 36.8% and 34.6% of the examined patients, respectively, had a moderate anxiety episode. At the same time by the Clinical Administered PTSD Scale (CAPS) patient's mental state corresponded to the state of clinically pronounced manifestations of PTSD.

In the clinical picture of adjustment disorders in the examined patients the most frequently observed were low mood and sadness affect (62.8 % of the group I and 71.1 % of the group II), unreasonable anxiety, feeling of internal tension (57.1 % and 62.2 %, respectively), feelings of inferiority (19.1 % of patients from group I and 25.2 % of patients from group II), various fears and worries (33.5 % and 35.9 %, respectively), anhedonia (29.8 % of group I and 31.1% of group II), apathy (33.8 % and 32.9 %, respectively), asthenic symptoms (56.8 % of subjects from group I and 60.2 % of subjects from group II) and autonomic paroxysms (39.2 % and 41.1 % respectively).

According to the Hamilton Depression and Anxiety Rating Scales, 45.3 % of the examined from group I and 46.8 % of the group II had a moderate depressive episode, 44.8 % of the group I patients and 41.0 % of the group II patients had a mild depressive episode, 9.9 % of group I and 11.2 % of the group II had a severe depressive episode, and 13.4 % of the surveyed from group I and 13.3 % of the surveyed from group II had a severe anxiety episode, 49.8 % of the subjects from group I and 52.1 % of the subjects from group II had a moderate anxiety episode, in 36.8 % and 34.6 % of the surveyed, respectively – a mild anxiety episode. These data indicate that patients in group II had slightly more pronounced anxiety symptoms, so we should consider it when prescribing complex treatment.

According to the results of psychodiagnostic examination, the mean value of the severity of stress-associated disorders by the Mississippi Scale for Combat-Related PTSD in the examined patients exceeded its normative value and was 97.8±2.2 points for the examined from group I and 95.6±2.2 for the examined from group II, and their symptoms were ranked as follows: avoidance (55.2 % of group I subjects and 61.1 % of group II subjects, intrusion (52.8 % and 49.9 % of subjects, respectively), hyperarousal (44.2 % of patients from group I and 42.9 % of patients from group II), guilt (39.8 % and 36.5 % of respondents, respectively).

In 68.2 % of the surveyed from group I and in 72.2 % of the surveyed from group II the presence of ultra-high level was noted, in 29.1 % and in 25.3 % of the surveyed respectively the increased level of social frustration, which is caused by combat stress factors: deaths of comrades in front of their own eyes, the need to touch dead bodies, serious injury, the presence of a real threat to life, communication with the wounded. Social frustration is most often manifested by the following signs: disorganization of consciousness and activity in a state of hopelessness, loss of prospects for the future, all of this is a factor that significantly affects the social adaptation of hostilities survivors.

There is evidence in world science that survivors of war develop post-traumatic stress disorder, and distress due to combat experience has certain "targets" of influence. However, the data obtained by us to a greater extent emphasize presence of the clinical structure of post-stress disorders and the peculiarities of the course of each clinical form of these disorders [5, 8]. Also, the research papers of other authors contain references to the clinical picture of post-stress disorders, and although the description is not complete enough, it coincides with the data obtained by us [9, 12].

According to many studies, the clinical symptoms of post-stress disorders significantly affect the tactics and targets of pharmacotherapy and psychotherapy, which is confirmed by the scientific publications of many authors [1, 10].

Conclusion

The clinical structure of post-stress disorders in the examined patients was represented by: moderate or severe depressive episode without psychotic symptoms; anxiety disorders; post-traumatic stress disorder; adjustment disorders.

Based on the data obtained during this study, a comprehensive personalized system of medical and psychological support was developed for survivors of military operations (servicemen who took a direct part in hostilities in the Anti-Terrorist Operation zone and volunteers involved in volunteer activities related to servicemen support in the military zone).

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