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STRESLƏ ƏLAQƏLİ PSİXİ POZUNTUSU OLAN KOMBATANTLARDA DEPRESSİYA VƏ HƏYƏCAN ƏLAMƏTLƏRİ

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Xülasə. Streslə əlaqədar psixi pozuntulara məruz qalmış döyüş iştirakçılarında həyəcanlanma və depressiya əlamətlərinin səviyyəsini öyrənmək məqsədilə tədqiqat aparılmışdır.

Tədqiqata cəlb edilmiş 129 kombatant 3 qrupa bölünmüşdür: 1) adaptasiya pozuntusu olanlar – 36 nəfər; 2) posttravmatik stres pozuntusu (PTSP) olanlar – 63 nəfər; 3) psixi pozuntusu olmayanlar (kontrol qrupu) – 30 nəfər. Qiymətləndirmə məqsədilə MKB-10 meyarlarına əsasən klinik müayinə, Bekin (Beck) həyəcanlanma-narahatlıq sorğusu (Beck Anxiety Inventory) və Bekin depressiya sorğusu (Beck Depression Inventory – II) meyarlarından istifadə edilmişdir. Streslə əlaqəli pozuntuları olan döyüşçülərdə depressiya və həyəcanlanma səviyyəsinin kontrol qrupundakına nisbətən yüksək olduğu müşahidə edilmişdir. PTSP qrupunda depressiya əlamətləri ($27,44 \pm 10,93$) adaptasiya pozuntusu olanlar qrupundakına nisbətən yüksək ($21,89 \pm 13,29$; $p=0,047$) olmuşdur. Ağır depressiya halı PTSP qrupunda pasiyentlərin 39,7 %-də, adaptasiya pozuntusu qrupunda isə – 27,8 %-də bu müşahidə edilmişdir. Həyəcanlanma-narahatlıq səviyyəsi PTSP qrupunda ən yüksək səviyyədə ($35,13 \pm 11,07$) olmuş və adaptasiya qrupunda bir qədər aşağı nəticə vermişdir ($27,57 \pm 16,93$; $p=0,026$). PTSP qrupundakı pasiyentlərdən 93,7%-də, adaptasiya pozulması olan qrupun pasiyentlərindən isə 63,9 %-də güclü həyəcan hissi müşahidə edilmişdir. Narahatlıq səviyyəsi isə PTSP qrupunda daha yüksək olmuşdur. Alınmış nəticələrdən belə məlum olur ki, PTSP olan xəstələr daha çox narahatlıq keçirirlər və hər bir psixi pozuntu növü üçün fərdi şəkildə məqsədyönlü müalicə təyin etmək lazımdır.

Açar sözlər: depressiya, həyəcan, adaptasiya pozulması, posttravmatik stres pozuntusu, müharibə, kombatantlar

Ключевые слова: депрессия, тревога, расстройство адаптации, посттравматическое стрессовое расстройство, стресс, война, комбатанты

Keywords: depression, anxiety, adjustment disorder, post-traumatic stress disorder, stress, war, combatants

DEPRESSIVE AND ANXIETY SIGNS IN COMBATANTS WITH STRESS-RELATED MENTAL DISORDERS

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Summary. A study was conducted to assess the levels of anxiety and depression symptoms in combat veterans who had experienced stress-related psychiatric disorders. The objective is to analyze the severity of anxiety and depression symptoms in combatants with stress-associated mental disorders. The study included 129 combatants divided into three groups: adjustment disorder ($n=36$), post-traumatic stress disorder (PTSD) ($n=63$), and controls without mental disorders ($n=30$). Assessment included clinical interviews based on ICD-10 criteria, Beck Depression Inventory-II, and Beck Anxiety Inventory. Combatants with stress-associated disorders demonstrated significantly higher levels of depression and anxiety compared to

controls. The PTSD group showed higher depression scores (27.44 ± 10.93) than the adjustment disorder group (21.89 ± 13.29 , $p=0.047$). Severe depression was observed in 39.7% of PTSD patients and 27.8% of adjustment disorder patients. Anxiety levels were highest in the PTSD group (35.13 ± 11.07), followed by the adjustment disorder group (27.57 ± 16.93 , $p=0.026$). Most notably, 93.7% of PTSD patients exhibited severe anxiety compared to 63.9% in the adjustment disorder group. While depression severity showed some differences between diagnostic groups, anxiety symptoms were significantly higher in PTSD patients compared to those with adjustment disorders, suggesting the need for targeted therapeutic approaches for each disorder type.

Introduction. According to studies, the prevalence of stress-related mental disorders among combatants ranges from 15% to 50%. The most common are post-traumatic stress disorder (PTSD) and adjustment disorders [1-3].

Combat stress is a complex phenomenon characterized by the impact of multiple traumatic events, including threats to life, loss of comrades-in-arms, physical injuries, and moral trauma. Prolonged exposure to combat conditions leads to the exhaustion of adaptive mechanisms and the development of various psychopathological conditions [4]. Studies demonstrate that the kind and intensity of combat experience directly affects the risk of developing mental disorders, with the most vulnerable being servicemen who have participated in direct hostilities with the enemy or witnessed the death of comrades [5].

PTSD is one of the most serious consequences of combat exposure. This disorder is characterized by constant re-experiencing of the traumatic event through intrusive memories, nightmares and flashbacks, avoidance of trauma-related triggers, negative changes in cognition and mood, and increased reactivity. Adjustment disorders, although considered less severe, also have a significant impact on the quality of life of combatants and may precede the development of more serious mental disorders [6]. The main difference between adjustment disorder and other mental disorders is the impact of a specific external stressor that triggers symptoms and significantly affects a person's ability to cope. The exact nature of the external stressor can vary from a serious accident to bereavement, financial problems, or divorce. Similar to post-traumatic stress disorder, people are aware of a stressor that needs to be identified before a diagnosis can be made [7-8].

Anxiety and depression are among the key signs of stress-related disorders that signifi-

cantly affect combatants' quality of life and social functioning. Anxiety symptoms often manifest themselves in the form of a constant sense of danger, hypervigilance, panic attacks, and somatic symptoms of stress. Depressive symptoms may include depressed mood, loss of interest in normal activities, sleep and appetite disturbances, feelings of guilt and hopelessness [8-10].

The timely diagnosis and assessment of the severity of these symptoms is important for determining treatment tactics and predicting the course of the disease. Studies show that early detection and adequate treatment of anxiety and depressive disorders significantly improve prognosis and reduce the risk of chronicity of symptoms. A differentiated approach to the assessment of symptoms in different stress-related disorders is especially important, as it affects the choice of therapeutic strategies [11,12].

Current research points to complex neurobiological mechanisms underlying the development of anxiety and depressive disorders in combatants. It has been established that prolonged stress leads to structural and functional changes in various parts of the brain, especially in the limbic system and prefrontal cortex. These changes are accompanied by dysregulation of the hypothalamic-pituitary-adrenal axis and changes in neurotransmitter systems, which may explain the persistence of symptoms and the need for a comprehensive therapeutic approach [13,14].

Existing approaches to treating stress-related disorders in combatants include both pharmacotherapy and various forms of psychotherapy. However, the effectiveness of these methods may vary depending on the type of disorder and the severity of individual symptoms. Understanding the peculiarities of anxiety and depressive symptoms in various stress-related disorders can help develop more effective therapeutic strategies.

Despite numerous studies of the mental health of military personnel, the peculiarities of anxiety and depressive symptoms in various stress-related disorders in combatants remain insufficiently studied. This necessitates further research in this area, especially in the context of evaluating the effectiveness of various therapeutic approaches and developing psychological rehabilitation programs.

The objective of the study is to analyze the severity of anxiety and depression symptoms in combatants with stress-related mental disorders.

Materials and methods. The research comprised 129 combatants, 99 of whom were hospitalized for stress-related mental health issues and 30 who received counseling at the Veteran Development Center. A clinical psychiatric interview was conducted for all participants to determine a diagnosis based on the ICD-10 guidelines. The study received approval from the Bioethics Committee at Poltava State Medical University, with the approval number 222, dated 12/21/2023. All participants provided informed consent to participate in the study.

Patients who met the following inclusion criteria were included in the study

- participation in active hostilities since 2022;
- ability to fill out the questionnaires independently;
- informed consent to participate in the study.

Participants with a history or at the time of the study of episodes of alcohol or substance abuse were excluded from the study. All patients received pharmacological treatment of the underlying disease according to the Unified clinical protocol of primary and specialized medical care “Acute reaction to stress. Post-traumatic stress disorder. Adaptation disorders” (Ukraine, 2024).

According to the results of the clinical interview, all participants were divided into 3 groups:

Group 1 – 36 combatants diagnosed with adjustment disorder;

Group 2 – 63 combatants diagnosed with PTSD;

Group 3 – 30 combatants with no clinical signs of mental and behavioral disorders

To assess the severity of depressive symptoms, the Beck Depression Inventory-II (BDI-II) was used (Cronbach's $\alpha = 0.90$). The questionnaire consists of 21 items, each of which is scored on a scale from 0 to 3. The total score ranges from 0 to 63 points, where:

- a) 0-13 points – no or minimal depression,
- b) 14-19 points – mild depression,
- c) 20-28 points – moderate depression,
- d) 29-63 points – severe depression.

The BDI-II covers two main components of depression: affective and somatic. The affective-cognitive component (items 1-13) includes symptoms related to mood and thinking, such as feelings of sadness, pessimism, low self-esteem, loss of interest in activities, and difficulty concentrating. The somatic (autonomic) component reflects the physical manifestations of depression, including fatigue, changes in appetite, sleep disorders, and decreased energy.

To assess anxiety, the Beck Anxiety Inventory (BAI) was used, which contains 21 items, each of which is rated on a scale of 0-3 points (Cronbach's $\alpha = 0.92$). The total score ranges from 0 to 63 points, and its interpretation is as follows:

- a) 0-7 points – minimal anxiety,
- b) 8-15 points – mild anxiety,
- c) 16-25 points – moderate anxiety,
- d) 26-63 points – high anxiety.

The BAI assesses both somatic and cognitive aspects of anxiety, helping to differentiate it from depressive symptoms.

Statistical analysis was conducted using the Jamovi 2.6.2 program. Given the different group sizes, the Kruskal-Wallis test with the Steel-Dwass post hoc test was used to compare quantitative data and the Chi-square test with the analysis of residuals with Bonferroni correction to analyze frequency data.

Results. All study participants were assessed for depressive symptoms, as shown in **Table**.

Table. Severity of depressive syndromes in various stress-related disorders in combatants, $M \pm SD$

Subscale by BDI-II	Group 1 (n=36)	Group 2 (n=63)	Group 3 (n=30)	p-value
Cognitive-affective component	13.36 $\pm$ 7.85	15.65 $\pm$ 7.28	2.67 $\pm$ 4.27	$p_{1-2}=0.534$ $p_{1-3}<0.001$ $p_{2-3}<0.001$
Somatic component	10.52 $\pm$ 5.03	11.79 $\pm$ 4.14	1.86 $\pm$ 2.80	$p_{1-2}=0.632$ $p_{1-3}<0.001$ $p_{2-3}<0.001$
Total score	21.89 $\pm$ 13.29	27.44 $\pm$ 10.93	4.46 $\pm$ 6.70	$p_{1-2}=0.047$ $p_{1-3}<0.001$ $p_{2-3}<0.001$

We found that the level of cognitive-affective component of depression was significantly higher in groups 1 and 2, but there were no significant differences between groups 1 and 2. Similar differences were found when analyzing the severity of somatic component of depression, which were lower in group 3 compared to group 1 and group 2, which did not differ from each other. Nevertheless, the overall severity of depression symptoms in group 2 was higher compared to group 1 and group 3, and in group 1 compared to group 3.

Fig. 1 shows the distribution of depression severity according to the BDI-II scale in the study groups.

As shown in Fig. 1, in group 1, 12 (33.3%) had no signs of depression, 3 (8.3%) had signs of mild depression, 11 (30.6%) had moderate depression, and 10 (27.8%) had severe depression. In group 2, 4 (6.3%) were found to have no signs of depression, 12 (19.0%) had signs of mild depression, 22 (34.9%) had moderate depression, and 25 (39.7%) had severe depression. No signs of depression in group 3 were observed in 27 (90.0%) patients,

mild depression in 1 (3.3%) and moderate depression in 2 (6.7%). Severe depression was not detected in patients of group 3. It was found that the frequency of absence of depression was higher in group 3 compared to group 1 ($p<0.001$) and group 2 ($p<0.001$). At the same time, the absence of depression was observed more often in group 1 than in group 2 ($p=0.001$). The frequency of mild depression did not differ between the groups. The prevalence of moderate depression was lower in group 3 compared to group 1 ($p=0.045$) and group 2 ($p=0.011$). Severe depression was observed only in groups 1 and 2 with no significant differences between them.

The severity of anxiety in group 1 was 27.57 ± 16.93 points, in group 2 - 35.13 ± 11.07 points, and in group 3 - 3.89 ± 4.19 points. It was found that the severity of anxiety in group 2 was higher compared to group 1 ($p=0.026$) and group 3 ($p<0.001$), and in group 1 it was higher than in group 3 ($p<0.001$).

Fig. 2 shows the distribution of anxiety severity according to the BAI scale in the study groups.

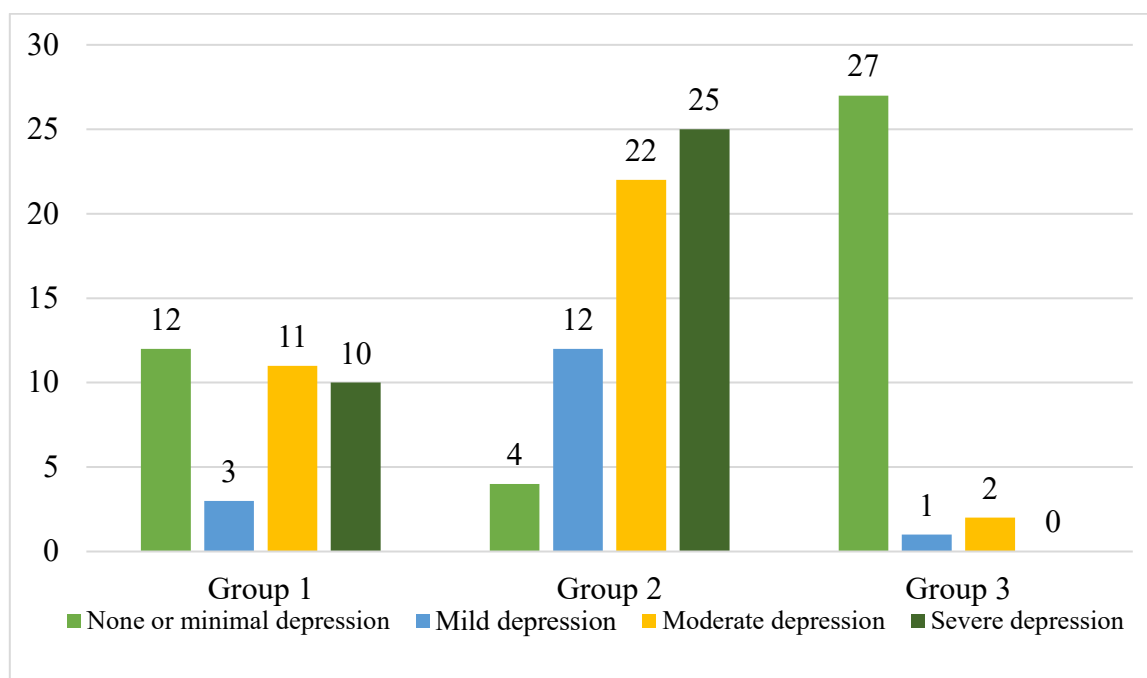


Figure 1. Prevalence of different levels of depression in combatants with and without stress-related disorders

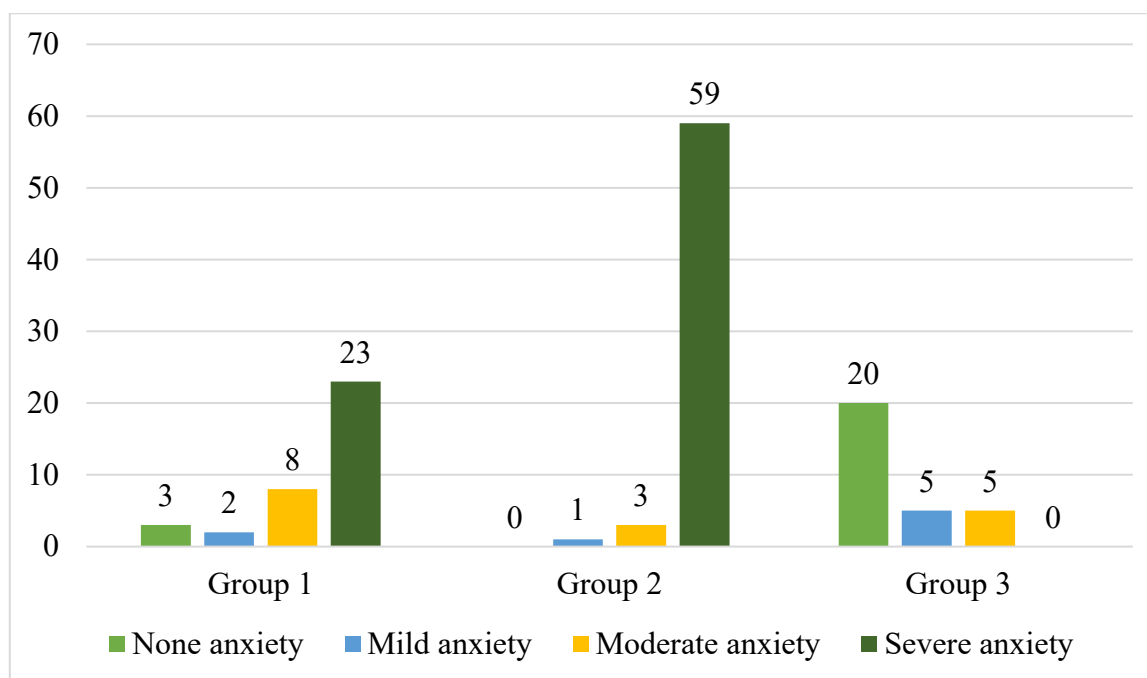


Figure 2. Prevalence of anxiety of different severity levels in combatants with and without stress-related disorders

As shown in **Fig. 2**, the absence of anxiety in group 1 was observed in 3 (8.3%) patients, in group 2 - not observed, and in group 3 - in 20 (66.7%) patients. Mild anxiety was observed in 2 (5.6%) patients in group 1, 1 (1.6%) patient in group 2, and 5 (16.7%) patients in group 3. Moderate anxiety was detected in 8 (22.2%) patients in group 1, 3 (4.8%) patients in group 2, and 5 (16.7%) patients in group 3. Severe anxiety was observed in 23 (63.9%) patients in group 1 and 59 (93.7%) patients in group 2. It was found that group 3 had a higher frequency of detection of absent ($p<0.001$) or mild ($p=0.017$) anxiety compared to groups 1 and 2. At the same time, moderate anxiety was most characteristic of group 1 ($p=0.023$), and severe anxiety was most characteristic of group 2 ($p<0.001$).

Discussion. The present study revealed significant differences in the expression of anxiety and depression in combatants depending on the presence and type of stress-related disorders. The results are in line with current data on the prevalence and characteristics of psychopathological symptoms in military personnel in combat [15].

The key finding of the study was the identification of significantly higher levels of anxiety and depression in combatants with PTSD and adjustment disorders compared to

the control group. These findings correlate with previous studies that have shown that the severity of PTSD is directly related to the severity of anxiety and depressive symptoms [16,17].

It is important to note that this group had a more heterogeneous distribution of symptoms: 33.3% had no signs of depression, while 27.8% demonstrated severe depression. When analyzing the structure of depressive manifestations, no significant differences were found between the groups of PTSD and adjustment disorders in terms of cognitive-affective and somatic components, which may indicate similar mechanisms of development of depressive symptoms in various stress-related disorders. This is consistent with the data on the neurobiological mechanisms of stress-induced depression [18,19].

It is especially important that 93.7% of patients with PTSD demonstrated severe anxiety, which may indicate the need for priority correction of anxiety in this category of patients. Combatants with adjustment disorders also demonstrated increased levels of anxiety and depression compared to the control group, but their scores were lower than in the PTSD group.

Particularly noteworthy is the fact that the control group also revealed cases of mild and

moderate anxiety (16.7% for each level) and depression (3.3% and 6.7%, respectively). This may indicate subclinical manifestations of stress-related disorders in combatants that do not meet the diagnostic criteria for disorders [20,21].

The identified patterns are important for clinical practice. First, the high incidence of severe anxiety in PTSD (93.7%) indicates the need for active use of anxiolytic drugs and psychotherapy methods aimed at reducing anxiety symptoms. Second, the variety of manifestations in adjustment disorders emphasizes the importance of an individualized approach to therapy [22,23].

Limitations of the study include the relatively small sample size and the lack of assessment of symptom dynamics over time. In addition, the influence of factors such as the duration and intensity of combat experience was not taken into account, which may be important for understanding the pathogenesis of stress-

related disorders [24,25].

The findings can be used to develop specific therapeutic protocols and programs for the psychological rehabilitation of combatants. Promising areas for further research include the study of predictors of severe anxiety and depression, as well as the evaluation of the effectiveness of various therapeutic approaches, taking into account the identified features of the clinical course.

Conclusions. It has been found that combatants with adjustment disorders and PTSD have higher levels of depression and anxiety compared to those without stress-related mental disorders. No differences in the severity of depressive symptoms were found in combatants with stress-related mental disorders, but it was found that adjustment disorder is characterized by less severe depression compared to PTSD. At the same time, combatants with PTSD had higher levels of anxiety than those with adjustment disorders.

Conflict of interest. The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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ДЕПРЕССИВНЫЕ И ТРЕВОЖНЫЕ ПРОЯВЛЕНИЯ У КОМБАТАНТОВ СО СТРЕСС-АССОЦИИРОВАННЫМИ ПСИХИЧЕСКИМИ РАССТРОЙСТВАМИ

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Резюме. Проведено исследование с целью проанализировать выраженность симптомов тревоги и депрессии у участников боевых действий со стресс-ассоциированными психическими расстройствами. В исследование были включены 129 комбатантов, разделенных на три группы: 1) расстройство адаптации (n=36), 2) посттравматическое стрессовое расстройство (ПТСР) (n=63) и 3) контрольная группа без психических расстройств (n=30). Оценка включала клиническое интервью на основе критериев МКБ-10, опросник депрессии Бека (Beck Depression Inventory-II) и опросник тревоги Бека (Beck Anxiety Inventory). Бойцы со стресс-ассоциированными расстройствами продемонстрировали значительно более высокие уровни депрессии и тревоги по сравнению с контрольной группой. В группе ПТСР показатели депрессии были выше (27,44±10,93), чем в группе расстройств адаптации (21,89±13,29, p=0,047). Тяжелая депрессия наблюдалась у 39,7% пациентов с ПТСР и у 27,8% пациентов с расстройством адаптации. Уровень тревоги был самым высоким в группе ПТСР

(35,13±11,07), за ней следовала группа расстройств адаптации (27,57±16,93, $p=0,026$). Примечательно, что 93,7 % пациентов с ПТСР демонстрировали сильную тревогу по сравнению с 63,9 % в группе расстройств адаптации. В то время, как тяжесть депрессии имела незначительные различия между диагностическими группами, симптомы тревоги были значительно выше у пациентов с ПТСР по сравнению с пациентами с расстройствами адаптации, что указывает на необходимость целенаправленных терапевтических подходов для каждого типа расстройств.

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