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Article

Consequences of Post-Traumatic Stress Disorder: Proneness to interpersonal conflict or depression

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Abstract

Post-traumatic stress disorders (PTSDs) are reported to be among the most prevalent and unfavourable mental disorders in individuals who have gone through life-threatening situations. For decades, they have been standing out against the background of marginal mental disorders. PTSDs are caused by an individual's direct involvement in a stress event, fraught with grave consequences and accompanied by mortal fear, horror, and sensation of powerlessness. The problem is pressing for today's Ukraine in view of the Donbas warfare, mass resettlement, changes of job, and forms of activity. The disorder may be diagnosed as PTSD when groups of symptoms persist more than a month since a traumatic event has occurred.

For a long time, many soldiers have been reported to reveal anxiety-phobic and behavioural disorders, as well as signs of organic cerebral lesion. Some of them occur during combat operations, whereas most symptoms develop and aggravate 1-2 years after coming home. The PTSD patients mostly develop insomnia,

anxiety, depression, and increased aggressiveness, which cause conflicts. An individual may become wicked, aggressive, discontented, and cynical on a social basis. Depressive symptoms are hypothesized to mediate the relationship between PTSD and aggression. The ATO men with PTSD, who do not take alcohol, develop depression 1-1.5 years after coming back and, with alcohol added, the problem of aggression arises. Based on this, we suggest that a staff of personnel, trained in psychological aid to the combatants with PTSD, should be formed. Besides, our cases prove that, with friendly support and compassion as well as being active in life and adequate social work, aggression and proneness to conflict are unlikely to develop. On the contrary, lack of support results in excessive alcohol consumption and, therefore, increased proneness to conflict.

The system of treatment and rehabilitation measures for survivors should involve combination of psychotherapy, psychological correction, and medicines.

Key words: post-traumatic stress disorders, conflicts, aggression, depression

Introduction

Extreme cases, natural disasters and catastrophes have an adverse effect on the psyches of the survivors. They develop post-traumatic stress disorder (PTSD). This is reported to be among the most prevalent and unfavourable mental disorders in individuals who have gone through life-threatening situations. For decades, they have been standing in the background with marginal mental disorders.

"War victims are regarded as one of the highest risk groups for mental disturbances. ... Results showed a high dissatisfaction rate (72%) with living conditions among IDPs. There was also high prevalence of PTSD (54%) and general distress (70%) among IDPs" (Hamid et al., 2010).

Gender distinctions have been found: "Female participants showed more somatic symptoms than their male counterparts. Married participants were more distressed, anxious, and showed more social dysfunction, while single ones reported more avoidance symptoms" (Hamid et al., 2010).

Like the rest of the world, Ukraine is inhabited by large population groups that have been exposed to various extreme events and, therefore, suffering from different mental disorders including PTSDs. Today, with warfare in the eastern regions of the country unleashed and a mass of people involved, the problem is utmost acute. Apart from the combatants, their parents and family members are also involved.

According to statistical data, "PTSD develops in 25-80% survivors of emergency cases. The disorder is supposed to occur in 1-3% of the total worldwide population throughout life, 15% suffering from separate symptoms. PTSD symptoms may persist from a few weeks to more than 30 years" (Voloshin et al., 2002). Varying degrees of PTSD manifestations and few cases of consulting a doctor taken into account, the aspects of each individual PTSD case durations as well as those of subsequent adaptation, development of psychosomatic illness and persistent personality changes, seem to be essential.

Doctors, psychologists, and social workers throughout the world have been involved in researching and analyzing the clinical manifestations of PTSD. However, there is no unambiguous idea as to the PTSD occurrence in the most liable combatants, as well as emergence of major clinical symptom or disorder and duration of PTSD manifestations.

Therefore, the objective of the research is to review the world-wide research findings concerning the emergence of basic clinical symptom, choice of the most adequate treatment mode for the warfare-associated PTSD and to analyze the clinical situations with the PTSD patients who reveal increased proneness to conflict and depression.

Analysis of psychotic disorders in individuals involved in armed conflict

The following clinical symptoms are observed in PTSD (Symptoms of PTSD and their manifestations):

- Unmotivated alertness. An individual keeps a watchful eye on what is going on around as if constantly endangered.
- "Explosive" reaction. An individual reacts swiftly to the slightest surprise (by pivoting and taking a guard at someone approaching from behind).
- Emotional dulling. An individual fails to express emotional manifestations fully or partly, experiencing problems in entering into relations with his fellowmen. Gladness, love, creative enthusiasm, playfulness, and spontaneity are beyond him.

- Aggressiveness. An individual is apt to resort to brute force in settling his problems. Though mostly referring to assault and battery, it may also be the matter of mental, emotional and verbal aggressiveness. A person is aggressively inclined in getting his way, no matter how essential the goal is.
- Memory and attention focusing disorders. It is difficult for an individual to concentrate upon or to recall something. Occasionally, the concentration ability may be perfect but, as a stress factor appears, the person is no more able to concentrate.
- Depression. In the state of post-traumatic stress, depression turns deadly desperate and everything seems senseless and vain. This is concurrent with nervous exhaustion, apathy, and negative attitude toward life.
- General anxiety. It manifests itself physiologically (back ache, intestinal spasm, headache), psychically (constant uneasiness and worry, "paranoid" phenomena – e.g. groundless persecution mania), and emotionally (constant apprehensiveness, self-doubt, guilt complex).
- Paroxysms of rage or moderate fits of anger. Many patients attribute these to the drug or alcohol effect, though free of influence cases have been reported.
- Drug or medicines abuse. In pursuit of relieving post-traumatic symptoms, many patients take marijuana, alcoholic drinks, and drugs.
- Unwanted reminiscences–probably the most significant symptom, indicating PTSD. All of a sudden, ghastly scenes of past traumatic events come back to a patient's memory. They may appear both in one's sleep and in wakefulness. Flashbacks of the past attack the psyche, thus causing severe stress. Post-traumatic "unwanted reminiscences" are accompanied by high anxiety and fear. When occurring during sleep, they are called nightmares. A person wakes up jaded, strained, and sweating.
- Hallucinatory anxiety. This is a specific variety of unwanted reminiscences when actual events are shadowed by recollections of the past and seem to be less real. In this state, an individual is sort of experiencing a previous traumatic event that is acting, thinking, and feeling just the way he was when his life was endangered.
- Insomnia (troubled falling asleep and broken sleep). When a person is tormented by nightmares, he is likely to resist falling asleep involuntarily for fear of experiencing dream anxiety again. Regular lack of sleep is fraught with extreme nervous exhaustion and contributes to the presentation of post-traumatic stress symptoms. Insomnia may also result from high anxiety, inability to relax as well as persistent feelings of physical pain and mental anguish.

- Suicidal ideas. A patient keeps thinking about suicide or planning eventually suicidal actions. When life appears to be intolerable, the very idea of putting an end to the sufferings might seem compelling. When a person is driven to deep despair, with no appropriate ways of improving the situation, suicidal ideas become obsessive.
- "Guilt of survival". Feeling of guilt because of survival in the ordeal, that has become fatal for his fellowmen, is characteristic of an individual with "emotional deafness" (inability to experience joy, love, solace, etc.). Many PTSD patients are ready to do anything to avoid reminding of what they have gone through, in particular, of their fellowmen's deaths.

It is our view that each patient may develop a few of the above-mentioned symptoms, and may occur during uncertain situations.

"Post-traumatic stress disorder (PTSD) is a severe disorder that develops following trauma, and often includes perceptual, cognitive, affective, physiological, and psychological features. PTSD is characterized by hyperarousal, intrusive thoughts, exaggerated startle response, flashbacks, nightmares, sleep disturbances, emotional numbness, and persistent avoidance of trauma-associated stimuli" (Novakovic et al., 2011).

According to scientific publications**,** the diagnosis may be given when a group of symptoms, such as "disturbing recurring flashbacks, avoidance or numbing of memories of the event, and hyperarousal, continue for more than a month after the occurrence of a traumatic event" (Arlington, 2013).

PTSD on one hand and acute reaction to the stress with adaptation disorders on the other hand are differentiated concerning the specifics of clinical presentation, as well as the time of onset and duration of disorders.

In addition, marked sex differences as to the number of PTSD cases have been found: "women are at higher risk than men for developing PTSD following certain types of trauma such as accidents and assaults" (Kobayashi et al., 2013).

Specific weight and correlation significance of the PTSD comorbid and axial symptoms makes it possible to distinguish several PTSD types that are of practical therapeutic importance (Omelianovich, 2003). They are:

(1). PTSD anxiety type (found in 32% of patients) is characterized by a high level of somatic and psychotic unmotivated anxiety at the hypothymic affective

background, with involuntary obsessive flashbacks of a traumatic situation occurring a few times a day. Dysphoric mood (inner discomfort, irritability and tension) is typical. Sleep disorders are marked by troubles falling asleep together with dominating anxious thoughts of one's condition, while fearing for the soundness of sleep and in fear of tormenting dreams (episodes of combat action and violence). The patients often deliberately delay falling asleep, trying to drift off at daybreak. Paroxysmal evening and night-time shortness of air, heartbeat, sweating, chill and surge of hot are typical. Although avoidance of trauma-associated situations remains a dominant motive, the patients resort for help on their own, longing for communication or any sort of relieving activity.

(2). PTSD asthenic type (27% of patients) is characterized by prevailing inertness and feebleness. Depression of spirit with indifference to once interesting events, family relations and work are observed. Passivity is a dominant behaviour trait, while the loss of vivacity is taken hard. The thoughts of one's own incapacity dominate. Flashbacks of psychological traumatic experience occur involuntarily several times a week. However, unlike with the anxiety type, they lack vividity, circumstantiality and sense-feeling, and are defined by the patients as "somewhat obsessive pictures in the mind". Sleep disorders are characterized by hypersomnia (getting up is a real problem) and unhealthy hypnoidal state, sometimes throughout the day. The patients are frank enough and mostly resort for help on their own.

(3). PTSD dysphoric type (21% of patients) is characterized by persistent inner displeasure, irritability, even outbursts of anger and rage with a background of depressed mood. High aggressiveness and propensity to vent the anger on somebody, as well as irritability and quick temper are acknowledged by the patients themselves. Aggressive visions of punishing imaginary offenders, brawls and fights dominate in the mind, frightening the patients and causing them to minimize their social contacts. When rebuked, they display violent reactions, afterwards regretting them. As well, involuntary imaginary scenes of psychological traumatic experiences occur. In addition, scenes of violence with the patients involved are numerous. From outward appearances, the patients are gloomy. The behaviour is that of self-isolation, reticence and taciturnity all of which are typical traits. Personally, they do not complain, their behavioural disorders being noticed by their relatives or colleagues.

(4). PTSD somatoform type (20% of patients) is characterized by massive somatoform disorders, with paroxysm-combined somatic sensations mainly localized in the area of the heart (54%), gastrointestinal tract (36%) and head (20%). PTSD symptoms appear in these patients 6 months after psychological traumatic experiences, thus defining the cases as delayed PTSD variety. Avoidance at the background of panic attacks is typical, the symptoms of emotional stupor and flashback phenomena occurring seldom. Depressive affect is represented by undifferentiated hypothymia with anxiety and phobic inclusions. The ideatory component of the symptom complex is represented by hypochondriacal fixation on bodily sensations and paroxysmal onset with marked expectation anxiety rather than by the hyperexcitation symptoms and psychological traumatic experience.

So, as mentioned above, patients with PTSD may develop insomnia, anxiety, depression, increased aggressiveness that is fraught with conflict situations. Additionally, post-traumatic syndrome reveals itself in anxiety, tribulation, flashbacks, insomnia, depression, etc. Unless treated, the PTSD may evolve into a serious behavioural disorder. For example, an individual may become wicked, aggressive, discontented and cynical on a social basis. "Post-traumatic stress includes irritability, strong agitation, and anger as specific symptoms that frequently co-occur with PTSD" (Taft et al., 2012).

According to the above-listed, PTSD patients basically develop anxiety, depression and sleeplessness. Other researchers regard aggressive behaviour and increased proneness to conflict as prevailing.

Aggressive behaviour is largely associated with post-traumatic stress disorder. "The findings revealed high rates of recent and lifetime aggressive behaviours (39.2% and 57.7%, respectively)" (Flanagan et al., 2014). The authors state that combatants who confirmed aggressive behaviour were younger, less educated, and revealed more severe PTSD numbing and hyperarousal symptoms. They were more likely to report recent suicidal ideas, more frequent alcohol and marijuana intake, had higher rates of physical and sexual violence, more serious involvement in combat actions, and more severe aftermath of battle experiences. The younger combatants who had confirmed lifetime aggression reported more severe PTSD symptoms, recurrent PTSD, severe depression and few stress factors. "Logistic regression analyses indicated that education and the number of drinking days were correlated with recent aggression, while depression and

post-deployment stressors were correlated with lifetime aggression" (Flanagan et al., 2014).

According to the other researchers' findings, war veterans demonstrated prevalence of intermittent explosive disorders associated with trauma, post-traumatic stress disorder, and other psychiatric diagnoses. "Regression analyses revealed lifetime PTSD severity to be a significant predictor of intermittent explosive disorder severity after controlling for combat, trauma exposure, and age. Finally, confirmatory factor analysis revealed significant cross-loadings of intermittent explosive disorder on both the externalizing and distress dimensions of psychopathology, suggesting that the association between intermittent explosive disorder and other psychiatric disorders may reflect underlying tendencies toward impulsivity and aggression and generalized distress and negative emotionality, respectively" (Reardon et al., 2014).

The researchers consider that "former soldiers who report combat-related aggression to be appetitive are more resilient to develop PTSD. Appetitive aggression should therefore prevent widespread mental suffering in perpetrators of severe atrocities even after decades. … Appetitive aggression appears to be a resilience factor for negative long-term effects of combat experiences in perpetrators of violence. This result has practical relevance for preventing trauma-related mental suffering in Peace Corps and for designing adequate homecoming reception for veterans" (Weierstall et al., 2012).

"Aggression is a problem of some combat veterans. Post-traumatic stress disorder is associated with physical aggression in veterans, and co-occurring depression increases the risk of committing aggressive acts. … Depressive symptoms are hypothesized to mediate the relationship between PTSD and four types of aggression: (1) physical aggression toward others, (2) physical aggression toward objects, (3) physical aggression toward oneself, and (4) verbal aggression. … Depressive symptoms indirectly mediated the relationship between PTSD and two forms of aggression: verbal aggression and physical aggression toward oneself. In contrast to some prior studies of intimate partner violence in veterans with PTSD, no mediation relationship between depression and physical aggression toward others was found" (Angkaw et al., 2013).

Browne et al. (2015) think that "… emotional and physical distress related to trauma memories partially mediates the relationship between guilt cognitions and post-traumatic guilt. … Results yielded a significant indirect effect from guilt cognitions to post-traumatic guilt via distress."

We have questioned the combatants – residents of the West Ukraine regions and their family members.

Box 1. The ATO combatant with PTSD manifestations

Patient U., 42 years, volunteered to the ATO in July, 2014. Combat mission as a grenade launcher man in Donetsk airport, Pisky village and "Butovka" mine. Demobilized in August, 2015. Constant depression, sleeplessness (3-4 hours' a day sleep); after coming back home drinks heavily. When drunk, takes ill any critical remark as to his involvement in the warfare, thus instigating conflicts. Loss of friends and family, problems in socialization and finding a job, longing to return to the combat zone. Fully unaware of the actual cost of living and, therefore, unable to adequately measure the desirable salary. Very short working record owing to constant interpersonal conflicts. No outward signs of aggression, rather persistent anxiety and depression.

So, the patient revealed both depressive and aggressive conditions, the data were confirmed by observational findings that were stated above **(**Angkaw et al., 2013).

Box 2. ATO combatant with PTSD manifestations

Patient K., 43 years, volunteered to the ATO in August, 2014 ignoring his disability (prosthetic eye as a result of a 5 year old home accident). Combat mission as a gunner in Pisky village, decoration for services in battle. Back home in December, 2015. No displays of aggression, no alcohol abuse; married, two children. Longing to return to the combat zone. However, he is prevented by family circumstances, drinking heavily. Outbursts of aggression and fighting, which are followed by prolonged depression.

Thus, this case confirms conclusions of Flanagan et al. (2014), when once a calm-tempered person resorts to heavy and aggression-associated drinking following combat mission.

Box 3. ATO combatant with PTSD manifestations

Patient T., 33 years volunteered to the ATO in September, 2014. Back home in September, 2015. Combat mission in Donetsk airport, Pisky village and "Butovka" mine. Decoration for services in battle. At present – abroad, popularizing documentary film on the airport cleansing. No alcohol misuse but sleeplessness as a result of his friend's death on his hands. Continuous depression, no aggressive outbursts.

So, the patient has developed depressive syndrome that correlates with data from Flanagan et al. (2014).Our recent findings suggest that all the ATO men are seized by persistent "alienation complex" and they are unwilling to impose themselves.

Box 4. ATO combatant's mother, PTSD manifestations

Patient M., 50 years. Her son volunteered to the ATO in May, 2015, leaving his wife and seven-month daughter. Since then, any recall of the son or the war makes her weep. She and her daughter-in-law tried to persuade her son to give up the idea of volunteering but he withdrew into himself and stopped communicating. This caused her anxiety, frequent weeping and depression. She retired into herself finding relief in talking on subjects far from warfare. A devoted church attender, a good housekeeper and a careful grandma. No alcohol problems; adequate, though a little decreased working capacity. No aggression towards the people around her.

Box 5. ATO combatant's wife, PTSD manifestations

Patient O., 47 years. Her husband was conscripted in February, 2015 and her mother had died 3 months before. Two powerful stress impacts caused depression. Living with her son, going in for sports and mastering a new trade. No alcohol; sociable, friendly, non-conflictive and diligent.

Besides, the three last cases prove that, with friendly support and compassion as well as being active in life and receiving adequate social work, aggression and proneness to conflict are unlikely to develop. On the contrary, lack of support results in excessive alcohol consumption and, thereof, increased proneness to conflict.

The system of treatment and rehabilitation measures for the survivors should involve psychotherapy, psychological correction, and medicines, their combination being prevalent. The treatment process is supposed to include active therapy, stabilizing therapy and preventive therapy. A six-month course of active treatment should be followed by an up to 12-month stabilizing treatment and three-year prophylactic treatment.

Pharmacotherapy is mostly durable, suggesting combined use of antidepressants, sedatives, thymostabilizers, nootropic agents, β-adenoblockers, antipsychotics and other drugs, antidepressants being of major significance. Antidepressants are administered along with tranquilizers and soporifics, and, if need be, with β-adenoblockers. Preference is given to the antidepressants of selective serotonin and noradrenalin reuptake inhibitors group

as well as to the heterocyclic one, prescribed initial minimal doses being gradually increased until the desired therapeutic effect has been achieved. Tranquilizers are usually administered for 3-4 weeks, and for up to 3 months if particularly needed. Combined sleep disturbance and affective disorders in the clinical presentation suggest short-term intake of soporifics. β-adenoblockers are administered in fractionated doses. According to methodological recommendations of Voloshin et al. (2002), antipsychotic agents are solely taken when the anxiety is accompanied by marked psychomotor agitation and/or mental disorganization, and when the other anxiolytics and sedatives proved to be ineffective.

From the very first day of treatment, the patient and his family ought to be involved in the psycho-educational activities for the purpose of better awareness of the disorder specifics, therapy course as well as of the patient's social rehabilitation. The treatment in a specialized clinic is supposed to result in the patient's recovery.

We adhere to the opinion that psychological and social rehabilitation together with psychoanalysis are more expedient ways of dealing with PTSD patients.

Discussion

As follows from our results, persons with PTSD, who do not take alcohol, develop depression 1-1.5 years after returning and, with alcohol added, the problem of aggression arises. Based on this, we suggest that a staff of personnel, trained in psychological aid to the combatants with PTSD, should be formed. Besides, with friendly support and compassion as well as an active stand in life and adequate social work, aggression and proneness to conflict are unlikely to develop. On the contrary, lack of support results in excessive alcohol consumption and, thereof, increased proneness to conflict.

The system of treatment and rehabilitation measures for survivors should involve a combination of psychotherapy, psychological correction, and medicines.

Thus, post-traumatic stress disorders are a grave problem of today. However, timely finding and adequate therapy are promising in view of improving a patient's condition and are likely to prevent outbursts of aggression and conflicts at the background of alcoholism.

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