Rivista di psichiatria 2023; 58: 237-240

Acute depressive reaction as a consequence of war trauma exposure: a case report of a Ukrainian refugee

TOMMASO BARLATTANI[1], GIULIO RENZI[1], CHIARA D'AMELIO[1], FRANCESCA PACITTI[1]

[1]Department of Biotechnological and Applied Clinical Sciences (DISCAB), University of L'Aquila, Italy.

Summary. We hereby report a case of a young Ukrainian woman refugee who immigrated in Italy after the war outbreak in February 2022. The researcher arrived in Italy in March 2022, thanks to a scholarship of the University of L'Aquila. Shortly after settling in L'Aquila, she started to manifest depressive symptoms, which eventually led her to seek psychological and pharmacological help in the local psychiatric unit. In April 2022, she accessed twice in a week to the emergency department of the "San Salvatore" Hospital of L'Aquila. The second time she presented an acute anxiety attack accompanied by psychomotor disturbances (negativism, mutism) that eventually required admission to the local psychiatric ward (Servizio Psichiatrico di Diagnosi e Cura - SPDC) with the aim of managing the clinical presentation from a pharmacological and psychotherapeutic perspective. The patient submitted a series of validated scales in her own language. After 13 days of hospitalization, the patient was discharged with a diagnosis of "Acute Depressive Disorder, mild severity", according to PHQ-9, and referred to psychiatric services with a dedicated program. The present report aims to underline the need to take into consideration the possibility of developing depressive symptoms and reactions among Ukrainian war refugees and, in light of this evidence, the importance of a cross-country shared program when addressing the mental health of all refugees.

Key words. Depression, refugees, mood disorder, trauma, Ukraine, War.

Reazione depressiva acuta in conseguenza all'esposizione a un trauma di guerra: il caso clinico di una rifugiata ucraina.

Riassunto. Riportiamo il caso di una giovane donna ucraina immigrata in Italia dopo lo scoppio della guerra nel febbraio 2022. La ricercatrice è arrivata in Italia nel marzo 2022, grazie a una borsa di studio dell'Università dell'Aquila. Poco dopo essersi stabilita a L'Aquila, ha iniziato a manifestare sintomi depressivi, che l'hanno spinta a cercare aiuto psicologico e farmacologico presso l'unità psichiatrica locale, con successivo ricovero presso il Servizio Psichiatrico Universitario di Diagnosi e Cura (SPUDC) del Presidio Ospedaliero di L'Aquila, per gli accertamenti diagnostici e le cure del caso. Alla paziente è stata somministrata una serie di scale validate nella sua lingua. Dopo 13 giorni di ricovero, la paziente è stata dimessa con diagnosi di "Disturbo Depressivo Maggiore, grado moderato, con ansia", utilizzando i criteri diagnostici della PHQ-9 e indirizzata ai servizi psichiatrici con un programma dedicato. L'obiettivo del lavoro è quello di sottolineare la necessità di un'ulteriore implementazione di programmi di screening e supporto per i rifugiati. Riteniamo inoltre che sia necessario rendere fruibile una maggiore quantità di strumenti valutativi, culturalmente adeguati (per es., scale convalidate nella lingua del paziente).

Parole chiave. Depressione, disturbo dell'umore, guerra, rifugiati, trauma, Ucraina.

Introduction

Refugees – a highly vulnerable population, generally presenting an increased risk for developing mental health disorders[1] – have often witnessed traumatic and violent war-related events in their home countries[2]. In addition, refugees are commonly exposed to potential dangers, threats, and traumatic events along their journey to host countries[3]. Moreover, they may experience the so-called displacement-related stressors, as proposed by Miller's ecological model[4]. For example, they often encounter difficulties with bureaucratic issues and document requirements in the country of resettlement[5]. Lack of contacts, concerns about parents, and loss of loved ones in the country of origin are often additional factors leading to the manifestation of distress symptoms. All these elements are eventually accountable for an increased risk of developing mental health conditions in refugees[6]. Epidemiological studies, including meta-analyses, have found Post-traumatic Stress Disorder (PTSD) and depression to be two of the most prevalent mental health diagnoses among refugees[7]. Sleep disturbances have been found to be another very common symptom in migrants and refugees[8]. There are ongoing concerns about Ukrainian refugees' health[9,10]; the Ukrainian exodus is predicted to be a European humanitarian crisis comparable to World War II[11]. Among the consequences of war outbreaks, the onset and related increase of mental health conditions is one of the most significant[12]. Noticeably, also the recent Covid-19 pandemic represented a traumatic experience for people worldwide, with war representing a "second hit" in subjects exposed[13]. The case followingly reported delineates the symptomatology manifested by a Ukrainian refugee right after

immigrating to Italy in an attempt to illustrate and underline the importance of prompt and specific mental health services for refugees.

Case report

Mrs. K is a 32-year-old Ukrainian woman who immigrated to Italy in March 2022 as a war refugee. Before the onset of the war, in February 2022, she was working as a researcher in engineering for a private pharmaceutical company and reported that she has previously worked as a teacher in a high school in Odessa. Being Odessa the biggest Ukrainian port on the Black Sea, it has been a major target of the Russian navy and army attack; so the risk of siege and fall under Russian control pushed a lot of people to escape[14]. Mrs. K was able to travel to Italy thanks to a scholarship financed by the University of L'Aquila. Moreover, she had to face further stressful situations and difficulties during her journey to reach Italy; at first bureaucratic issues regarding her passport caused troubles in obtaining the scholarship, later, because of difficulties in reaching the border and finding a flight to Italy. She was eventually able to arrive and settle in L'Aquila thanks to the support of the university and her tutor.

Since the beginning of her experience as a researcher in Italy, she manifested difficulties in building relationships with her co-workers and facing work tasks. She progressively developed a symptomatology characterized by insomnia, abulia, anhedonia, depressed mood, and lack of energy that eventually led to work and social impairment. At first, she sought help in the psychiatric consultation unit, where she was prescribed melatonin to treat insomnia. Later on, she presented to the emergency department of the "San Salvatore" hospital in L'Aquila twice between the 6th and the 13th of April. During the first access, on Apr 6, she refused the psychiatry consultation and eventually left the emergency room. In the following access to the emergency department, she presented with an acute anxiety attack, as evidenced by sinus tachycardia (Heart Rate: 155 bpm), along with psychomotor disturbances such as mutism and negativism that required hospitalization in the Psychiatry ward. At admission, it was not possible to explore the thought content due to the oppositional attitude of the patient, who manifested mutism and psychomotor retardation. Nevertheless, she accepted pharmacological treatment. In light of the difficulties encountered in the clinical setting, due to both the oppositive attitude of the patient and the linguistic barrier, validated scales in patients' own language were administered, including the Patient Health Questionnaire (PHQ-9), the International Trauma Questionnaire (ITQ), the Life Events Checklist for DSM-5 (LEC-5) and the WHO Disability Assessment Schedule 2.0 (WHODAS-12), according to Mental Health Resources for Clinicians and Researchers offered by the International Trauma Consortium. She scored 58.33% on the Whodas 2.0 (12 items); the PHQ-9 scoring was 10, which, along with the clinical presentation, allowed us to put a diagnosis of a "Major Depressive Episode, moderate severity"; on the other hand, the DSM-V criteria for PTSD and Acute Stress Disorder were not met and confirmed with negative results of the ITQ and Trauma Exposure LEC5. Pharmacological treatment included lorazepam 1 mg per day; trazodone 60 mg/ml, 10 drops a day; and sertraline 50 mg per day. Psychological support was offered along with pharmacological treatment, a combination that has been shown to be most effective in treating depressive symptoms[15]. The pharmacotherapeutic strategy has been set according to an accurate rationale: sertraline has been preferred over other antidepressant drugs since it has proven its effectiveness in the treatment of refugees affected by trauma[16] as well as in depressive symptoms and anxiety; low doses of trazodone have been demonstrated to be an effective therapy on insomnia[17]; and finally, lorazepam has been added to therapy to mitigate the anxiety and insomnia that occurred along with depression, to promptly reduce symptoms severity[18,19] and improve the effectiveness of antidepressant therapy. During the course of the hospitalization, the patient showed a progressive partial relief of acute anxiety and distress symptoms as she became more cooperative with physicians and more easily accessible during daily clinical examinations. In the interviews, which were carried out in the English language, the patient mainly expressed concerns about the conflict and about the well-being of her family members who remained in Ukraine. Since her arrival in Italy, the woman kept in contact with her mother, who was at the time still living in Odessa. She reported having expressed the desire to receive only good news from her mother. The patient also manifested somatic concerns about inherent urination and defecation with a decreasing trend of intensity during the course of hospitalization. After a 13-days of inpatient care, Mrs. K was discharged with the diagnosis of "Acute Depressive Episode, moderate severity" in accordance with the PHQ-9[20] scoring. At discharge, the patient appeared more easily accessible to the clinical interview, her mood and sleep quality had improved, and she also manifested decreased distress about the ongoing conflict in her home country. Moreover, she didn't manifest somatic concerns anymore. She left the ward accompanied by her university tutor, her attending psychiatrist, and her psychotherapist. In order to ensure adequate follow-up care and greater support, the patient was accompanied to a residence with a Ukrainian compatriot, another university researcher refugee. Follow-up meetings for psychotherapeutic support were scheduled, as well as control

visits to assess adherence to and efficacy of the pharmacological therapy.

Conclusions

This report confirms that, although symptoms of Trauma Spectrum Disorders would be expected to be more prevalent in war refugees, depressive symptoms should be considered as well[21]. Interestingly, previous reports about adults from war-affected regions showed how depressive symptoms are a common manifestation spanning throughout the whole migration process[22]. Although depressive symptoms are more extensively studied and observed among individuals still living in war-affected territories, our case aims to shed light on those who, on the other hand, emigrated to other countries[9]. This record's objective is to underlie the necessity for adequate screening and support programs for refugees[23], especially considering Ukrainians' migration routes. The harsh aftermath of war necessitates appropriate and dedicated care programs to preserve the mental health of those affected. We furthermore believe that it's necessary to implement culturally dedicated tools for patient assessment, which must be made available to every healthcare professional[24]. Validated scales in the patients' language and cross-country shared common treatment programs are needed.

Conflict of interests: the authors have no conflict of interests to declare.

References

1. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. Lancet 2005; 365: 1309-14.
2. Nicholl C, Thompson A. The psychological treatment of post-traumatic stress disorder (PTSD) in adult refugees: a review of the current state of psychological therapies. J Ment Health 2004; 13: 351-62.
3. Acarturk C, Cetinkaya M, Senay I, Gulen B, Aker T, Hinton D. Prevalence and predictors of post-traumatic stress and depression symptoms among syrian refugees in a refugee camp. J Nerv Ment Dis 2018; 206: 40-5.
4. Miller KE, Rasmussen A. The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. Epidemiol Psychiatr Sci 2017; 26: 129-38.
5. Nickerson A, Steel Z, Bryant R, Brooks R, Silove D. Change in visa status amongst Mandaean refugees: relationship to psychological symptoms and living difficulties. Psychiatry Res 2011; 187: 267-74.
6. Nickerson A, Liddell B, Asnaani A, et al. Trauma and mental health in forcibly displaced populations an International Society for Traumatic Stress Studies Briefing Paper. Stress Stud: Int Soc Trauma; 2017. Available from: https://lc.cx/qb85AZ [last accessed 2023, July 28].
7. Lindert J, Ehrenstein OS, Priebe S, Mielck A, Brähler E. Depression and anxiety in labor migrants and refugees: a systematic review and meta-analysis. Soc Sci Med 2009; 69: 246-57.
8. Morina N, Stam K, Pollet TV, Priebe S. Prevalence of depression and post-traumatic stress disorder in adult civilian survivors of war who stay in war-afflicted regions. A systematic review and meta-analysis of epidemiological studies. J Affect Disord 2018; 239: 328-38.
9. Richter K, Baumgärtner L, Niklewski G, et al. Sleep disorders in migrants and refugees: a systematic review with implications for personalized medical approach. EPMA J 2020; 11: 251-60.
10. Murphy A, Fuhr D, Roberts B, Jarvis CI, Tarasenko A, McKee M. The health needs of refugees from Ukraine. BMJ 2022; 377: o864.
11. Pita A, Sánchez Costa R. Ukrainian exodus could be Europe's biggest refugee crisis since World War II. El Pais 2022; March 3.
12. Murthy RS, Lakshminarayana R. Mental health consequences of war: a brief review of research findings. World Psychiatry 2006; 5: 25-30.
13. Jeftić A, Ikizer G, Tuominen J, Chrona S, Kumaga R. Connection between the COVID-19 pandemic, war trauma reminders, perceived stress, loneliness, and PTSD in Bosnia and Herzegovina. Curr Psychol 2023; 42: 8582-94.
14. Invaders fire on two localities in Odessa region from sea. Ukrinform 2022; March 15.
15. de Maat S, Dekker J, Schoevers R, et al. Short psychodynamic supportive psychotherapy, antidepressants, and their combination in the treatment of major depression: a mega-analysis based on three randomized clinical trials. Depress Anxiety 2008; 25: 565-74.
16. Sonne C, Carlsson J, Bech P, Elklit A, Mortensen EL. Treatment of trauma-affected refugees with venlafaxine versus sertraline combined with psychotherapy - a randomised study. BMC Psychiatry 2016; 16: 383.
17. Jaffer KY, Chang T, Vanle B, et al. Trazodone for insomnia: a systematic review. Innov Clin Neurosci 2017; 14: 24-34.
18. Furukawa TA, Streiner DL, Young LT. Antidepressant plus benzodiazepine for major depression. Cochrane Database Syst Rev 2001; (2): CD001026.
19. Smith WT, Londborg PD, Glaudin V, Painter JR; Summit Research Network. Is extended clonazepam cotherapy of fluoxetine effective for outpatients with major depression? J Affect Disord 2002; 70: 251-9.
20. Costantini L, Pasquarella C, Odone A, et al. Screening for depression in primary care with Patient Health Questionnaire-9 (PHQ-9): a systematic review. J Affect Disord 2021; 279: 473-83.
21. Ahmad F, Othman N, Hynie M, Bayoumi AM, Oda A, McKenzie K. Depression-level symptoms among Syrian refugees: findings from a Canadian longitudinal study. J Ment Health 2021; 30: 246-54.
22. Lin SL, Kobayashi K, Tong H, Davison KM, Arora SRA, Fuller-Thomson E. Close relations matter: the association between depression and refugee status in the Canadian Longitudinal Study on Aging (CLSA). J Immigr Minor Health 2020; 22: 946-56.
23. Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. World Psychiatry 2017; 16: 130-9.
24. Wylie L, Van Meyel R, Harder H, et al. Assessing trauma in a transcultural context: challenges in mental health care with immigrants and refugees. Public Health Rev 2018; 39: 22.

APPENDIX - WHODAS 12: English version

In the last 30 days how much difficulty did you have in:	None	Mild	Moderate	Severe	Extreme or cannot do
1. Standing for long periods such as 30 minutes?_	1	2	3	4	(5)
2. Taking care of your household responsibilities?	1	2	3	4	(5)
3. Learning a new task, for example, learning how to get to a new place?	1	2	3	4	(5)
4. How much of a problem did you have joining in community activities (e.g., festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	(5)
5. Have you been emotionally affected by your health problems?	1	2	3	4	(5)
6. Concentrating on doing something for ten minutes?	1	2	(3)	4	5
7. Walking a long distance such as a kilometre [or equivalent]?	1	(2)	3	4	5
8. Washing your whole body?	(1)	2	3	4	5
9. Getting dressed?	1	2	3	4	(5)
10. Dealing with people you do not know?	1	2	3	(4)	5
11. Maintaining a friendship?	(1)	2	3	4	5
12. Your day-to-day work?	1	2	(3)	4	5

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	(1)	2	3
2. Feeling down, depressed, or hopeless	0	1	2	(3)
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	(3)
4. Feeling tired or having little energy	0	1	2	(3)
5. Poor appetite or overeating	(0)	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	(0)	1	2	3
7. Troubleconcentrating on things, such as reading the newspaper or watching television	(0)	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	(0)	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	(0)	1	2	3
	Not difficult at all	**Somewhat difficult**	**Difficult**	**Very difficult**
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	(0)	1	2	3

Scoring: In "simple scoring", the scores assigned to each of the items – "none" (1), "mild" (2) "moderate" (3), "severe" (4) and "extreme" (5) – are summed.

Corresponding author:
Dr Giulio Renzi
Department of Biotechnological and Applied Clinical Science
University of L'Aquila Coppito 2
Via Vetoio
67100 Coppito (L'Aquila), Italy
E-mail: giulio.renzi@graduate.univaq.it