

Case Report



PSYCHOPATHOLOGICAL DYNAMICS OF A DISASTER VICTIM, REJECTING MENTAL HEALTH CARE – A CASE REPORT AND DISCUSSION

Ivan Aleksandrov¹, Yassen Yanev¹, Mariana Arnaudova¹, Ivan Dimitrov², Valeri Stoyanov³

1) Department of Psychiatry and Medical Psychology, Faculty of Medicine, Medical University, Varna, University hospital “St. Marina”, Varna, Bulgaria

2) Department of Neurology, Faculty of Medicine, Medical University, Varna, University hospital “St. Marina”, Varna, Bulgaria

3) Department of Psychology, Faculty of Social Sciences, Varna Free University “Chernorizets Hrabar”, Bulgaria.

ABSTRACT

Background: Seeking and receiving psychological help after a stressful life event is associated with certain prejudice attitudes, especially present in minority ethnic groups.

Case description: This case report describes the specific reactions and psychopathological dynamics of a female patient, the age of 43, who survived the terrible accident on December the 10th 2016, in Hitrino village.

Discussion: Due to stigmatising beliefs, patient reluctantly had only a few meeting with a clinical psychologist, refused proper psychiatric treatment, and developed an acute stress reaction in the first few days after the accident, followed by post-traumatic stress disorder the next few weeks, as described chronologically in the ICD-10.

Conclusion: Stigmatising beliefs are further amplified by ethnic minorities’ prejudice of seeking mental health and having a mental illness, which affects professionals’ ability to provide comprehensive medical care.

Keywords: psychiatric stigma, acute stress reaction, PTSD, disaster

BACKGROUND:

Stressful life events are known to cause significant suffering. They play a leading role in developing clinically manifested disorders of different types [1]. A more profound analysis includes the inherited and acquired personality features in biological, psychological and social aspects. The multifactorial modality implies the determination of the dominant factors, among which stands out the psychological. The “information significance” of stimulus is essential, as the personality develops its social specific peculiarities. Different people appear to have a different threshold for an event to be considered as traumatic [2]. As some authors comment “for affected individuals, this event is a watershed in their lives” [3].

Risk factors are those variables that contribute to a person developing a particular psychiatric disorder. These

variables in acute stress disorder (ASD) or in post-traumatic stress disorder (PTSD) can be related to person’s childhood emotional problems, to person’s environment such as lower socioeconomic status, lower education, cultural and ethnic characteristics, female gender, younger age, etc. The major difference between the two conditions is that, in acute stress disorder, symptoms such as dissociation, reliving the trauma, avoiding stimuli associated with the trauma and increased arousal are present for at least 3 days and up to a month. When the symptoms persist longer, a change in diagnosis must be considered to a post-traumatic stress disorder [4]. Approximately half of the individuals who eventually develop PTSD initially present with acute stress disorder [5].

One of the greatest predictors of emotional distress following a traumatic event is having suffered a traumatic event sometime in the past. One of the biggest protective factors is social support (family, friends, specialised services, etc.). Getting effective treatment after PTSD symptoms can be critical to reduce symptoms and improve function [6].

Psychological support in the form of psychotherapy or medication prescribed by a psychiatrist could minimise suffering or reduce negative outcomes. However, seeking and receiving psychological help after a stressful life event is associated with certain prejudice attitudes [7]. The stigma of psychiatry and mental illness is undeniable, comes in many forms and us as professionals need to be aware of how this affects patients, their tendencies of seeking care, and our ability to help them truly.

Despite various investigations, approaches and definitions, which have been used to conceptualise psychiatric stigma this phenomenon are not fully understood. It encompasses devaluation, discrimination, decreased self-esteem, self-restricted behaviour, and dysfunctional coping [8].

This stigma can be even more pronounced within ethnic minority communities. Although the reasons behind stigma may vary, there is relatively greater pressure from within these communities not to seek psychiatric care. Mi-

nority groups are already at greater risk for developing a mental health disorder because ethnical status has a significant effect on a patient's tendency to seek treatment [9]. Cultural properties of Bulgarian ethnic minorities make no exception in this regard.

In the following paragraphs, we will present a case, where it is easy to see how ethnical status can be of crucial importance for a patient's tendency to seek treatment and receive comprehensive medical care. We will illustrate how the lack of such treatment may lead to adverse consequences, as it did, in a sequence of symptoms which chronologically match the ICD-10 criteria descriptions of an acute stress reaction in the first few days after the accident, followed by post-traumatic stress disorder in the next few weeks [10].

CASE DESCRIPTION:

We present a case of a female patient (initials N.H., age 43), who survived a terrible accident. The event occurred on December the 10th 2016, early in the morning at 05:37, in Hitrino village [11]. It involved a train crash, followed by a gas leakage, which resulted in an immense explosion. The patient was in her bed at that time, and could only report that she heard "a huge bang, and then there was only pain... pain and darkness...".

The explosion practically destroyed a whole street, including patient's home. Final reports count about 50 buildings destroyed, 7 dead and 25 wounded [12]. N. H. survived the initial explosion; however, she suffered multiple intense lacerations on the face, neck and chest, laceration wound on the right eyelid, periocular area and of tear ducts, multiple foreign bodies in both eyeballs, traumatic perforation of the right eardrum, and lack of tissue in the front lower quadrant.

First hours after the accident, the patient was at the hospital, at the intensive care department, as well as the following days and weeks. An initial consultation with a clinical psychologist was required. The patient described feelings of constant, intensive fear of every noise, stomach ache, sweating, and restlessness. She was unable to recreate the moments after the accident, she was not even certain whether her husband was alive or not, which further amplified the feelings of uncertainty and anxiety (hospital staff was unaware of the whereabouts of her husband at the time). She was diagnosed to develop an Acute stress reaction, based on ICD-10 criteria, expressed by *agitation and overactivity (flight reaction or fugue), autonomic signs (sweating, flushing) and partial amnesia for the event.*

Second meeting with a clinical psychologist was required the following week due to complaints of excruciating nightmares, dark thoughts and visions, which ultimately led to ideas about euthanasia. The patient described an intrusive, repetitive vision of a pit filled with rats, wanting to bite her face off, and waves of fire and glass. At the same time, the patient was utterly reluctant to take advice (or medication) from a clinical psychologist (or a psychiatrist) to ease her suffering, despite the persisting anxiety, "flashbacks", and overall anhedonia.

Summarized, we can establish presence of several

symptoms of a Post-traumatic stress disorder, namely *episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma, and associated symptoms of anxiety and suicidal ideation.*

Later, it became known that N. H.'s husband was alive and in better condition than hers. However, normal social functioning has become severely disturbed as the patient did not want to reunite with her family, because of feelings of shame and guilt. The shame of her appearance, the fact that she needs to be taken care of, instead of her taking care of her children; guilt, because she would become a burden to her family, incapable of taking care of herself.

At this time, her somatic condition was fairly stable (except for the vision impairment), especially given the initial condition that she was hospitalised in a few weeks ago. However, she refused to accept that she could be discharged from the hospital, rejected psychiatric hospitalisation, medication, or any other kind of mental health care treatment, saying she did not want "everybody to know she went crazy". Exceptions were the brief meetings with a clinical psychologist, where she was repeatedly asked to share some information about her current emotional state and plans for the future.

DISCUSSION:

The symptoms were developed in this sequence, which reflects the pre-established structure of the aftermath of a stressful life event set in the ICD-10, namely the criteria descriptions of an acute stress reaction in the first few days after the accident, followed by post-traumatic stress disorder in the next few weeks. During the development of those disorders, the patient was reluctant to receive proper psychiatric treatment, due to stigmatising beliefs regarding her family, friends, and members of her community knowing that she has a mental disorder.

Stigmatising beliefs are certainly present for ethnic minorities with regard to seeking mental health services and having a mental illness. This influences the ability of professionals to provide proper treatment, in the case of psychiatric medication, or hospitalisation in a psychiatric institution, as well as the quality of the care provided, in the case of psychotherapeutic sessions.

Both approaches require some form of motivation on patients' side and have little or no success when a person is pre-convinced that he or she should not need such assistance because is too preoccupied with the opinions of others regarding receiving psychiatric care or having a mental disorder. Research regarding stigmatising beliefs and their impact on receiving proper care has shown us that anti-stigma initiatives generally take three approaches: (a) education to challenge inaccurate stereotypes; (b) interpersonal contact with a person with a mental illness; and (c) different forms of social activism [13].

What this, and many other cases that have to do with timely receiving proper psychiatric care (either in the form of medication or temporary hospitalisation) tells us, is that the use of mental health services cannot be separated from the impact of stigmatising beliefs. Furthermore, these stigmatising beliefs are even further pronounced within ethnic minority communities. We need to be aware of how the beliefs of ethnic communities regarding receiving proper medical (not limited to psychiatric) care could influence professionals' ability to provide proper care and prevent further development of pathology.

CONCLUSION:

Our report puts an accent on some psychological consequences of stressful life events. Attempts to provide appropriate mental health care and prevent further development of psychopathology are hindered by the stigmatising beliefs of certain ethnic minority communities. Regardless, the need of supportive care of the victims, and the consequences of lack of such care are present.

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Address for correspondence:

Assoc. prof. Ivan Aleksandrov,
Department of psychiatry and medical psychology, Medical University,
55, Marin Drinov str., 9002 Varna, Bulgaria
Mobile: +359 887 799 008
e-mail: i_s_aleksandrov@abv.bg