

PSYCHOLOGY AND PSYCHIATRY

ANALYSIS OF EMOTIONAL STATES OF PERSONS WITH POST-TRAUMATIC STRESS

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RESUME

Introduction. There is insufficient data in modern psychology on the specifics of the development of post-traumatic stress disorders, in particular emotional disorders, in individuals who are faced with life emergencies (military operations, violence, loss of a loved one, etc.) in comparison with people who have suffered coronavirus infection.

The aim. To conduct a theoretical problem analysis and study the characteristics of personality manifestations with signs of post-traumatic stress disorder (PTSD) empirically, test methods of psychological assistance to patients who have suffered traumatic stress.

Materials and methods. Forty five adult respondents (25–45 years old) took part in the study. Methods used in the study include structured clinical diagnostic interview – SCID, clinical diagnostic scale (CAPS), Freiburg Personality Inventory (FPI), Lemur – Tessier – Fillion psychological stress scale PSM-25, self-assessment test of stress resistance by S. Cohen and G. Williamson, The Test of Self-Conscious Affect TOSCA by J.P. Tangney, A. Beck Depression Test Questionnaire. Methods of descriptive statistics, Mann – Winty U-test, and Spearman's r-test were also used.

Results. There were identified similar emotional states that occur in individuals with psychotraumatic stress disorder for various reasons. At the same time, one of the groups of respondents participating in the study also included people who passed coronavirus. In this case, it was mandatory for the person to admit that he had signs characteristic of psychotrauma. It is substantiated that emotional manifestations are similar in different situations of PTSD. In the course of studying the characteristics of the manifestation of emotional states in PTSD among respondents from different groups, it was revealed that the severity of post-traumatic stress disorder is accompanied by the frequency and intensity of experienced sensations, the experience of depression, tension in stress, the experience of guilt and shame.

Conclusion. The materials of the work can later become the basis for work in identifying the system of determinants for overcoming post-traumatic stress conditions and carrying out their correction. The program we have developed can be used to help people with PTSD.

Keywords: coronavirus, post-traumatic stress disorder, PTSD, psychotrauma, emotional states

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АНАЛИЗ ЭМОЦИОНАЛЬНЫХ СОСТОЯНИЙ ЛИЦ С ПОСТТРАВМАТИЧЕСКИМ СТРЕССОМ

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РЕЗЮМЕ

Введение. В современной психологии недостаточно данных о специфике развития посттравматических стрессовых расстройств, в частности нарушений в эмоциональной сфере у личностей, столкнувшихся с чрезвычайными жизненными ситуациями (военные действия, насилие, утрата близкого и пр.) в сравнении с людьми, которые перенесли коронавирусную инфекцию.

Цель. Провести теоретический анализ проблемы и эмпирически изучить особенности проявлений личности с признаками посттравматического стрессового расстройства (ПТСР), апробировать способы психологической помощи пациентам, перенесшим психотравмирующий стресс.

Материалы и методы. В исследовании принимали участие 45 респондентов взрослого возраста (25–45 лет). Используемые в исследовании методики включают структурированное клиническое диагностическое интервью – СКИД (SCID), клиническую диагностическую шкалу (CAPS), Фрайбургский личностный опросник (FPI), шкалу психологического стресса PSM-25 Лемура – Тесье – Филлиона, тест самооценки стрессоустойчивости С. Коухена и Г. Виллиансона, The Test of Self-Conscious Affect TOSCA Дж. П. Тангняя и тест-опросник депрессии А. Бека. Применялись методы описательной статистики, U-критерий Манна – Уитни, коэффициент r-Спирмена.

Результаты. Выявлены сходные эмоциональные состояния, возникающие у лиц с психотравматическим стрессовым расстройством по разным причинам. При этом в числе одной из групп респондентов-участников исследования были также лица, перенесшие коронавирус. В данном случае обязательным было признание человеком наличия у себя характерных для психотравмы признаков. Обосновано, что эмоциональные проявления сходны в разных ситуациях ПТСР. В ходе изучения особенностей проявления эмоциональных состояний при ПТСР у респондентов разных групп было выявлено, что степень выраженности ПТСР сопровождается частотой и интенсивностью переживаемых ощущений, переживанием депрессии, напряженности в стрессе, переживанием вины и стыда.

Заключение. Материалы работы в дальнейшем могут стать основой для работы в части выявления системы детерминант преодоления посттравматических стрессовых состояний и проведения их коррекции. Разработанная нами программа может использоваться при оказании помощи лицам с ПТСР.

Ключевые слова: коронавирус, посттравматическое стрессовое расстройство, ПТСР, психотравма, эмоциональные состояния

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INTRODUCTION

Currently, there is increasing discussion regarding the widespread prevalence of mental health issues associated with various types of stressful situations, both chronic and acute. In this context, it is crucial to consider the phenomenon of post-traumatic stress disorder (PTSD). Research indicates that PTSD can manifest in a prolonged manner and have a significant impact on all aspects of an individual's life. Potential causes include serious man-made disasters, life-threatening situations, violent events, and military activities, among others [1, 2, 3].

We can observe that post-traumatic stress disorder can currently occur for various reasons, including current events related to armed conflicts. In such situations, both military personnel and civilians residing directly in these areas are exposed to stress. These individuals experience a constant sense of threat and fear, among other symptoms [4, 5]. This can adversely affect the condition of all organs and systems within a person and has a direct impact on their mental health. A number of studies have demonstrated that PTSD is a common occurrence in situations involving military action [6, 7, 8].

In addition, post-traumatic stress disorder may be a consequence of the coronavirus pandemic that has shaken the entire world in recent years [9, 10]. Researchers note that due to this, many people have been in a state of isolation, information overload, and constant concern for their health [11, 12]. As a result of the illness, a person may experience conditions similar to those of psychotraumatic stress [13].

Research into post-traumatic stress disorder is being conducted around the world. The study conducted by Kadyrov R.V. et al. (2021) states that as a result of psychological trauma, individuals often experience mental and emotional changes, such as increased anxiety, decreased ability to enjoy life, and reduced communication with loved ones, leading to increased self-isolation. Flattening of emotions and an increased prevalence of negative feelings and experiences have also been noted [14]. Another study showed that serious conditions such as depression, anxiety disorders, and various types of addiction may arise as a result [15].

Other studies have suggested that trauma can also have more delayed consequences that may manifest themselves even years after the event, complicating the lives of the individual and their loved ones [16, 17].

In cases of PTSD, individuals may experience high levels of anxiety, intrusive thoughts about the traumatic event, or alternatively, avoidance of thoughts or feelings related to the trauma [3]. According to Padun M.A. et al. (2012), the severity of symptoms depends on an individual's psychological characteristics, their level of sensitivity, and their ability to cope with such situations. Individuals cannot

independently overcome this state, and may return to it repeatedly in their thoughts. It becomes obvious that psychologically traumatic events have a significant impact on an individual's identity [18].

The identity structure of a person who has experienced a traumatic event has been established. Internal conflicts in such individuals lead to significant changes in their value system, emotional, and personal spheres. Manifestations of addictive, anti-social, and self-harming behavior may occur. Traumatic experiences often lead to depression and psychosomatic conditions [16].

In cases of PTSD, emotional difficulties often arise, manifesting as a loss of interest in activities or interactions with others. Anhedonia, or a lack of pleasure in life, occurs, as does a desire to isolate oneself from others and a reluctance to think about the future. Individuals with these symptoms become withdrawn and uncommunicative, making it difficult for them to form new relationships due to fears of attachment and loss. Previously enjoyable activities now evoke indifference or avoidance [19].

After experiencing traumatic events, individuals may face challenges in their perception of the world and their understanding of reality. They may experience feelings of depression and communication difficulties. Strong emotional tension may arise, as well as fears and other negative emotions. A positive outlook on the future may be lost, and adaptation processes may be hindered, potentially affecting behavior. Maladaptive behaviors may occur as a result of the need to cope with intense emotional experiences.

However, at present, there is limited data available from modern psychology on the specific development of post-traumatic stress disorder, particularly in relation to emotional issues, in individuals who have experienced life-threatening emergencies, such as military action, violence, or the loss of a loved one. This is in comparison to individuals who have suffered from coronavirus infection. Currently, there is a discrepancy regarding the importance of researching PTSD due to its potential negative impact on an individual's health and personality. Despite this, there is insufficient information available on the emotional manifestations of PTSD and the specific characteristics of implementing corrective programs for individuals with this condition, including those who have also experienced the post-COVID condition.

AIM

To conduct a theoretical analysis of the issue and empirically investigate the features of personality traits with signs of post-traumatic stress disorder, as well as to test methods of psychological support for individuals who have experienced traumatic stress.

The subject of the study is on emotional states in PTSD and their management.

RESEARCH METHODS

The following methods were employed in the study: the Structured Clinical Interview for DSM (SCID); the Clinician-Administered PTSD Scale (CAPS); the Freiburg Personality Inventory (FPI); the Lemur-Tessier-Fillion Psychological Stress Scale (PSM-25); the Cohen-Willianson Self-Assessment Stress Resistance Test; the Test of Self-Conscious Affect (TOSCA-3) by J.P. Tangney; and the Beck Depression Inventory.

The Structured Clinical Interview for DSM (SCID) consists of a series of questions grouped into blocks for a sequential analysis of mental disorders according to the DSM-5 criteria (affective, psychotic, anxiety, substance-induced, etc.). It is possible to administer the interview in a modular format. In this study, the questions were used to address issues related to PTSD.

The Clinician-Administered PTSD Scale (CAPS) allows for the analysis of the severity of existing PTSD manifestations over the previous month, as well as over the entire period since the traumatic event. This scale serves as a supplement to the Structured Clinical Interview and allows for the identification of the frequency and intensity of negative symptoms.

The Freiburg Personality Inventory (FPI) is designed to diagnose states and personality traits that may affect the course of personality adaptation processes and their ability to regulate their own behavior. This questionnaire includes scales that assess the following characteristics: neuroticism, aggressiveness, depressiveness, irritability, sociability, balance, shyness, openness, extraversion, emotional lability, and others.

The Lemur-Tessier-Fillion Psychological Stress Scale (PSM-25) is aimed at determining the level of stress and the features of its manifestation in each individual.

The Cohen-Willianson Self-Assessment Stress Resistance Test allows the assessment of an individual's stress resilience: excellent, good, satisfactory, poor, or very poor.

The TOSCA-3 questionnaire by J.P. Tangney provides a means of measuring the cognitive, emotional, and behavioral aspects of guilt, shame, and other emotional experiences related to self-awareness. The method assumes that manifestations of shame affect the severity of negative self-esteem. Guilt is considered as a tendency toward negative self-evaluation in specific circumstances.

The Beck Depression Inventory is used to diagnose the level of depression in a person. This questionnaire analyzes various depressive manifestations and their severity.

The main criteria for selecting the methods were their validity, reliability, and accessibility for use with different samples of individuals with PTSD.

The chosen methods allowed us to examine various aspects of emotional experiences in PTSD across different groups of participants and to test the following hypotheses: (1) an individual with PTSD may experience emotions such as anxiety, irritability, and depression; (2) PTSD resulting from emergencies, trauma, violence, loss, or other events, as well as PTSD related to the post-COVID syndrome, may manifest similar emotional and psychological symptoms.

Thirty adult respondents (aged 25–45) who had experienced psychological trauma were included in the study, as well as 15 participants who had not experienced psychological trauma (Group 3). Additionally, the study participants were divided into two subgroups based on their PTSD symptoms: 15 individuals who had faced emergencies, experienced injuries or violence, suffered loss, or participated in military action (Group 1); and 15 individuals suspected of experiencing PTSD as a result of COVID-19 infection and post-COVID syndrome (Group 2). The design and protocols of the study were approved by the local ethics committee (Protocol No. 265 dated September 12, 2022).

To determine participants in Group 2, it was mandatory not only to have manifestations related to the consequences of the disease, but also for individuals to acknowledge signs of psychotraumatic experience (according to the SCID questionnaire, it was mandatory to have positive responses to the questions in the PTSD module, which allows for the diagnosis of current symptoms).

Statistical data processing was conducted using the Statistica 6.1 software (StatSoft Inc., USA). The Shapiro – Wilk test was used to determine the normality of data distribution. Methods of descriptive statistics, the Mann – Whitney U-test, and Spearman's rank correlation coefficient were used.

RESULTS

First, we conducted a Structured Clinical Interview for DSM (SCID) with the study participants. Based on the results, the samples of respondents in Group 1, Group 2, and Group 3 were finally determined.

All respondents in Groups 1 and 2 responded positively to questions about their involvement in or witnessing extreme traumatic events, including serious injuries, death, or the threat of death for themselves or others. The causes of trauma included accidents, various forms of violence, fires, natural disasters, military action, loss of loved ones, and other events that were intensely experienced for at least one month. All participants demonstrated avoidance of relevant thoughts about these events in the present. The SCID data was supplemented by the Clinician-Administered PTSD Scale (CAPS).

The Clinician-Administered PTSD Scale showed the following results, as shown in Table 1.

TABLE 1
AVERAGE LEVELS OF FREQUENCY AND INTENSITY OF PTSD SYMPTOMS

Sample	Average values		
	Frequency	Intensity	Total average score
Group 1	25.53	29.41	54.93
Group 2	24.4	24.66	49.06
Group 3	13.7	10.8	24.53

It was revealed that respondents in Groups 1 and 2 experienced traumatic events with a high frequency and intensity, which has an impact on their well-being and social activities.

Analysis of the data using the Mann – Whitney U-test showed that there are significant differences in the level of symptoms intensity between participants in Group 1 and Group 2 at $p \leq 0.05$. The U value was 70.5 ($p \leq 0.01 = 56$, $p \leq 0.05 = 72$). We found that respondents with PTSD in Group 2 reported less intense symptoms compared to those in Group 1. When comparing the data with Sample 3, differences in the severity of PTSD symptoms were statistically significant at $p \leq 0.01$, since the U value compared to Group 1 was 0, and compared to Group 2 was 0.

The Psychological Stress Scale (PSM-25) showed the following results, as shown in Table 2.

The stress levels of respondents in Groups 1 and 2 were similar, with most falling in the medium to high range. In Group 3, stress levels were relatively low. Analysis of the data using the Mann – Whitney U-test showed that there were no statistically significant differences in the severity of stress between respondents in Groups 1 and Group 2 at $p \leq 0.01$, since the U value was 104.5 ($p \leq 0.01 = 56$, $p \leq 0.05 = 72$). When comparing indicators with those from Sample 3, significant differences were observed at $p \leq 0.01$, since the U value compared to Group 1 was 2, and compared to Group 2 was 2.5.

The Self-Assessment Stress Resistance Test (Cohen and Williamson) showed the following results, as shown in Table 3.

Average stress resistance indicators in respondents of Groups 1 and 2 were similar, indicating inadequate (satisfactory or low) resistance to stressors. Differences in the level of stress resistance between respondents in Group 1 and Group 2 were not statistically significant at $p \leq 0.01$, since the U value was 111.5 ($p \leq 0.01 = 56$, $p \leq 0.05 = 72$). When comparing the indicators with data from Sample 3, the differences in stress resistance were statistically significant at $p \leq 0.01$, since the U value compared to Group 1 was 4, and compared to Group 2 was 2.5.

TABLE 2
AVERAGE STRESS LEVELS

Sample	Average values
Group 1	107.13
Group 2	109
Group 3	46.53

TABLE 3
AVERAGE STRESS RESISTANCE INDICATORS

Sample	Average values
Group 1	23.26
Group 2	22.4
Group 3	11.93

Based on the Beck Depression Inventory results, most representatives of both groups demonstrated symptoms of depression on both cognitive-affective and somatic levels (Table 4).

Differences in the level of depression between respondents in Group 1 and Group 2 were not statistically significant at $p \leq 0.01$, since the U value was 74.5 ($p \leq 0.01 = 56$, $p \leq 0.05 = 72$). When comparing indicators with data from Sample 3, differences in depression were statistically significant at $p \leq 0.01$, since the U value compared to Group 1 was 0, and compared to Group 2 was 0.

The results of the TOSCA-3 questionnaire are presented in Table 5. It was noted that the average values of guilt, shame, and externalization were higher in Group 1. The average values for detachment, alpha-pride, and beta-pride were higher in Group 2.

Differences in the levels of guilt, shame, externalization, detachment, and alpha-pride between respondents in Group 1 and Group 2 were not statistically significant. Significant differences were found only on the beta-pride scale at $p \leq 0.02$, since the U value was 60.5 ($p \leq 0.01 = 56$, $p \leq 0.05 = 72$). When comparing indicators with data from Sample 3, differences in the levels of guilt, shame, externalization, detachment, alpha-pride, and beta-pride were statistically significant at $p \leq 0.01$, both for Group 1 and Group 2, on all scales of the method.

Consider the results of the Freiburg Personality Inventory as presented in Table 6.

It was revealed that among respondents in Group 1 and Group 2, there were elevated levels of neuroticism, spontaneous and reactive aggressiveness, depressiveness, irritability, and shyness. The values on the scales of sociability, balance, and openness were lower.

Differences in the levels of neuroticism, spontaneous and reactive aggressiveness, depressiveness, irritability, shyness, as well as sociability,

balance, and openness between respondents in Group 1 and Group 2 were not statistically significant. When comparing the results with data from Sample 3, the differences on all scales except for extraversion and masculinity were statistically significant at $p \leq 0.01$, both for Group 1 and Group 2.

Based on the research conducted, it was concluded that when working with patients experiencing PTSD, special attention should be given to addressing emotional experiences. It was proposed that a correctional program aimed at providing psychological assistance to patients who have experienced psychotraumatic stress was suggested to lead to a decrease in the intensity of negative emotional states.

The tasks of the program were defined as follows:

1. To create conditions for the person to appreciate the value of their life.
2. To assist the patient in adjusting to life, re-assessing traumatic experiences and the consequences of psychotrauma.
3. To systematically address the symptoms of a psychotraumatic condition.
4. To facilitate awareness and understanding of emotional experiences.
5. To assist in developing new behavioral patterns.
6. To broaden the range of emotional responses in various situations.
7. To redefine the individual's time perspective and develop new attitudes towards the future.
8. To search for and activate positive resources within the individual.

The following areas of work can be identified: diagnostic, advisory, corrective and developmental, informational and educational.

In the process of psychological work, significant attention is given to manifestations of grief. To this end, a support group is formed. Activities are also actively undertaken in the direction of overcoming fear and other negative emotional states through work with traumatic experiences.

TABLE 4
AVERAGE DEPRESSION SEVERITY LEVELS AMONG RESPONDENTS

Sample	Average values
Group 1	36.93
Group 2	32.06
Group 3	10.4

TABLE 5
AVERAGE DEPRESSION SEVERITY VALUES AMONG RESPONDENTS

Sample	Average values					
	Guilt	Shame	Externalization	Detachment	Alpha-pride	Beta-pride
Group 1	38.53	35.73	31.8	22.26	11.73	10.73
Group 2	31.26	30.73	28.6	23.33	14.53	17.4
Group 3	21.46	18.66	21.13	17.26	17.33	15.2

The program also involves the use of various specialized correctional techniques. Specifically, the technique of psychological debriefing has been employed. In this case, we are referring to the provision of assistance in crisis situations immediately following an event that has caused mental trauma. This is primarily an individual form of intervention. However, in some situations, debriefing may also be used in a group, as well as some time after the trauma. The program should be comprehensive, differentiated, and structured.

The initial stage is of significant importance in the process. It is essential to thoroughly familiarize oneself with the situation at hand, conduct an assessment of the client's needs, establish rapport with them, as well as preliminarily define the objectives and principles of corrective intervention. During this phase, it is also necessary to select appropriate psychocorrective techniques.

Initially, the work is conducted on an individual basis.

Let us examine the stages of the program.

Stage 1.

Establishing contact. This stage involves working with the patient's motivation and interest in the results

of therapy. Initially, the patient may be hesitant or even resistant to the work. In this regard, resistance and attempts to devalue any achievements arise. During this stage, the role of the psychologist is crucial. The specialist must recognize that such manifestations may be due to the patient's unconscious desire for secondary gains from the negative state. These secondary gains may include avoiding direct experience of psychotraumatic events, which can lead to a sense of hopelessness and the belief that no one can help. Therefore, the primary goal of this stage is to establish a positive attitude toward therapy. The psychologist should explain the tasks, directions of help, and inform the patient about drug therapy options and psychological interventions. It is also essential to discuss the clients' concerns and apprehensions.

Stage 2. "Working through grief" as a life stage.

Meetings within the program involve explaining to patients the nature of the processes they are experiencing. The activities follow a similar structure to those used in working with patients who are experiencing grief. The psychologist educates patients about the experience of traumatic situations. The need for this area of work is due to the fact that patients are often frightened by what is happening to them, they do not

TABLE 6
AVERAGE FREIBURG PERSONALITY QUESTIONNAIRE SCORES AMONG RESPONDENTS

Average values	Sample		
	Group 1	Group 2	Group 3
Neuroticism	8.2	7.9	3.7
Spontaneous aggressiveness	7.9	7.8	2.1
Depressiveness	8.4	7.9	1.8
Irritability	7.6	8.1	2.2
Sociability	4.1	5.2	7
Balance	4.2	3.1	8.4
Reactive aggressiveness	8.8	7.9	1.8
Shyness	6.9	7.3	2.3
Openness	1.7	2.3	6.6
Extraversion	5.6	6.2	4.4
Emotional lability	7.8	8.3	2.1
Masculinity	2.4	3.3	5.1

understand why are feeling so distressed, and they do not know if the situation will ever end. Therefore, it is crucial for the psychologist to clarify the natural course of this state. It is essential not only to describe the process, but also to provide examples of individuals who have faced similar challenges and successfully overcome them. This allows patients to feel connected to their current experience, recognizing themselves as individuals going through a specific stage of grief. Therefore, the life perspective becomes more realistic. This is the first and most significant step for a person to be able to view their future life in a more positive light. The psychologist should be very attentive to the patient's words. Careful attention to the patient's statements will allow for the timely identification of signs of a negative outcome and negative attitudes. This forms the basis for subsequent reprogramming and the alleviation of suffering. The psychologist employs techniques such as confrontation, questioning, rephrasing, and others.

Stage 3.

Processing guilt, shame, and aggression. This stage is devoted to processing negative emotions, such as guilt, shame, etc. These states often prevent a person from objectively viewing a situation and moving forward with it. Therefore, the psychologist assists the patient in expressing grievances, thereby helping to alleviate their condition.

Stage 4.

Processing of traumatic memories. During this stage, the patient, in collaboration with the psychologist, processes the state of psychological trauma. Specific attention is given to the processing of traumatic events. Various techniques can be employed, including the eye movement desensitization and reprocessing (EMDR) technique, which helps to organize the functional aspects of information and reduce the significance of many traumatic events and experiences.

Stage 5.

The ultimate goal of working with the patient may be to transform acute grief into a "heightened sense of consciousness". This stage concludes the period of individual therapy in our program. During this stage, the goal is to transform the state of acute grief into a more manageable and conscious state. Discussions about psychotraumatic events become less painful, and new insights into the meaning of the experience are revealed. A person can determine how they will lead their life differently, what new meanings have emerged for them as a result of the situation, and how to best relate to others.

Subsequently, group work and mutual support are implemented. Cognitive-behavioral therapy is predominantly used in correctional group work. This means that a person can gradually immerse themselves, together with their thoughts and feelings, in a troubling and traumatic situation, and analyze it from the inside, and their experiences. It is important

to focus on identifying psychotraumatic elements, including identifying distorted and irrational thoughts. This will subsequently help replace them with more constructive, adequate, and rational attitudes.

DISCUSSION

Based on the diagnostic results, it was revealed that all respondents with PTSD report a decrease in interest in leisure activities, usual social interactions and responsibilities; feeling of loneliness, increased frequency of experiences; the impact of traumatic events on their daily lives; sleep disturbances; changes in emotional states (irritability, anger, etc.); difficulty concentrating, tension.

It was revealed that respondents with PTSD experience traumatic events at a high frequency and with significant intensity, which affects their well-being and social functioning. It was noted that individuals in Group 2 reported less intense traumatic experiences than those in Group 1.

The stress levels of participants in the two groups were similar, with most participants reporting moderate or high levels of stress. Additionally, we found that participants had insufficient (satisfactory or poor) resilience to stressors.

A significant number of participants in each group exhibited symptoms of depression, both cognitively and physically. This was manifested in low mood, depressive thoughts and attitudes, feelings of self-worthlessness, increased irritability, sleep disturbances, changes in appetite, decreased libido, and other physical symptoms.

Analysis of the diagnostic data suggests that all individuals with PTSD, including those who have experienced coronavirus infection, are highly prone to feelings of guilt and shame. These feelings arise from a negative self-assessment of their behavior, both in general and in specific situations. These individuals may find it difficult to become emotionally involved in a given situation, and may appear indifferent to what is going on around them. Their ability to take pride in their own achievements and performance may be diminished. However, when PTSD is linked to coronavirus infection, individuals may still experience some level of pride regarding their specific behavior.

PTSD is characterized by symptoms that are highly indicative of a psychopathological depressive condition, manifesting in emotional state, behavior, attitudes towards others, and society as a whole. Elevated irritability also suggests an unstable emotional state, with a tendency towards emotional responses. The intensity of aggression towards the world and others increases, and occasionally an unjustified desire for dominance emerges.

Individuals with PTSD do not exhibit a strong need for communication or a constant readiness to meet this need. They demonstrate reduced stress

resilience and susceptibility to stressors in everyday situations, accompanied by a lack of trust and openness in interactions with others. Emotional volatility is observed.

CONCLUSIONS

During the research, it was possible to confirm the proposed hypotheses:

1. An individual with PTSD may experience emotions such as anxiety, irritability, and depression.
2. Those who experience PTSD due to emergencies, injuries, violence, loss, etc. and those who experience post-COVID syndrome may have similar emotional and personal difficulties.
3. A psychological intervention program for patients who have undergone psychotraumatic stress can lead to a decrease in the severity of negative emotions.

Based on the research conducted, a correctional program has been developed and implemented. It has been noted that if a person experiences depression as a result of psychotrauma, it is essential to address their emotional issues. A traumatized individual often finds it difficult to find a way out of their situation and may believe that others will judge them for it, which can lead to further decreased activity and avoidance of contact and activities. In this state, it is crucial for the individual to see that they are able to perform simple tasks and that there are instances where they can succeed. It is also essential to address situations that evoke feelings of shame and guilt. A psychologist can help the individual recognize their emotions, clarify their experiences, and become aware of their feelings. Efforts are made to eliminate negative emotions such as guilt, shame, and depression, as well as teach different ways to respond to stress.

Based on the research conducted, it can be concluded that when working with patients suffering from PTSD, special attention should be given to processing emotional experiences.

CONCLUDING REMARKS

This study has investigated the characteristics of the emotional aspect of personality following PTSD. It has been demonstrated that emotional expressions are similar in various situations of post-traumatic stress, including the possibility of this condition being observed as an expression of post-COVID syndrome. The program we have developed and the intervention we implemented have led to a substantial decrease in negative emotional expressions in patients who have experienced psychological trauma. The findings of this research can later form the basis for establishing a system of factors for overcoming and correcting post-traumatic conditions.

Conflicts of interest

The authors declare no conflicts of interest.

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