

Acute Stress Reactions and Disorders in Participants of the war in Artsakh

Sukiasyan SG^{1,2*}, Tadevosyan MYa^{1,4}, Babakhanyan AA¹ and Grigoryan AK³

¹Medical Rehabilitation Center «Artmed», Department of Mental Health Rehabilitation «Stress», Armenia

²Armenian State Pedagogical University Named after Kh. Abovan, Armenia

³Yerevan State University, Armenia

⁴Yerevan State Medical University Named After M. Heratsi, Yerevan, Armenia

***Corresponding Author:** Sukiasyan SG, Medical Rehabilitation Center «Artmed», Department of Mental Health Rehabilitation «Stress», Armenia.

Received: March 04, 2022; **Published:** April 28, 2022

Abstract

Relevance: Psychological trauma, stress-related disorders are the main problem in modern psychiatry, particularly acute stress disorder (ASD), post-traumatic stress disorder (PTSD). In the conditions of fifth generation modern wars, combat trauma has a special meaning and content, reflected in the nature of mental disorders.

The Aim: To examine the main forms of psychopathological disorders among 44-day Artsakh war participants.

Material, Methods: 104 war veterans aged 18-50 were examined with clinical-psychopathological, laboratory, instrumental, psychological methods (SCL-90-R, Mississippi PTSD scale, Shmishek Personality Scale).

Results: Identified; ACD 77 patient (74%), depressive, psychotic disorders etc 27 participants (26%). Among them 39 (37.5%) had PTSD at the earliest stage of pathological development. The most frequent type of personality accentuation was exalted type (69 people, 66.3%). There are significant links between combatants' age, military duty type, hospital admission period (SCL-90-R scale, Mississippi scale of personality). Predictively and statistically significant symptoms were identified.

Discussion: All forms of psychopathological disorders were because of an unusual combat trauma, which, in the current case is characterized by «invisibility, inaccessibility of the source of trauma, its reality, tangibility». Boundaries between post-trauma clinical manifestations are amorphous, overlap, chronological criteria do not correspond to ICD and DSM. Combat trauma is a catalyst factor for all posttrauma disorders.

Conclusion: The uncommon trauma criteria lose its value. PTSD and ACD chronological criteria do not correspond to clinical reality. ASD, PTSD problem differentiation is appeared. The data obtained allow us to speak of peritraumatic stress disorders, uniting all posttrauma disorders.

Keywords: *Combat Trauma; Trauma Predictors; Risk Factors; ASD; PTSD; Peritraumatic Stress Disorder*

Introduction

Throughout human history, wars large and small, mass bloodshed, destruction, acts of terrorism, violence have periodically arisen, which have created and continue to create an atmosphere of disorder, chaos, tension, forcing people to experience the horrors of unforeseen suffering, injury, loss and death. This chaos is fraught with physical and, especially, mental trauma for those who are directly exposed to trauma, who are present at the suffering and death of other people, at the destruction of the physical environment, as a result of the horror and helplessness that are caused by the totality of these events-experiences [1]. At the same time, psychic trauma can occur in isolation or in combination with physical trauma.

As a stressful phenomenon, psychic trauma is characterized by three main features - criteria: it occurs suddenly and unexpectedly, it threatens the life and psychophysical integrity of the organism and personality, and the trauma is outside the normal everyday life experience. Our research allows us to add a fourth criterion, which will be discussed later.

The problem of psychic trauma and post-traumatic disorders is an actual problem of modern psychiatry [2-4]. At the same time, combat trauma and its acute stress reactions and post-traumatic stress disorders are of particular relevance. There are still no clear theoretical concepts that define approaches to the study of the psychological and biological mechanisms of the development of post-traumatic disorders. Frequent natural and even more frequent anthropogenic disasters, unusual "sociogenic" events (terrorist acts, hostilities, wars), changes in the environmental situation are accompanied by deep traumatic experiences, cause the multifactorial and polymorphic nature of post-traumatic disorders, the study and systematization of which has become the imperative of the times [2,5].

In this article, we will talk about acute stress disorder (ASD), post-traumatic stress disorder (PTSD), concepts that are presented in both world classifications. However, given a number of features of the emergence and development of these disorders in the participants of the 44-day war in Artsakh, we prefer to talk about peritraumatic disorders that do not quite meet the rather controversial criteria for post-traumatic disorders according to ICD-10 and DSM-5, and we will try to justify this form. traumatic disorders.

Relevance

Speaking of psychic trauma and its consequences, we mean the reactions that arose as a result of an event of an extreme nature, an event that went beyond the limits of ordinary human experiences, causing them intense fear, horror, a feeling of helplessness [6,7]. In the ICD-10, these reactions are defined as "acute stress reactions" (ASR) [8], in DSM-5 as "acute stress disorder" (ASD) [9]. In terms of clinical criteria and manifestations, these disorders are very close and similar, but there is a difference in the chronological criteria - for ASR 48 hours after exposure to trauma and 72 hours for ASD. In this study, we proceeded from the DSM-5 criteria, since, like most scientific studies, evidence-based recommendations, many psychological scales and tests were developed mainly on the basis of the criteria of the American classification.

A combat injury, unlike a number of other injuries, is not only just stress, not even just extraordinary stress, as noted in the classifications of mental disorders. This phenomenon is more voluminous and massive. This is a mental, and physical, and social, and moral trauma. This is a trauma that affects all the deep and "superficial" foundations and layers of the personality and the individual, his socio-psychological and biological essence. Combat trauma occurs during combat operations, but continues (with unfavorable dynamics) throughout the life of the combatant. Moreover, it has a destructive effect on subsequent generations, both through the mechanisms of social inheritance (the reason is in special relationships in the families of veterans) [10], and the possible genetic inheritance of acquired pathological changes. In the aspect of combat trauma, different wars are usually considered in the literature: the Vietnamese and Afghan wars, the

war in the Gulf, the Iraqi Desert Storm campaign, and the Falkland Islands war. At the same time, there are similarities between them and smaller-scale, more localized military conflicts. Many studies have shown that the intensity of a combat injury erases the individual and personal characteristics of the victims and contributes to the development of post-traumatic disorders in the future, which can develop in extreme situations in almost every person [11].

Our analysis of the manifestations of post-traumatic disorders in the participants of the first Karabakh war showed that a prerequisite for the occurrence of PTSD is the presence of extreme stress against the background of additional factors that determine the nature of the disorder (psychogenic, exogenous, exogenous-organic, endogenous, constitutional), which complicate the picture of the disease and cause the development of comorbid pathology [11].

The pathogenetic mechanisms of OSR development remain largely unknown. Questions remain open as to why After a traumatic event, some people develop ASD and others do not, why some ASD develops into PTSD, others do not. However, despite this, some conceptual models and scientific studies shed light on the role of a number of factors in the development of post-traumatic disorders. There is an opinion that dissociative symptoms, such as impaired consciousness, memory, motor skills, identity or awareness of the body, self or environment in response to trauma, are a key factor in maladaptive reactions to trauma. Dissociation of trauma memories and associated affect interferes with the processing of these responses and thus leads to subsequent PTSD [12].

Despite the fact that mental trauma is singled out as the main criterion for diagnosing ASD, but in varying degrees of severity, it can precede other mental disorders, both as an etiological factor, and as a concomitant, and as an indifferent one. Trauma can cause, in addition to post-traumatic, also depressive, anxiety, dissociative, personality disorders. Trauma can also cause cognitive impairment, perceptual pathology, and somatic symptoms. These data cast doubt on the leading role of psychic trauma as the main factor in the development of ASD and PTSD.

The issue of differentiation and verification of risk factors for the occurrence and development of ASD remains debatable. As such, most of which are also associated with PTSD [6] the presence of a mental disorder is highlighted history, family, female gender, genetic and neuroendocrine factors, personality traits, early traumatization, negative upbringing experience, low level of education, trauma severity, neuroticism, avoidance behavior, stressor intensity, preparedness for unexpected events and reactions to them, severity of symptoms, availability of social support. But these factors have been assessed by psychological tests in survivors of trauma. A different picture is possible when testing and persons before the impact of trauma. These studies carried out on the firefighters, revealed certain individual differences in reactivity to stressors, learning difficulties, a tendency to catastrophic thinking. In a traumatic situation, these people show worse results.

The participants in the hostilities in Afghanistan and those who are in a combat situation for a long time, A.L. Pushkarev., *et al.* [13] identified a number of simultaneously or sequentially influencing factors: 1) a clearly perceived feeling of a threat to life; 2) pronounced stress of a direct participant in hostilities, as well as psycho-emotional stress associated with the death in front of comrades in arms or the need to kill people; 3) the impact of specific factors of the combat situation; 4) hardships and hardships of wartime; 5) climatic conditions. An extraordinary mental trauma leads to a restructuring of the personality and a global reassessment of its entire value system: physical, mental, spiritual, social.

Quite controversial is the problem of the injury itself as a necessary and sufficient conditions (predictor) for the development of ASD and PTSD [14]. Questions of possible predictors of RSD are discussed. The literature lists a huge number of predictors, controversial and

reliable, clinical and dynamic, personal and non-personal [15-18]. From the point of view of Paris J. [14], personality traits can be considered as predictors of ASD and PTSD. Gunderson JG and Sabo AN [19] showed that what vulnerable to ASD development may be considered individuals with borderline personality disorder who have limited resources to resolve traumatic experiences. The need to study the role of protective psychological mechanisms, in particular, a positive orientation to the future, in predicting traumatic stress is emphasized. In fact, SSRs describe the state of individuals who have experienced extraordinary stress, and, by definition, Bryant R.A., are “a moderate predictor of late post-traumatic stress disorder” [11]. A Spanish-Swedish research group [7] identified 130 potential risk factors based on 33 systematic reviews and meta - analysis. Of these, 57 showed a significant association with PTSD. Among them are socio - demographic factors (women, Native Americans), pre- traumatic factors (history of somatic and mental illnesses, in the family), peri - traumatic factors (cumulative impact of potentially traumatic experiences, severity of trauma, hopelessness of the situation).

Clinical practice shows that the “limiting criterion of duration” (i.e., symptoms that appear within the first 48 hours according to the ICD-10 criteria [8] and 72 hours according to the DSM - 5 criteria [9]) is valid only in 10% of victims. At least in relation to ICD-10, the question of revising the guidelines is being raised. According to DSM-5 [9], ASD lasts up to 3 days and is accompanied by dissociative symptoms that dominate the clinical picture of the disorder. Dissociation, as a violation of the integration of mental activity, includes a feeling of isolation and loss of connection with reality, insensitivity, derealization, depersonalization and dissociative amnesia. In cases where the stress disorder lasts up to 4 weeks, dissociation is considered as a predictor of PTSD.

As far as the clinical picture of PTSD is understood and studied, the clinical manifestations of ASD are just as variable and unstable, which are described by different authors as psychologically understandable reactions, as states manifested by psychovegetative disorders with a pronounced emotional component, as states of emotional shock, confusion, dissociative disorders, etc., with equally variable clinical symptoms (intrusive memories, avoidance behavior, etc. [20], distancing from people, dullness of emotions, intense psycho-vegetative manifestations, irascibility and aggressiveness, increased sensitivity and vulnerability, sleep disturbances, nightmares, perceptual sensations (smells of smoke, gunpowder, blood, sweat, combustible materials), attention deficit [21], decreased working memory and attention [22], symptom of “ short future “.

Longitudinal studies show that a high level of acute stress indicates a high risk of subsequent health problems [23].

Goals and objectives of the study. The purpose of this study was to study the main forms of psychopathological disorders detected in the participants of the 44-day Artsakh war, the severity of these disorders and their nosological forms in veterans who are hospitalized in the mental health rehabilitation department “Stress”. The task was to study the possible correlations and interdependencies between the severity of the injury, the nature of the hostilities and the personal and psychopathological profile of the combatants, to study the issues of predicting acute stress disorders and PTSD, the degree and nature of psychopathological disorders, and also to determine the nosological framework of known stress - related disorders. The task was also set to investigate the problem risk factors for post-traumatic disorders and highlight symptoms specific to these disorders.

Material and Methods

We examined 104 patients - participants in the war in Artsakh, aged 18 to 50 years, whose average age was $29.98 \pm 8,17$ years old. Socio-demographic characteristics of the examined patients are presented in table 1.

| N | Parameter | Quantity surveyed | |
|------|--|--------------------------------|--------------------------------------|
| | | Abs. | % |
| one | Number of examined | 104 | 100.0 |
| 2 | Live in cities | 62 | 59.6 |
| 3 | Live in villages | 42 | 40.4 |
| 4 | Education: <ul style="list-style-type: none"> • the average • specialized secondary • incomplete special • higher | 49 6 2 47 | 47.1 5.8 1.9 45.2 |
| five | Type of service (military responsibilities) : <ul style="list-style-type: none"> • urgent • officers • contractors • volunteers • mobilized | 21 33 eleven 17 22 | 20.2 31.7 10.6 16.3 21.2 |
| 6 | Family status <ul style="list-style-type: none"> • married • single | 57 47 | 54.8 45.2 |

Table 1: Socio-demographic characteristics of the examined patients.

All patients underwent a complete clinical-psychopathological, psychological, laboratory examination, and instrumental examination is also necessary. The average length of stay of combatants in the hospital was 24.6 days (min = 6, max = 57). The main instruments of psychological examination were:

1. Mississippi PTSD scale, military variant. Clinical test method developed in 1987 by Keane T.M., *et al.* [24] to assess the severity of post-traumatic stress disorder in combat veterans. The scale contains statements reflecting the state of people who have experienced a traumatic situation and includes three main scales (intrusions, avoidance, excitability), as well as questions describing symptoms related to guilt and suicidal tendencies. The scale has high sensitivity and specificity in diagnosing PTSD in individuals with mental disorders. It is intended to confirm the diagnosis of PTSD in the appropriate population and assess the severity of the disorder. Theoretical foundations, internal structure, clinical significance, interpretation of the scale are presented in the monographs of Tarabrina N.V [25].
2. G. Shmishek’s personal questionnaire is designed to diagnose the type of personality accentuation [26]. Using this technique, 10 types of personality accentuation are determined (according to the classification of K. Leonhard): demonstrative, pedantic, stuck personality type, excitable, hyperthymic, dysthymic, anxious-fearful, cyclothymic, exalted, emotivic [27].
3. Symptomatic questionnaire SCL-90-R (Simptom Check List-90-Revised) is a clinical test and screening technique designed to assess patterns of psychological signs in individuals with mental disorders, as well as in healthy individuals [28]. The structure, calculation of results, interpretation, clinical significance of the questionnaire are presented in the monographs of Tarabrina N.V. [25].

The present study involved combatants with acute mental disorders that arose immediately after a combat injury. They were admitted to the mental health rehabilitation department “Stress” of the MRC “Artmed” within 1 - 12 days after traumatization. Clinico-psychopathologically, 77 combatants (74%) were diagnosed with acute stress disorders (F43.0), and 27 (26%) combatants were diagnosed with acute psychotic disorders (F22, F23), depression (F32), mental disorders due to damage or dysfunction of the brain (F06) in the form of affective, anxiety and dissociative disorders, personality and behavioral disorders due to illness, damage and dysfunction of the brain (F07), anxiety - phobic (F40), anxiety disorders (F41). Our study shows that combat stress does not always cause ASD, and PTSD symptoms appear already 1 - 2 weeks after the injury, at least the symptoms of ASD are difficult to differentiate from the symptoms of PTSD. That is, the diagnosis of ASD does not adequately identify the majority of people who eventually develop PTSD. There is a need to formally describe a wide range of initial acute stress responses. These results are to a certain extent consistent with the opinion prevailing in the literature that combat trauma can cause both the development of acute stress disorder and PTSD, as well as non-specific “post-traumatic” types of reactions to extreme stress - depressive, anxiety, obsessive-compulsive and others. forms of reactions and psychological consequences (acute stress disorders, fear, pain, unexplained physical symptoms, family problems). Shalev AY, *et al.* [29] they underline that ... any ... herb ma maybe ... OS false thread Xia depression ... or PTSD. Assessment of acute mental reactions to traumatic events is an important marker for morbidity and mortality associated with mental trauma, which requires long-term monitoring and/or early intervention [23].

In a number of cases, as clinical practice shows, in the course of military operations, acute transient psychotic disorders are observed in injured soldiers. They are interpreted as psychogenic disorders because they largely meet the criteria for psychogenic, reactive disorders. But in a number of cases, it becomes necessary to differentiate them with schizophrenic or affective spectrum disorders, since a high risk of subsequent development of schizophrenia, schizophrenic spectrum disorders, and bipolar affective disorder is revealed [24,30].

Disorders of extreme stress (Disorders of extreme stress not otherwise specified - DESNOS), the development of which is associated with such factors as trauma in early childhood and participation in atrocities in the war zone, an extreme level of experience of obsessive trauma, insufficient characterological functioning, etc [31]. In the context of the principles underlying modern classifications, PTSD is just a syndrome - a typical non-specific pathological condition that can occur in the structure of various mental disorders.

Examination of our patients with the Mississippi PTSD scale revealed that 39 combatants (37.5%) had PTSD, which is not consistent with the chronological framework of the DSM-5 and ICD-10. The severity of PTSD according to the Mississippi scale in the examined patients showed a wide range - from 54 points to 139 (mean level - 106.65 ± 19.91). The survey results are presented in table 2.

| N N | Parameter | Number of examinations | |
|-----|------------------------------|-------------------------------------|---------------------|
| | | Abs. | % |
| | Patients with PTSD | 39 | 37.5 |
| | Patients without PTSD | 62 | 59.6 |
| | Not response | 3 | 2.9 |
| | The severity of the disorder | Min - 54 points Max - 139 points | M±m 106.65±19.91 |

Table 2: Results of the Mississippi PTSD Scale.

We can assume that combat trauma in these cases acts not as a specific etiological, but as a provoking or catalyzing factor. The “post-stress response” that follows this stress manifests itself from psychological forms of defense in the form of affective, dissociative forms of impaired consciousness, acute shock (stress) reactions of a “non-personal” nature, through adaptation disorders of an already “personal”

nature to cerebrasthenic, neurosis-like, psychopathic, psycho-organic syndromes, the formation of which depends on many external and internal factors. It is noted in the literature that the more severe the “to- catastrophic assessments” of the consequences of trauma in the initial period after traumatic exposure, the higher the possibility of developing PTSD. And negative and exaggerated assessments of a traumatic event, the severity of symptoms, and expressed beliefs about a possible future illness increase the likelihood of developing PTSD. The onset of PTSD symptoms so early in the posttraumatic period in our patients, perhaps due to a combination of psychic trauma with craniocerebral, barotrauma in the combat zone, as some authors say [32]. But Yurgil., *et al.* [33] note that even a history of TBI can be a predictor of the development of PTSD in military personnel. Although our patients did not have any indications of traumatic brain injury, with the exception of barotrauma.

The most common type of personal accentuation was exalted (69 people, 66.3%) in pure and combined variants, less often were anxious (12 people, 11.5%) hyperthymic (7 people, 6.7%) and demonstrative types (6 people, 5.8%). The results obtained are presented in table 3.

| N | Parameter | Abs. | % |
|-------|-------------------|------|-------|
| | Demonstrative | 6 | 5.8 |
| | Stuck | 1 | 1.0 |
| | Excitable | 1 | 1.0 |
| | Hyperthymic | 7 | 6.7 |
| | Distymny | 2 | 1.9 |
| | Alarming | 12 | 11.5 |
| | Exalted | 69 | 66.3 |
| | Emotive | 1 | 1.0 |
| | Cyclothymic | 1 | 1.0 |
| | Pedantic | 0 | 0 |
| | Not gave response | 4 | 3.8 |
| Total | | 104 | 100.0 |

Table 3: The results of the examination according to the Shmishek personality questionnaire.

Persons of the exalted type are distinguished by high plasticity, intensity and variability of emotional reactions. They easily fall from one extreme to another, go from a state of delight to a state of sadness, react violently to any events. At the same time, emotional experiences are accompanied by pronounced vegetative and somatic reactions: trembling, cold sweat, tachycardia, suffocation, etc. Exalted persons are more altruistic than egoists ; they tend to be empathetic and compassionate. In a stressful situation, they show such maladaptive reactions as dependence on mood swings, weakness of self-control (irritability, irascibility, impatience), anxiety and panic, avoidance of difficulties, a tendency to self-blame, selfishness.

Miller M.W. [34] data are associated with the noted features. In a review on the influence of personality on the development, course and behavioral expression of PTSD, analyzing the literature in connection with three broad-range personality traits such as negative emotionality (NEM), positive emotionality (PEM) and limitation/inhibition CO), the author came to the conclusion that that high negative emotionality is the main personal risk factor for the development of PTSD, while low inhibition of emotionality, positive emotionality serve as deterrents. From these positions, the author believes that a premorbid personality, characterized by high negative emotionality

combined with low positive one, predisposes the trauma-prone individual to an internalizing form of post-traumatic reaction, characterized by pronounced social avoidance, anxiety and depression.

According to Iranian researchers [35], the most common personality disorder among veterans with PTSD identified by the Millon Clinical Multi-axial Questionnaires 3 (MCMI-III) was borderline personality disorder (17.9% versus 4.8% in veterans without PTSD). Other types were identified less frequently – avoidant type 10.4% and 1.9% respectively, affiliated type 10.4% and 0%, pessimistic type 7.5% and 1.0%.

The relationship between borderline personality disorders and the spectrum of post-traumatic disorders has been pointed out by Dell’Osso L., *et al.* [36]. In the development of PTSD, personality traits are also given importance by Anestis, J. C., *et al.* [37]. They note that personality traits associated with a deficit of emotionality, empathy and inhibitory control may be adaptive in certain situations, maladaptive in others. The authors showed that the relationship of combat traumatic impact with PTSD decreases as the frequency of interpersonal-affective psychopathic traits increases.

Mattson E., *et al.* [38] showed that the attitude of personality (coping style) to trauma determines post-traumatic outcomes: while adaptive coping with trauma and positive personality traits, such as openness, were positively correlated with post-traumatic growth, and maladaptive coping and neuroticism were positively correlated with symptoms of PTSD. Higher neuroticism predicts lower reactivity to stress, greater reduction in positive affect, and lower subjective controllability. Individuals with higher levels of extraversion showed less of an increase in negative affect. In addition, a higher openness score was associated with a lower stress response to cortisol. These data indicate that personality trait dimensions such as neuroticism, extraversion, and openness are associated with various aspects of the stress response.

Descriptive statistics of SCL - 90 parameters are presented in table 4. The most pronounced indicators were identified in terms of somatization (1.8 ± 0.19), depression 1.8 ± 0.10 and anxiety (1.73 ± 0.22).

| Parameter | Minimum | Maximum | Average value | Standard - no deviation |
|-----------------------------------|---------|---------|---------------|-------------------------|
| • Somatization (Som) | 1.10 | 2.20 | 1.8317 | 0.19120 |
| • Obsession (O - C) | 1.10 | 2.00 | 1.5337 | 0.17660 |
| • Interpersonal Sensitivity (int) | 0.90 | 1.50 | 1.1731 | 0.11925 |
| • Depression | 1.60 | 2.00 | 1.8154 | 0.09831 |
| • Anxiety | 0.16 | 2.20 | 1.7333 | 0.22244 |
| • Hostility (Hos) | 1.20 | 2.10 | 1.5173 | 0.18299 |
| • Phobic Anxiety (Phob) | 0.80 | 1.80 | 1.3240 | 0.20832 |
| • Paranoid Tendencies (Par) | 0.80 | 1.80 | 1.0173 | 0.18085 |
| • Psychoticism (Psy) | 0.00 | 1.70 | 0.9154 | 0.23014 |

Table 4: Descriptive statistics of SCL parameters - 90 – R.

The “somatization” scale reflects the distress arising from the sensation of bodily dysfunction. The scale includes complaints from all organs and systems, pain sensations and somatic equivalents of anxiety. The symptoms of the “somatization” scale can indicate both the presence of a psychogenic disorder and the manifestation of real somatic diseases. The depression scale reflects a wide range of manifestations of clinical depression: depressed mood, dysphoria, anhedonia, loss of meaning, impotence, suicidal tendencies, regardless of etiology, nosology and structure. The anxiety scale consists of a number of symptoms that clinically associated with a high level of manifest

anxiety. The main symptom is anxiety with all its components: anxiety, tension, fussiness, a sense of impending threat and danger, motor excitation, tremor.

Research Results

Analysis of the relationships between the parameters of the Mississippi PTSD scale, the Shmishek questionnaire and SCL-90-R and a number of demographic indicators was carried out by the method of group comparisons (T Student and one-way ANOVA). A low level of PTSD ($t(99) = 2.155, p = 0.034$) was found in the group of married combatants ($M = 111.23, SD = 18.86$) compared with unmarried combatants ($M = 102.82, SD = 20.124$). Statistically significant differences were also found in the severity of PTSD in groups with different types of military service ($F(4.96) = 3.149, p = 0.018$). They were the highest among conscripts ($M = 119.8, SD = 11.546$) compared with officers ($M = 105.27, SD = 19.504$), volunteers ($M = 103.35, SD = 20.208$), mobilized ($M = 100.52, SD = 22.479$). In other words, the most severe manifestations of PTSD were noted among conscripts, as the youngest, not burdened with family problems and not wiser with life experience. These links will be presented below. Statistically significant differences were not found in the place of residence (urban, rural) and the level of education.

Analysis of the relationship between the parameters of the Mississippi PTSD scale and SCL-90-R, carried out by the method of correlation analysis using the Pearson formula, revealed strong positive relationships between the severity of PTSD and scales "somatization" ($r = 0.422^{**}, p < 0.0001$), "compulsion" ($r = 0.573^{**}, p < 0.0001$), "interpersonal sensitivity" ($r = 0.462^{**}, p < 0.0001$), "depression" ($r = 0.603^{**}, p < 0.0001$) and "hostility" ($r = 0.400^{**}, p < 0.0001$). At the same time, an inverse relationship with phobic anxiety is found ($r = -0.196^{**}, p = 0.049$). At the same time, stepwise regression analysis revealed that, in addition to a pronounced correlation between the above parameters, the SCL-90-R scales "depression" ($\beta = 0.425, p < 0.0001$), "obsession" ($\beta = 0.352, p < 0.0001$) and "hostility" ($\beta = 0.273, p < 0.0001$) are contingent on PTSD. The explanatory value of the model is 55.4% (adjusted $R^2 = 0.554$). The obtained data testify that the development of PTSD at 55.4% is due to the presence of depressed mood, obsessive phenomena in the psychopathology of the developing disorder, and aggressive tendencies in patients.

In the literature on post-stress disorders, the problem of predicting ASD and PTSD, risk factors for post-traumatic disorders is actively studied, specific symptoms for ASD and PTSD, as well as symptoms that are predictors of the possible development of PTSD, are highlighted. These questions were also addressed in the present study. We looked for correlations between the length of stay of combatants in the hospital, that is, the duration (more precisely, effectiveness) of therapy, the duration of the period from injury to hospitalization (that is, the period during which the combatant did not receive specialized medical care), the age of patients and the SCL-90-R scales, in other words, between the main symptoms disorders, psychopathological status of patients. Correlation analysis revealed a number of significant relationships. Thus, it turned out that the age of patients is a factor determining the length of stay in the hospital: the older the age, the earlier they were discharged from the hospital ($r = -0.271^{**}, p = 0.005$). In turn, the length of stay in the hospital showed a strong positive relationship with the scales SCL-90-R "compulsiveness" ($r = 0.369^{**}, p < 0.0001$), "interpersonal sensitivity" ($r = 0.256, p = 0.009$) and "depression" ($r = 0.267, p = 0.006$). This suggests that, in addition to depressed mood, "delay" in the hospital is also facilitated by obsessive phenomena, personal characteristics - a sense of one's own inadequacy and inferiority, discomfort in interpersonal communication, negative expectations in relationships with other people; continuous, irresistible and alien "I" thoughts, impulses and actions.

The symptoms of post-stress disorders, including the symptoms of PTSD on the Mississippi scale, were in reverse relationship with the age of the combatants ($r = -0.251^*, p = 0.011$), which allows us to assume that the younger the combatant, the more severe and pronounced the clinical manifestations of post-stress disorders of the acute period and the symptoms of PTSD.

Analysis of the features of relationships in patients with and without PTSD with SCL-90-R scales, length of stay in hospital, period of time, previous hospitalization and age was carried out using the Pearson formula. It was shown that younger patients, regardless of the

presence or absence of PTSD symptoms, stayed longer in the hospital ($r_1 = -0.335^*$, $p = 0.028$; $r_2 = -0.407^{**}$, $p = 0.002$). In the group of patients with PTSD, a strong inverse relationship was found between the age of patients and the duration of the period from injury to hospitalization. This suggests that younger patients with PTSD have higher stress tolerance and are later admitted to the hospital for treatment ($r = -0.409^{**}$, $p = 0.007$). Later (delayed from the moment of injury) admission of combatants to a hospital was inversely correlated with a high level scale "obsessiveness" according to SCL-90-R ($r = -0.231^*$, $p = 0.018$) and the severity of PTSD according to the Mississippi scale ($r = -0.319^{**}$, $p = 0.001$). The severity of PTSD according to the Mississippi scale is inversely related to anxiety ($r = -0.224^{**}$, $p = 0.022$), phobic anxiety ($r = -0.275$, $p = 0.003$) and the age of the respondents ($r = -0.387$, $p < 0.0001$). That is, the young age of the combatants correlates with the severity of the symptoms of the disorder; the more severe the clinical picture of PTSD, the less pronounced anxiety-phobic symptoms, such as nervousness, tension and trembling, panic states, a sense of danger, fears and fears, irrational reaction reactions.

As noted above, 27 (26%) combatants were diagnosed not with acute psychotic disorders, depression, dysfunctional mental disorders and personality and behavioral disorders due to somatic diseases or disorders of the brain, anxiety-phobic, anxiety disorders. Comparison of these two diagnostic groups (with and without acute stress disorders) according to the SCL-90-R scales revealed differences in psychotic scales - "paranoia" ($t(102) = 2.153$, $p = 0.039$) and "psychoticism" ($t(102) = 2.369$, $p = 0.02$). At the same time, these scales were most pronounced in the group of combatants with psychotic disorders ($M_{\text{paran}} = 1.09$, $SD = 0.242$; $M_{\text{psycho}} = 1.003$, $SD = 0.129$), while in the group of combatants with acute stress disorders, the severity of the scales was less: paranoid $M = 0.99$, $SD = 0.145$, psychotism $M = 0.88$, $SD = 0.227$). The data obtained are quite understandable and adequate. The "paranoia" scale in the questionnaire reflects the type of thinking disorders. Its cardinal characteristics are: hostility, suspicion, propensity for supervalues, fear of loss of independence, distrust, need for protection. Characterized by fixation on one's self and its overestimation, delusions of attitude, jealousy, rigidity of judgments, a tendency to interpretive delusions, pronounced sensitivity to failures and rejections. The scale "psychoticism" reflects the tendency of the individual to distort reality, there is an obvious discrepancy between the behavior of the surrounding reality, the subjectivity of perception and assessment of reality, immersion in the world of one's own ideas.

Differences between the diagnostic groups in terms of types of personal accentuation. Analysis of the results obtained on the personality questionnaire from Shmishek, showed that in the vast majority of cases (Table 2) patients were found to have exalted traits (69 people, 66.3%) in pure and combined variants, which allowed us to conditionally distinguish two groups: 1) patients with exalted character traits and 2) patients with non-exalted traits (31 people, 29.8%). Four questionnaires (3.8%) turned out to be invalid. Persons of the exalted type are distinguished by high plasticity, intensity and instability of emotional manifestations. They react violently to any events, falling from one extreme to another. Their psychological experiences are accompanied by pronounced somato-vegetative reactions. The exaltation of behavior is mostly motivated by altruistic tendencies in the personality than by egoistic ones; they tend to be compassionate to the point of despair. In a stressful situation, they show such maladaptive reactions as dependence on mood swings, weakness of self-control (irritability, irascibility, impatience), anxiety and panic, avoidance of difficulties, a tendency to self-blame, selfishness.

Based on the hypothesis that the type of personality accentuation is a possible predictor of post-stress disorder, we undertook a study of the relationship between the type of personality accentuation (according to the Shmishek personality questionnaire) and the SCL-90-R scales, the Mississippi PTSD scale and socio-demographic parameters. The analysis was carried out on two selected groups - persons with exalted accentuation and not exalted ones. Data from statistical analysis are presented in tables 5-7. As follows from Table 5, the identified positive relationships between the SCL-90-R scales, between the SCL-90-R scale and the Mississippi PTSD scale are not due to the exalted type of personality accentuation.

In both groups (Table 5), correlations were found between the parameters on the scales within the SCL-90-R symptomatic questionnaire, between SCL-90-R and the severity of PTSD according to the Mississippi scale, and in the group of exalted combatants, between the SCL-90-R scales and some socio-demographic parameters, such as the relationship between length of stay in the hospital and the scales SCL-90-R "anxiety" ($r = -0.278^*$, $p = 0.016$), "phobic anxiety" ($r = -0.272^*$, $p = 0.018$), with age of combatants ($r = -0.424^{**}$, $p < 0.0001$), as

well as a positive relationship with the severity of PTSD on the Mississippi scale ($r = 0.329^{**}$, $p < 0.004$), between interpersonal sensitivity and hostility ($r = 0.425$, $p < 0.0001$), interpersonal sensitivity and length of hospital stay ($r = 0.293$, $p < 0.01$), interpersonal sensitivity and anxiety ($r = 0.330^*$, $p = 0.004$). In the group of non-exalted patients, no such relationships were found, which indicates that the noted interdependencies are due to a certain extent to exalted dispositions of the personality.

| N | Parameter | Group exalted | | Group not exalted | |
|---|--|---------------|---------|-------------------|---------|
| | | R | P | R | P |
| | Somatization – PTSD | 0.373** | 0.001 | 0.521 | 0.009 |
| | obsession - interpersonal sensitivity | 0.427** | 0.0001 | 0.549* | 0.004 |
| | obsession – depression | 0.237* | 0.04 | 0.700** | <0.0001 |
| | obsession – PTSD | 0.455 | <0.0001 | 0.835** | <0.0001 |
| | Interpersonal _ sensitivity - psychotism | 0.267* | 0.021 | 0.666** | <0.0001 |
| | Interpersonal _ sensitivity – obsession | 0.427** | <0.0001 | 0.549** | 0.004 |
| | Interpersonal _ sensitivity – PTSD | 0.425** | <0.0001 | 0.613** | 0.001 |
| | Depression – PTSD | 0.421 | <0.0001 | 0.893** | <0.0001 |
| | Hostility – PTSD | 0.329** | 0.004 | 0.541** | 0.006 |
| | PTSD - duration of stay in b-tse | 0.272* | 0.019 | 0.426* | 0.038 |

Table 5: Positive correlations with the SCL-90-R scale, the Mississippi PTSD scale, and socio-demographic parameters in individuals with exalted accentuation and without exaltation.

At the same time, such relationships as “depression - hostility” ($r = 0.543^{**}$, $p = 0.005$), “depression - psychotism” ($r = 0.529$, $p = 0.007$), “depression - length of hospital stay” ($r = 0.417^*$, $p = 0.038$) are due to non-exalted personality accentuations (Table 6).

| Persons with an exalted personality accentuation | | | |
|---|---|----------|---------|
| N | Parameter | r | p |
| | Obsession - length of hospital stay | 0.383** | 0.001 |
| | Interpersonal sensitivity – hostility | 0.425** | <0.0001 |
| | Interpersonal sensitivity - length of stay in the hospital | 0.295* | 0.01 |
| | Somatization – depression | 0.278* | 0.016 |
| | Interpersonal sensitivity – anxiety | -0.330** | 0.004 |
| | Length of hospital stay – anxiety | -0.278* | 0.016 |
| | Length of hospital stay - phobic anxiety | -0.272* | 0.018 |
| | Length of hospital stay – age | -0.424** | <0.0001 |
| | Hostility - phobic anxiety | -0.249* | 0.031 |
| | PTSD – age | -0.237* | 0.042 |
| Persons with non-exalted personality accentuation | | | |
| N | Parameter | r | p |
| | Obsession – hostility | 0.478* | 0.016 |
| | Obsession – psychotism | 0.482* | 0.015 |
| | Interpersonal Sensitivity – Depression | 0.480* | 0.015 |
| | Interpersonal Sensitivity – Paranoia | 0.538** | 0.006 |
| | Depression – hostility | 0.543** | 0.005 |
| | Depression – psychotism | 0.529* | 0.007 |
| | Depression - duration stay | 0.417* | 0.038 |
| | Somatization – hostility | 0.629** | 0.001 |
| | Somatization – paranoia | 0.430* | 0.032 |
| | Phobic anxiety - period before hospitalization | -0.414* | 0.039 |

Table 6: Relationships between the SCL-90-R scales, the Mississippi PTSD scale and socio-demographic parameters in individuals with exalted personality accentuation and in individuals with non-exalted personality accentuation.

The observed relationships in the group of exalted patients obviously correlate with such clinical manifestations of depression as symptoms of anhedonia, feelings of hopelessness, lack of interest in life, decreased motivation, vitality, suicidal thoughts, as well as cognitive and somatic correlates of depression. And in the group of non-exalted patients, in which persons with anxious, hyperthymic and demonstrative features dominated, affective-neurotic symptoms and demonstrativeness were detected. Anxious individuals were dominated by features of uncertainty, indecisiveness, low self-esteem, constant doubts about the correctness of their actions and thoughts, which do not have visible reasons, the desire to smooth out conflicts and avoid them. These are mostly timid and submissive people, but in extreme cases they compensate for their timidity with self-confident and defiant behavior. On the other hand, hyperthymic faces are characterized by activity, vigor, optimism, and high vitality. Distinguished by talkativeness, violently experiencing failures, frivolous attitude to rules and duties; impulsive, fussy, prone to adventurism, fickle in interpersonal relationships, promiscuous in contacts. Persons of a demonstrative type are sociable people, focused on their own success and recognition in any conditions, prone to overestimating their personality and their own capabilities. They are jealous and envious people. They can conflict, lie and manipulate people, do not differentiate between reality and fiction. These personality traits can actually be seen as predictors of post-stress disorder. As such, the results obtained allow us to consider the scales “into hostility” and “paranoia” SCL-90-R that includes thoughts, feelings, or actions affective-negative content, including aggressive behavior, irritability, anger and resentment.

In order to identify differences in the SCL-90-R scales in patients with and without PTSD, according to the Mississippi scale, an analysis was carried out according to the Student’s T formula for independent groups. The difference between the two groups was revealed in many parameters (Table 7).

| N | Parameter | Mississippi PTSD scale | |
|---|--|------------------------|-------------------|
| | | +PTSD | -PTSD |
| 1 | Somatization (t(99) = -3,338, p=0.001) | M =1.90, SD=0.178 | M =1.79, SD=0.158 |
| 2 | Obsession (t(99) = -5,260, p<0.0001) | M =1.63, SD=0.142 | M =1.46, SD=0.169 |
| 3 | interpersonal sensitivity (t(99) = -5.033, p<0.0001) | M =1.24, SD=0.122 | M =1.13, SD=0.933 |
| 4 | Depression (t(99) = -4.904, p<0.0001) | M =1.87, SD=0.892 | M =1.78, SD=0.893 |
| 5 | Hostility (t(99) = -2,639, p = 0.01) | M =1.58, SD=0.197 | M =1.48, SD=0.160 |
| 6 | phobic anxiety (t(99)=-2,209, p = 0.029) | M =1.27, SD=0.173 | M =1.36, SD=0.224 |

Table 7: Severity of SCL-90-R parameters in patients with and without PTSD according to the Mississippi scale.

As follows from the table, with the exception of phobic anxiety (an irrational fear reaction), the scales SCL-90-R (somatization, obsession, interpersonal sensitivity, depression, etc.) were more pronounced in individuals with PTSD on the Mississippi scale. This is consistent, in principle, with the clinical picture of PTSD and its structure.

Based on the assumption that a number of clinical symptoms identified in patients in the first days after a psychic trauma may act as predictors of the development of a pathological process and its transformation into PTSD, we performed a logistic regression analysis. As a predictive factor, we considered all 105 symptoms identified in patients with varying frequency. According to the obtained results, the logistic regression model is statistically significant - $\chi^2(13) = 84.306, p < 0.0001$. The latter accounts for 77% (Nagelkerke R²) of the dispersion PTSD and classifies 88.9% of cases. In the entire model, the predictive-conditioning values of the following symptoms are statistically significant (Table 8):

| N | Symptom | B | SE | Wald | p |
|---|-------------------------------|--------|-------|--------|-------|
| | Cry | -3.939 | 1.592 | 6.125 | 0.013 |
| | And vomit | 6.796 | 3.181 | 4.564, | 0.033 |
| | Oh dullness of consciousness | -4.079 | 1.537 | 7.042 | 0.008 |
| | Battle scenes and voices | -5.172 | 1.635 | 10.001 | 0.002 |
| | P arrestes | -5.267 | 1.791 | 8.647 | 0.003 |
| | Fucking _ | 2.748 | 1.159 | 5.623 | 0.018 |
| | Bole sensations | 3.953 | 1.758 | 5.059 | 0.025 |
| | Vomiting | 10.814 | 5.217 | 4.296 | 0.038 |
| | About feeling short of breath | -5.751 | 2.834 | 4.116 | 0.042 |

Table 8: Statistically significant predictive-causing symptoms of PTSD and their meanings.

In addition, we undertook a logistic regression analysis of the predictive value of the most frequently occurring symptoms. For each symptom, the regression model was tested separately. The model is statistically significant for the predictive value:

- Dizziness ($\chi^2(1) = 7.756, p = 0.005$), which account for 9.9% (Nagelkerke R^2) of PTSD dispersion and classifies 63.4% of cases ($B = 1.148, SE = 0.422, Wald = 7.407, p = 0.006$);
- Headache ($\chi^2(1) = 4.638, p = 0.031$), causing 0.06% (Nagelkerke R^2) dispersion of PTSD and classifies 62.4% of cases ($B = 0.913, SE = 0.428, Wald = 4549, p = 0.033$);
- Crying ($\chi^2(1) = 5.089, p = 0.024$), accounts for 6.6% (Nagelkerke R^2) of PTSD variance and classifies 62.4% of cases ($B = -1.695, SE = 0.830, Wald = 4.171, p = 0.041$);
- Symptom “battle voices” ($\chi^2(1) = 4.157, p = 0.041$, determines 5.4% (Nagelkerke R^2) of PTSD variance and classifies 62.4% of cases ($B = -1.167, SE = 0.591, Wald = 3.9, p = 0.048$);
- Symptom “battle scenes” ($\chi^2(1) = 4.023, p = 0.045$), causes 5.2% (Nagelkerke R^2) of PTSD variance and classifies 62.4% of cases ($B = -1.03, SE = 0.527, Wald = 3.866, p = 0.049$).

In other words, the listed symptoms can be considered as factors associated with the development of early PTSD. As prognostic criteria for the development of PTSD in the acute period of injury Bergiannaki JD., *et al.* [12-39] noted an increased heart rate and a feeling of derealization during the first 48 hours after a traumatic event in earthquake survivors. We did not find such works with regard to combat trauma. In addition, we tried to determine the predictive value of a number of symptom complexes - similar in essence and content of symptoms, such as conflict and aggressiveness, gloom and depressed mood, sleep disorders and nightmares, tinnitus, headaches and hearing loss. Logistic regression analysis showed that the associations between the latter with symptoms - tinnitus, headaches and hearing loss ($\chi^2(1) = 8.813, p = 0.003$) were statistically significant. This constellation of symptoms accounts for 11.2% (Nagelkerke R^2) of the variance in PTSD and classifies 66.3% of cases ($B = 1.312, SE = 0.454, Wald = 8.376, p = 0.004$). It can be considered as the basis of the cerebrastrhenic syndrome, a predictor of subsequent PTSD.

Discussion

A huge number of articles are devoted to the description of the clinical manifestations of traumatic disorders on the materials of various large and small wars, local hostilities, and military conflicts. There are no works comparing the clinic of traumatic disorders depend-

ing on the power of the military conflict. But it should be noted that the latest war in Artsakh, in its power and character, is noticeably different from all previous wars. The authors mainly emphasized the relationship between the severity of traumatic experience and the variety of clinical symptoms of trauma. The most interesting and significant works in this aspect are related to the war in Korea and Vietnam, which, in fact, served as the basis for the allocation of post-traumatic disorders: ASD and PTSD.

The clinical picture of ASR is quite variable depending on the type of injury, severity, and individual characteristics of a person. The reactions to trauma in our patients were at the level of psychopathological reactions, manifested by acute stress disorders, post-traumatic stress disorder, as well as acute psychotic, depressive, anxiety-phobic and other disorders. All this set of psychopathological reactions had one common root, from which they manifested themselves - combat mental trauma. Psychic trauma as a stressful phenomenon is characterized by three main features - criteria: it occurs suddenly and unexpectedly, it threatens the life and psychophysical integrity of the organism and personality, and the trauma is outside the normal everyday life experience. As the 4th criterion, based on the peculiarities of the Artsakh war, we consider the invisibility and inaccessibility of the source of trauma, and its reality and tangibility for patients. Based on the noted features of trauma and the clinical diversity of psychopathological phenomena after trauma, we prefer to speak of peritraumatic disorders. At the same time, we mean the reactions that arose as a result of an event of an extreme nature, an event that went beyond the limits of ordinary human experiences, causing them strong fear, horror, a feeling of helplessness. This approach is due to the fact that the boundaries between the clinical manifestations of post-traumatic trauma are quite amorphous and largely overlap, the chronological criteria for determining acute and post-traumatic disorders, both in ICD-10 and DSM-5, are far from clinical reality. Moreover, both classifications offer different time frames.

The source of mental disorders is not the combat trauma itself and the traumatic situation, but the negative meaning that the combatant put into this event. This, from our point of view, is confirmed by statistically significant differences in the severity of PTSD depending on the age of military personnel, their marital status, and the time of admission to the hospital. Trauma is the loss of vital meanings, trauma is negative semantic experiences, negative meaning formation and meaning generation. According to the requirements of DSM-5, the diagnosis of ASD requires the presence of two criteria: 1) exposure to a traumatic event and 2) the presence of 9 out of 14 symptoms from the following clusters: 1) intrusion; 2) negative mood, 3) dissociation; 4) avoidance; and 5) arousal. Symptoms can last from 72 hours (three days) to four weeks after exposure to a traumatic event and present with two types of reactions: peritraumatic distress and peritraumatic dissociation. Peritraumatic distress indicates emotional and physical reactions during or immediately after exposure to trauma [6,40]; peritraumatic dissociation concerns disturbances in the perception of time, place, and people [41].

Ozer EJ., *et al.* [6] supplements these two types of reactions with 5 more disorders considered by the authors as predictors of PTSD or its symptoms: (1) previous trauma, (2) previous psychological adaptation, (3) family psychopathological history, (4) perceived threat life during trauma, (5) posttraumatic social support, (6) peritraumatic emotional responses, and (7) peritraumatic dissociation. At the same time, the authors emphasize that peritraumatic psychological processes, rather than previous ones, are significant predictors of PTSD.

Note that in the ICD-10, rheumatic stress is defined as an independent disorder, manifested by symptoms such as obsessive re-experiencing of a traumatic event; avoidance of anything related to trauma; inability to remember important episodes of the trauma; a feeling of detachment and alienation from others; dullness of emotions, sleep problems, irritability or outbursts of anger, impaired memory and concentration, hypervigilance, etc. In most cases, symptoms develop within a few minutes, and their severity decreases within 2 - 3 to 48 hours. After the reaction, partial or complete amnesia may persist. Previous research has shown that trauma victims typically experience dissociative, anxiety, and other symptoms during or shortly after the traumatic event. Although some of these symptoms are protective, they can lead to the development of post-traumatic stress disorder and other disorders.

Despite the fact that for many years both "acute stress reactions" and "acute stress disorders" have been singled out as a separate diagnostic rubric in both ICD-10 and DSM-5, some authors question the validity of their isolation [42]. The authors discuss the evidence

for and against the disorder, for and against the current focus on peritraumatic dissociation, and analyze the spectrum of biological and cognitive mechanisms that potentially mediate the acute traumatic response. They believe the evidence points to the need to consider alternative ways of conceptualizing ASD and identifying severely traumatized individuals at risk of developing PTSD.

At the clinical level, the main symptoms in our patients were not usually described flashback syndromes, obsessions, nightmares, etc., but dizziness, headaches, crying, "battle voices" and "battle scenes", as well as tinnitus, headaches and hearing loss. The experience of trauma leads to the development of anxiety-depressive reactions with a pronounced somatovegetative component already at the initial stages of the disorder, as evidenced by the SCL-90-R scale (depression, anxiety and somatization). These symptoms continue to be observed in more distant periods of trauma, when PTSD is formed, they are accompanied by an acute anxiety state, overexcitation, a feeling of complete helplessness and prostration, obsessive memories and inappropriate actions and behavior, aggressiveness, irascibility, a feeling of powerlessness, a feeling of fear, striving for isolation [43]. Despite the fact that the literature reports that the development of ASR is most often observed in individuals with disturbing personality traits, which can be a significant prognostic factor in response to acute stress, our results showed that the majority of hospitalized individuals with post-traumatic disorders were of the exalted type according to personality predispositions. Anxiety is regarded as a powerful predictor of sympathetic response [44].

Conclusion

The peculiarity of hostilities during the 44-day war was, from our point of view, that the source of the threat caused a feeling of uncertainty among the military personnel due to the absolute novelty of the experience of experiences from strikes "invisible" aircraft, a fundamental disagreement with what they believed, experienced and what they expected before arriving in the theater of operations. Under the "heavenly" fire, it was not possible to defend oneself with available methods (attack, retreat, take cover), strike back, come to the aid of wounded comrades. This presents us with a completely new and special character of the last war, which determined a number of clinical and chronological features among the participants in this war.

Our study showed that combat stress does not always cause ASD (other psychopathological disorders were also diagnosed), and PTSD symptoms were detected already 1 - 2 weeks after the injury, which contradicts the general approaches laid down in the ICD-10 and DSM-5. That is, the diagnosis of ASD does not adequately identify disorders that eventually transform into PTSD. Our study identified PTSD in more than a third of the combatants examined. (37.5%), which is not consistent with the chronological criteria and framework of the DSM-5. Moreover, almost every fourth (26%) combatant had acute psychotic and affective (depressive) disorders, affective, anxiety and dissociative disorders due to brain dysfunction and others. We assume that combat psychological trauma in the conditions of this war acts as a provoking or catalytic factor. The appearance of PTSD symptoms in the early stages of trauma in our patients may be due to a combination of psychic trauma with massive barotrauma in the war zone, as well as the psychological and technological impact of the enemy. In the formation of post-stress disorders, the personality factor is also important. Our study showed a statistically significant dependence of post-traumatic manifestations, in particular the symptoms of PTSD, on the personal characteristics of the combatants. The vast majority of combatants showed exalted character traits that determined the interdependence between the scales of the SCL-90-R symptomatic questionnaire and socio-demographic parameters.

It was found that the most severe manifestations of PTSD were observed in conscripts, as the youngest, not burdened with family problems and not wiser life experience. Development of PTSD at 55.4% were due to the depression, obsession, and hostility scales of the SCL-90-R symptomatic questionnaire, that is, the presence of depressed mood, obsessive phenomena in the psychopathology of the developing disorder, and aggressive tendencies in patients. The most pronounced indicators according to the questionnaire were in the parameters "somatization", "depression" and "anxiety". The more severe the clinical picture of PTSD, the less pronounced anxiety-phobic symptoms were, such as nervousness, tension and trembling, panic states, a sense of danger, fears and fears, irrational reactions. At the

same time, it was found that younger patients with PTSD have a higher stress resistance and later enter the hospital for treatment. They, regardless of the presence or absence of PTSD, stayed longer in the hospital. This was facilitated by depressive mood, obsessive phenomena, personal predispositions, such as a sense of one's own inadequacy and inferiority, discomfort in interpersonal communication, negative expectations in relationships with other people; continuous, irresistible and alien "I" thoughts, impulses and actions.

Many aspects of the identification and classification of ASD and PTSD the combatants confirm and x clinical reality. However, after the recognition of their reality, a lot of questions arise related to the nosological and ontological aspects of this problem. First, the severe, extraordinary combat trauma that all of our patients underwent caused various forms of pathology in them, from acute stress reactions to acute transient psychotic disorders. That is, the criterion of "uncommonness" of traumatic experiences loses its significance for the diagnosis of ASD. Secondly, the chronological criteria for post-traumatic disorders require clarification, which, in the existing framework, create more problems than they allow them to be resolved. B - a third of them, there arises the problem of distinguishing not only ASD from PTSD, but also the problem of distinguishing normal reactions to trauma from ASD, the various, personally conditioned forms of which seem to be psychologically understandable and adequate. There is a need to distinguish between symptoms as manifestations diseases and as reactive forms of behavior. Primary responses to traumatic events emerge as adaptive, coping and survival responses. And this process involves all the physiological and psychological resources of the body and the mechanisms of co-ownership. And in cases where they are insufficient, the process of adaptation is transformed into a maladaptive one, and pathological forms of resistance to trauma develop - acute stress disorders, anxiety, depressive and other disorders. Trauma depresses everyone without exception and causes constant obsessive memories and experiences, complicated by dissociative, depressive disorders. The trauma experienced by our patients had particular features in the conditions of the 44-day war in Artsakh. which consisted in some characteristics of the war in Artsakh. First, it was, as experts define it, war the fifth generation, which relied not on military power, not on the combat potential of the state in achieving strategic goals, but on information and psychological pressure on the population of the country, its state apparatus and on high science-intensive technologies. In this war, the enemy used such types of weapons that completely changed the nature of the war as a whole. Almost the entire process of armed struggle proceeded in the form of long-range massive strikes with high-precision ground and air weapons on military-economic and social targets, on manpower, with the widespread use of electronic warfare. Secondly, most military personnel, especially in the first 1 - 2 weeks of the war, noted that there were no direct contacts with enemy personnel, but instead they were under direct fire from unmanned aerial vehicles, shelling and rocket attacks. Under these conditions, the source of the threat caused a feeling of uncertainty among the military personnel due to the incongruity of the situation, that is, the absolute novelty of the experience of experiences from strikes and the fundamental disagreement with what they believed, experienced and what they expected before arriving in the theater of operations: there was no way to defend themselves (to go on the attack, retreat under fire, take cover), strike back, come to the aid of wounded comrades. This presents us with a completely new and special character of the last war, which determined a number of clinical and chronological features among the participants in this war. Third, the trauma was certainly extraordinary. But in the conditions of any trauma, the individual has the ability to respond to it within the capabilities of protective mechanisms - instinctive, psychological, behavioral. A traumatized person strives to protect and secure himself, both in adaptive and maladaptive ways. Almost all of our patients emphasized one significant fact - "the fire poured on them from above, and there was no way to respond to them with a counterblow, there was no way to protect themselves and come to the aid of wounded comrades." All this eventually led to such disorders that do not fit into the framework of "acute stress reactions" (according to ICD-10) or "acute stress disorders" (according to DSM-5). The symptoms of PTSD, which, according to two world classifications, should develop months later, were noted literally from the first moments of the injury.

Finally, all the features noted by us allow us to talk about peritraumatic stress disorders without differentiating them into known clinical forms, the boundaries between which have always been unclear. The category of "peritraumatic disorders" seems to us the most adequate for distinguishing between psychopathological disorders that develop after a combat injury. It includes all the disorders that arise after an extraordinary mental trauma, in particular, a combat one, and could not manifest itself without it.

Bibliography

1. Batarshev AV. "Diagnosis of personality traits and accentuations". Practical Guide. M.: Psychotherapy (2006): 288.
2. Lytkin VM., et al. "To the problem of mental health of combatants". *Russian Psychiatric Journal* 6 (2007): 63-68.
3. ICD-10: Classification of mental and behavioral disorders". Clinical descriptions and instructions for diagnosis. Per. into Russian, edition. Yu.L. Nuller, S.Yu. Tsirkin. St. Petersburg (1994): 304.
4. Post-traumatic stress disorder. Ed. V.A. Soldatkin. GBOU VPO RostGMU of the Ministry of Health of Russia". Rostov n/a: Publishing house of RostGMU (2015): 624.
5. Pushkarev AL., et al. "Diagnosis of post-traumatic stress disorder (PTSD) in combatants: Guidelines". Minsk: BNIETIN (1999): 17.
6. Reznik AM., et al. "Psychotic disorders in veterans of local wars". *Journal of Neurology and Psychiatry* 120.6-2 (2020): 31-36.
7. Snedkov EV. "The problem of nosological independence of post-traumatic stress disorder". *Journal Neurology and Psychiatry* 109.12 (2009): 8-11.
8. Tadevosyan MYa and Sukiasyan SG. "Psychic trauma, its consequences and predisposing factors". *Journal of Neurology and Psychiatry* 111.11 (2011): 95-100.
9. Tarabrina NV. "Workshop on the psychology of post-traumatic stress". St. Petersburg: Peter (2001): 272.
10. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th edition. Arlington: American Psychiatric Association (2013).
11. Anestis JC., et al. "Psychopathic Personality Traits as Protective Factors against the Development of Post-Traumatic Stress Disorder Symptoms in a Sample of National Guard Combat Veterans". *Journal of Psychopathology and Behavioral Assessment* 39 (2017): 220-229.
12. Bergiannaki JD., et al. "Protracted acute stress reaction following an earthquake". *Acta Psychiatrica Scandinavica* 107.1 (2003): 18-24.
13. Bomyea J., et al. "Information processing in PTSD: Evidence for biased attentional, interpretation, and memory processes". *Psychopathology Review* 4.3 (2017): 218-243.
14. Bryant RA. "The Current Evidence for Acute Stress Disorder". *Current Psychiatry Reports* 20 (2018): 111.
15. Cero I and Kilpatrick DG. "Network Analysis of Posttraumatic Stress Disorder Symptoms in a National Sample of U.S. Adults: Implications for the Phenotype and the ICD-11 Model of PTSD". *Journal of Trauma Stress* 33.1 (2020): 52-63.
16. Dell'Osso L., et al. "Rumination, posttraumatic stress disorder, and mood symptoms in borderline personality disorder". *Neuropsychiatric Disease and Treatment* 15 (2019): 1231-1238.
17. Derogatis L., et al. "The SCL-90 and the MMPI: A Step in the Validation of a New Self-Report Scale". *British Journal of Psychiatry* 128.3 (1976): 280-289.
18. Esmaeilimotlagh M., et al. "To Study the Prevalence of Post-Traumatic Stress Disorder and its Comorbidity with personality disorders among veterans of Tehran". *Journal of Human Genetics* 2.1 (2018): 6-13.

19. Ford JD. "Disorders of extreme stress following war-zone military trauma: associated features of posttraumatic stress disorder or comorbid but distinct syndromes?" *Journal of Consulting and Clinical Psychology* 67.1 (1999): 3-12.
20. Ford JD and Courtois CA. "Complex PTSD and borderline personality disorder". *Borderline Personality Disorder and Emotion Dysregulation* 8.1 (2021) 16.
21. Garfin DR., et al. "Acute stress and subsequent health outcomes: A systematic review". *Journal of Psychosomatic Research* 112 (2018): 107-113.
22. Gunderson JG and Sabo AN. "The phenomenological and conceptual interface between borderline personality disorder and PTSD". *The American Journal of Psychiatry* 150 (1993): 19-27.
23. Haag C., et al. "Understanding the Emergence of Chronic Posttraumatic Stress Disorder Through Acute Stress Symptom Networks". *JAMA Psychiatry* 74.6 (2017): 649-650.
24. Harvey HG and Bryant RA. "Acute stress disorder: A synthesis and critique". *Psychological Bulletin* 128.6 (2002): 886-902.
25. Huini PENG., et al. "Trait anxiety predicts the response to acute psychological stress". *Acta Psychologica Sinica* 50.9 (2018): 997-1006.
26. Katrinli S., et al. "Evaluating the impact of trauma and PTSD on epigenetic prediction of lifespan and neural integrity". *Neuropsychopharmacology* 45 (2020): 1609-1616.
27. Keane TM., et al. "Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity". *Journal of Consulting and Clinical Psychology* 56.1 (1988): 85-90.
28. Kessler RC., et al. "Trauma and PTSD in the WHO World Mental Health Surveys". *European Journal of Psychotraumatology* (2017): 5.
29. Mattson E., et al. "Personality Factors and Their Impact on PTSD and Post-traumatic Growth is Mediated by Coping Style Among OIF/OEF Veterans". *Military Medicine* 183.9-10 (2018): e475-e480.
30. McCanlies EC., et al. "Association of peritraumatic dissociation with symptoms of depression and posttraumatic stress disorder". *Psychological Trauma: Theory, Research, Practice, and Policy* 9.4 (2017): 479-484.
31. McNally RJ., et al. "Mental disorders as causal systems: a network approach to posttraumatic stress disorder". *Clinical Psychological Science* 3.6 (2015): 836-849.
32. Miller MW. "Personality and the etiology and expression of PTSD: A three-factor model perspective". *Clinical Psychology: Science and Practice* 10.4 (2003): 373-393.
33. Ozer EJ., et al. "Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis". *Psychological Bulletin* 129.1 (2003): 52-73.
34. Paris J. "Predispositions, Personality Traits, and Posttraumatic Stress Disorder". *Harvard Review of Psychiatry* 8.4 (2000): 175-183.
35. Schmieschek H. "Fragebogen zur Ermittlung akzentuierter Persönlichkeiten [Questionnaire for the determination of accentuated personalities]". *Psychiatry, Neurology and Medical Psychology* 22.10 (1970): 378-381.
36. Shalev AY., et al. "Prospective study of posttraumatic stress disorder and depression following trauma". *The American Journal of Psychiatry* 155 (1998): 630-637.

37. Shalev AY, et al. "Predictors of PTSD in injured trauma survivors: a prospective study". *The American Journal of Psychiatry* 153.2 (1996): 219-225.
38. Smith GP and Hartelius G. "Resolution of Dissociated Ego States Relieves Flashback-Related Symptoms in Combat-Related PTSD: A Brief Mindfulness Based Intervention". *Military Psychology* 32.2 (2020): 135-148.
39. Tortella-Feliu M, et al. "Risk factors for posttraumatic stress disorder: An umbrella review of systematic reviews and meta-analyses". *Neuroscience and Biobehavioral Review* 107 (2019): 154-165.
40. Vaillant GE. "Adaptive mental mechanisms. Their role in a positive psychology". *American Psychologist* 55 (2000): 89-98.
41. Vance MC, et al. "Peritraumatic distress: A review and synthesis of 15 years of research". *Journal of Clinical Psychology* 74.9 (2018): 1457-1484.
42. Vasterling JJ, et al. "Longitudinal Associations among Posttraumatic Stress Disorder Symptoms, Traumatic Brain Injury, and Neurocognitive Functioning in Army Soldiers Deployed to the Iraq War". *Journal of the International Neuropsychological Society* 24.4 (2018): 311-323.
43. Visser E, et al. "The course, prediction, and treatment of acute and posttraumatic stress in trauma patients: A systematic review". *The Journal of Trauma and Acute Care Surgery* 82.6 (2017): 1158-1183.
44. Yurgil KA, et al. "Association Between Traumatic Brain Injury and Risk of Posttraumatic Stress Disorder in Active-Duty Marines". *JAMA Psychiatry* 71.2 (2014): 149-157.

Volume 11 Issue 5 May 2022

©All rights reserved by Sukiasyan SG., et al.