



Post-traumatic Stress Disorder Secondary to Arm Banditry Attack in A Known Hypertensive: The Menace of Arm Banditry Attack in A Primary Care Clinic of A Tertiary Hospital in Northern Nigeria

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Abstract

Original Research

Post-traumatic stress disorder following acute trauma frequently presents in primary care settings but remains under recognized and under-treated, particularly when comorbid conditions complicate the clinical picture. We report the case of a 45-year-old woman with pre-existing hypertension who developed PTSD after surviving a two month kidnapping. She presented with nightmares, sleep disturbance, and guilt lasting two months after her release, meeting DSM-5 criteria for PTSD despite initial reluctance to seek care. Coordinated management by the author (family physician), clinical psychologist and psychiatrist, including pharmacotherapy with fluoxetine, lisinopril and a thiazide-based antihypertensive regimen, combined with cognitive behavioral therapy and psychosocial support, resulted in complete symptom resolution within eight months. Blood pressure control improved concurrently with mental health treatment. This case highlights the importance of first-contact assessment by the family physician, timely psychiatric referral, and integrated care coordination for patients with psychological trauma and chronic disease. Early recognition and coordinated intervention after trauma can prevent PTSD development and optimize long-term outcomes.

Keywords: post-traumatic stress disorder, family practice, care coordination, hypertension, cognitive behavioral therapy.

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Introduction

Post-traumatic stress disorder affects a significant proportion of trauma survivors and represents a major source of disability globally. The disorder develops following exposure to a traumatic event—

such as Kidnapping, serious injury, death, sexual violence, or a threat to safety—and is characterized by intrusive memories, negative mood alterations, avoidance behaviours, and hyperarousal symptoms lasting more than one month. The incidence of PTSD



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varies with trauma type and survivor characteristics, with particular vulnerability in individuals who experience significant delays in receiving mental health care. Kidnapping and violent crime are recognized high-risk traumatic exposures. Female sex and limited access to early mental health intervention are established risk factors for developing PTSD after such events as seen in the index patient. When PTSD occurs alongside chronic conditions such as hypertension, the patient's overall disease burden increases. Cardiovascular abnormalities, including elevated blood pressure and increased coronary risk, frequently accompany PTSD and may represent both direct physiological consequences of chronic stress and bidirectional consequences of untreated anxiety. The family physician occupies a strategic position as the first point of contact for trauma survivors. Evidence-based guidelines from the National Institute for Health and Care Excellence (NICE) recommend that family physicians provide initial assessment and care coordination for PTSD, with timely referral to specialized mental health services.

This case illustrates how coordinated care across primary and tertiary care settings resulted in resolution of both PTSD and improved management of hypertension. The author initially saw this patient at the General Outpatient Clinic of Federal Medical Centre Gusau, and his care was subsequently coordinated with the clinical psychologist and psychiatrist at the same hospital.

Case Presentation

A 45-year-old married woman from Mareri, Gusau, presented on May 13, 2021, with a two-month history of nightmares and sleep difficulty, persistent guilt, and headaches. Four months before presentation, she had been kidnapped while travelling the Zaria-Funtua road to Gusau. During her two-month captivity, she witnessed the killing of other hostages whose families could not meet ransom demands. Her family secured her release through financial negotiation. She was neither tortured nor sexually abused. Starting at the time of her release, the patient experienced recurrent intrusive memories

during sleep and developed significant sleep disturbance. She slept only a few hours nightly and could not return to sleep after waking from nightmares. She attributed her trauma to her decision to take the journey that led to her kidnapping and expressed strong feelings of guilt related to this choice. She had no history of loss of concentration, fatigue, restlessness, low mood, loss of interest in pleasurable activities, suicidal thoughts or ideation. There was no history of hearing voices of unseen people in clear consciousness. She had a history of headaches, worse in the morning, dull in quality, and temporarily relieved by tablet acetaminophen 1 gram statum. Other symptoms like cough, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, and body swelling were absent. Her husband had attempted repeatedly to bring her to the hospital after her release, but she refused care until her symptoms became unbearable. The nightmares and sleep problems, which she linked directly to witnessing the killings, became the primary concerns and increasingly interfered with her daily activities. She came to the hospital expecting improvement. The patient had secondary education and was married to a 55-year-old lecturer with a master's degree. She lived with her family in a three-bedroom rented apartment. She had two children: an 8-year-old in primary school and another younger child, both living and doing well. Her family occupied the school-aged child stage according to Duvall family developmental model, with a Family Apgar score of 7 indicating a functionally intact family unit.

Past Medical and surgical history included no prior mental illness or diabetes mellitus; she also had no previous hospital admission, blood transfusion, or surgery. She had been known to have hypertension for five years, diagnosed at a government hospital and treated with medication, but adherence had deteriorated significantly since her captivity. Both her parents had hypertension, but the family history was otherwise unremarkable for diabetes mellitus or mental illness.

She did not smoke cigarettes nor drank alcoholic beverage and she was insured through the National Health Insurance Authority.

The index patient's premorbid personality was

described as quiet, reserved, and easygoing. She maintained good relationships with her husband, family, and friends and enjoyed watching Hausa movies.

Her predominant mood before trauma was happiness and had no previous forensic history.

On physical examination she was alert and oriented to time, place and person. She was not pale, afebrile, with a normal axillary temperature of 36.8°C, anicteric, acyanosed with no dehydration. She had no significant peripheral lymphadenopathy and no pitting pedal edema. Her weight was 60 kg, height 1.5 m, and her BMI was 27 kg/m² (overweight category).

Her mental state examination revealed a well-groomed, appropriately dressed woman. She made good eye contact and demonstrated responsive affect. Her speech was spontaneous with normal tone, volume, and rate. Her thought content and processes were normal. She had intact short- and long-term memory, and her insight was good.

On cardiovascular examination, she had a regular pulse of 86 beats per minute with full volume and normal synchrony. Her blood pressure was 150/90 mmHg, and the apex beat was palpable at the fifth left intercostal space at the midclavicular line. The heart sounds S1 and S2 were normal with no audible murmur.

Her chest was bilaterally symmetrical, trachea was central, she had vesicular breath sounds, and no added sounds.

Her abdomen was full moves with respiration with no area of tenderness and she had no palpable organomegaly, with nomaactive bowel sound.

Her diagnosis based on clinical presentation meet the DSM-5 criteria for PTSD with comorbid hypertension.

Acute stress disorder and generalized anxiety disorder were considered as differential diagnosis. The diagnosis and management plans were discussed with the index patient and her husband, their concerns were addressed and common ground was achieved on the need for investigations and treatment options.

The investigations ordered included urinalysis, full blood count, serum electrolytes, urea and creatinine, lipid profile, electrocardiography, and fasting blood glucose. The medications prescribed to the index patient for hypertension were tablet lisinopril 5 mg daily and tablet bendroflumethiazide 5 mg daily for one month. Also, tablet fluoxetine 20 mg daily for one month for PTSD and tablet nitrazepam 5 mg daily for one week for acute sleep disturbance were all prescribed to the index patient. The patient received counseling on the importance of presenting early to hospital after psychological trauma, practical coping strategies, lifestyle modifications, the role of social support in recovery, and the importance of regular follow-up and medication adherence.

She reflected on her reasons for poor medication adherence to antihypertensive therapy in the past and committed to regular treatment going forward. Her referral to the psychiatric clinic was arranged for specialized psychological assessment and management. She was given two weeks appointment for the next follow up visit.

First Follow-up Visit (March 29, 2021) The patient returned with her husband. Nightmares and sleep difficulty had improved considerably. She reported no new complaints and she was clinically stable. The pulse rate was 80 beats per minute, blood pressure 140/80 mmHg. The laboratory investigations showed normal urinalysis, fasting blood glucose of 5.6 mmol/L, and normal lipid profile. The electrocardiography showed normal sinus rhythm. Full blood count was normal. Serum electrolytes were within normal range. The psychiatrist confirmed the diagnosis of PTSD and continued fluoxetine 20 mg daily. The patient had a cognitive behavioral therapy session with the clinical psychologist. The clinical team reinforced the importance of medication adherence, social support, and regular follow-up at both outpatient clinics. She was given one month appointment for the next visit.

Second Follow-up Visit (April 26, 2021) The index patient was attended with her husband and reported no complaints. She remained clinically stable. Her pulse rate was 80 beats per minute, blood pressure was 110/70 mmHg. She was maintaining regular attendance at psychiatric clinic follow-up visit and

she was taking her medications regularly as prescribed along with regular CBT sessions with clinical psychologist. The tablet lisinopril 5 mg daily and bendroflumethiazide 5 mg daily were continued. The clinical team reinforced the need for family support, medication adherence, and regular follow-up at both outpatient clinics. She was also given one month appointment.

Third follow up and subsequent Follow-up visits (May 24 2021 to November 15)

The index patient maintained regular follow up at both outpatient clinics, she remained adherent to medications and follow up schedules, and reported complete resolution of presenting symptoms on 13/6/2021. At each visit, the team reinforced the importance of family support and continued medication adherence. After nine months of coordinated care of the index patient, (medications and CBT), she was discharged from the psychiatric clinic.

At the general outpatient clinic, she was maintained on two-monthly follow-up appointments for hypertension management, with blood pressure readings remaining well controlled.

Discussion

Post-traumatic stress disorder is common in primary care but frequently goes unrecognized.¹ The disorder follows significant trauma and is marked by intrusive memories, negative alterations in mood, cognition, changes in arousal reactivity, and functional impairment. This patient presented with typical features: nightmares and sleep disturbance as manifestations of intrusive memories, guilt and self-blame as negative mood symptoms, and clear impairment in daily function.²

Kidnapping and violent crime are well-established causes of PTSD.³ The index patient began to manifest symptoms of PTSD following her release from captivity. Other risk factors for developing PTSD include female sex and delayed access to mental health care.⁴ This patient had both risk factors, as she presented to the hospital for two months after captivity despite her husband's repeated attempts to bring her, and her initial reluctance to

seek care may have contributed to the development of frank PTSD rather than resolution of normal post-traumatic stress responses. The link between PTSD and cardiovascular disease is increasingly recognized.⁵ Chronic psychological stress triggers sustained activation of the sympathetic nervous system and hypothalamic-pituitary-adrenal axis, which can worsen or precipitate hypertension.⁵ This patient had documented hypertension with poor medication adherence before her trauma; her PTSD may have compounded blood pressure control. Conversely, her improvement in both psychological symptoms and blood pressure control during coordinated treatment suggests the interrelation of these conditions. Evidence-based treatment for PTSD combines pharmacotherapy with psychotherapy.⁶ Selective serotonin reuptake inhibitors are first-line medication.⁶ Cognitive behavioural therapy (CBT) is the most effective psychological intervention and is recommended as first-line psychotherapy in the management of PTSD.⁶ In this case, the combination of fluoxetine and CBT, delivered through coordinated care by the managing physicians, produced marked clinical improvement in the patient. The role of the family physician is essential. The NICE guidelines recommend that family physicians provide initial assessment, establish the diagnosis, discuss treatment options, coordinate referral to specialist mental health services, and monitor the patient's overall health, including the management of comorbid chronic diseases. Early identification and prompt referral may prevent the development of PTSD and reduce suffering to the patient.⁷

This case illustrates the impact of banditry-exposed trauma and its effect on the development of PTSD. The case further illustrates the successful first-contact care and coordination by the author, who evaluated the patient, made the diagnosis, initiated appropriate treatment, and ensured specialist input while maintaining oversight of her hypertension management.

The importance of psychosocial support, particularly from family, help in rapid recovery of clinical condition of the patient. In this case, the patient's husband was actively involved in her care,

accompanying her to clinic visits and supporting her medication adherence. Family involvement and a functionally intact family system may have contributed to her favourable outcome.

Conclusion: This case demonstrates the successful management of PTSD comorbid with hypertension through coordinated care. Early recognition of post-traumatic stress symptoms, timely specialist referral, and appropriate pharmacotherapy combined with evidence-based psychotherapy, and integration of family support all contributed to complete symptom resolution. The case underscores the central role of the family physician in providing initial assessment and care coordination for psychological trauma and the importance of recognizing the bidirectional relationship between mental health and chronic disease. Early presentation and psychological intervention after trauma are essential to prevent progression to PTSD and to achieve optimal outcomes in both mental and physical health.

Confidentiality: Informed consent for the publication of this case report was obtained from the index patient after complete resolution of PTSD symptoms.

Ethical approval: Ethical approval for the publication of this case report was obtained from the research and ethics committee of the Federal Medical Centre Gusau

References

1. Madoro D, Kerebih H, Habtamu Y, Tsadik M, Mokona H, Molla A, et al. Post-traumatic stress disorder and associated factors among internally displaced people in South Ethiopia: a cross-sectional study. *Neuropsychiatric Disease and Treatment*. 2020;16(1):2317-2326.
2. Bovin MJ, Marx BP, Schnurr PP. Evolving DSM diagnostic criteria for PTSD: relevance for assessment and treatment. *Current Treatment Options in Psychiatry*. 2015;2(1):86-98.
3. Amusan L, Ejoke UP. The psychological trauma inflicted by Boko Haram insurgency in North Eastern Nigeria. *Aggression and Violent Behaviour*. 2017;36(1):52-59.
4. Sareen J. Post-traumatic stress disorder in adults: impact, comorbidity, risk factors, and treatment. *Canadian Journal of Psychiatry*. 2014;59(9):460-467.
5. Beristianos MH, Yaffe K, Cohen B, Byers AL. PTSD and risk of incident cardiovascular disease in aging veterans. *American Journal of Geriatric Psychiatry*. 2016;24(3):192-200.
6. Merz J, Schwarzer G, Gerger H. Comparative efficacy and acceptability of pharmacological, psychotherapeutic, and combination treatments in adults with post-traumatic stress disorder: a network meta-analysis. *JAMA*. 2019;76(9):904-913.
7. Forneris CA, Gartlehner G, Brownley KA, Gaynes BN, Sonis J, Coker-Schwimmer E, et al. Interventions to prevent post-traumatic stress disorder: a systematic review. *American Journal of Preventive Medicine*. 2013;44(6):635-650.