Coordinated Biopsychosocial and Voluntary Faith-Sensitive Care for Post-Traumatic Stress Disorder Following Kidnapping: A Case Report

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Abstract

Background

Kidnapping exposes survivors to threatened death, coercion, confinement, loss of control, and possible physical or sexual violence. Survivors may subsequently develop post-traumatic stress disorder, depressive symptoms, anxiety, functional impairment, and continuing concerns about personal safety. Management may require coordinated medical, psychological, social, and culturally responsive interventions.

Case presentation

A married Nigerian woman in her early twenties presented several months after being kidnapped. She reported recurrent trauma-related nightmares, intrusive memories, avoidance of reminders, persistent fear, exaggerated threat perception, insomnia, autonomic anxiety, reduced interest, self-blame, poor appetite, impaired concentration, and substantial restriction of independent movement. Physical and neurological examinations were reported as unremarkable, and no acute alternative medical explanation was identified. The clinical formulation was post-traumatic stress disorder accompanied by clinically significant depressive symptoms.

Therapeutic intervention and outcomes

The patient received psychoeducation, collaborative safety planning, basic arousal-regulation support, and paroxetine 20 mg daily. She was referred for trauma-focused psychological treatment. At her request and with her consent, her spouse and an imam provided informal chaplaincy practical and spiritual support alongside clinical care. Serial follow-up reportedly showed progressive improvement in sleep, nightmares, fear, social participation, and independent functioning. Paroxetine was gradually discontinued after sustained remission. However, the exact psychotherapy protocol, treatment sequence, symptom-scale scores, medication duration, and follow-up intervals require confirmation from the clinical record.

Conclusion

This case illustrates the potential value of coordinated biopsychosocial care after kidnapping-related trauma. Patient-led faith-sensitive support may complement evidence-based PTSD treatment when it is voluntary, non-blaming, culturally respectful, and clinically governed. Publication should proceed only after the clinical timeline has been verified, potentially identifying information has been removed, and written informed consent for publication has been documented.

Keywords: post-traumatic stress disorder, kidnapping, trauma-focused psychotherapy, paroxetine, faith-sensitive care, Nigeria

Introduction

Post-traumatic stress disorder is a trauma-related mental disorder that may develop after exposure to actual or threatened death, serious injury, or sexual violence. Its principal clinical features include intrusive re-experiencing, avoidance, negative changes in cognition or mood, persistent alterations in arousal or reactivity, and associated functional impairment. Depression, anxiety disorders, substance-use disorders, and suicidal behaviour may complicate its course.[1–3]

Kidnapping represents a particularly complex form of interpersonal trauma. It may involve threatened death, forced confinement, physical assault, humiliation, uncertainty, financial exploitation, and prolonged loss of personal control. Following release, survivors may continue to experience realistic or perceived threats, fear of re-abduction, social withdrawal, and reluctance to travel independently.

Current clinical guidelines generally prioritise individual, manualised trauma-focused psychotherapies for adults with PTSD. Recommended approaches include cognitive processing therapy, prolonged exposure therapy, trauma-focused cognitive therapy, and eye movement desensitisation and reprocessing. Pharmacotherapy may be considered where psychotherapy is unavailable, declined, clinically unsuitable, or required for important comorbid symptoms. Paroxetine, sertraline, and venlafaxine are among the medications supported by contemporary guidelines.[4,5]

Cultural and religious resources may influence how patients interpret traumatic experiences, seek help, and engage with treatment. Patient-led integration of religious or spiritual resources may improve treatment acceptability for some individuals. Such support should remain voluntary and should not replace diagnostic assessment, risk evaluation, or evidence-based treatment.[6]

This report describes the coordinated management of a young Nigerian woman who developed PTSD symptoms following kidnapping. It highlights diagnostic considerations, restoration of personal autonomy, involvement of family and religious support, and the ethical requirements for reporting a potentially identifiable trauma-related case.

Case Presentation

Patient information

A married woman in her early twenties, who lived with her spouse and child, presented to a family-medicine clinic with severe sleep disturbance and recurrent distressing dreams. The symptoms had reportedly persisted for approximately two months.

Several months before presentation, she had entered a commercial tricycle and was abducted by two individuals. She reported being threatened with weapons, taken to an unfamiliar location, confined in a dark room, and subjected to physical or psychological mistreatment.

Presenting concerns

Following her release, she developed recurrent involuntary memories of the kidnapping and distressing trauma-related nightmares. She avoided reminders of the event, became socially detached, and experienced persistent apprehension that another harmful event might occur.

She also reported poor concentration, palpitations, chest tightness, breathlessness, headaches, markedly reduced sleep, and non-restorative sleep. Her independent functioning deteriorated considerably. She became unable to leave the home alone and required accompaniment for activities she had previously undertaken independently.

Other symptoms included diminished interest, crying episodes, self-blame, reduced appetite, and impaired domestic and social functioning. She expressed fear that she might lose control of her mind. She attributed the change in her mental state to the kidnapping and sought medical assistance. Before presentation, she had used non-prescribed sleeping medication and analgesics without sustained benefit.

Relevant medical, psychiatric, and social history

There is no previous psychiatric disorder, family history of psychiatric illness, psychoactive-substance use, significant head injury, or symptoms strongly suggestive of thyroid disease. She reportedly had supportive relationships with her spouse, wider family, and religious community. These relationships constituted important potential resources during treatment.

Clinical findings

Mental-state examination reportedly showed an anxious patient with depressed affect. No hallucinations, delusions, formal thought disorder, or cognitive disorientation were documented. Physical and neurological examinations were unremarkable. Basic laboratory investigations were reportedly within normal limits.

Diagnostic assessment

The reported symptom pattern was clinically consistent with the DSM-5 criteria for PTSD following kidnapping. Supporting features included:

Exposure to threatened death and coercive confinement.

Recurrent intrusive memories and trauma-related nightmares.

Avoidance of trauma reminders.

Negative mood and self-appraisal.

Persistent fear and exaggerated threat perception.

Sleep disturbance and autonomic hyperarousal.

Clinically significant restriction of social and independent functioning.

Symptoms reportedly lasting longer than one month.

The patient also experienced clinically significant depressive symptoms. However, there were insufficient symptoms to determine her meeting full criteria for a major depressive episode or another depressive disorder.

Relevant differential diagnoses included acute stress disorder, adjustment disorder, panic disorder, major depressive disorder, a trauma-related dissociative disorder, substance- or medication-induced symptoms, hyperthyroidism, anaemia, cardiac arrhythmia, and other cardiopulmonary causes of palpitations or breathlessness.

Acute stress disorder was considered less likely because the reported symptoms persisted beyond one month. Panic attacks may have occurred within the broader PTSD presentation, although the symptomatology recorded did not establish recurrent unexpected panic attacks followed by the characteristic persistent behavioural or cognitive

consequences required for a separate panic-disorder diagnosis.

There was no documented evidence of psychosis, delirium, or an overt neurological disorder. Nevertheless, the absence of a structured diagnostic interview, validated symptom measures, and a clearly documented risk assessment limits diagnostic certainty.

Therapeutic Intervention

Psychoeducation and collaborative formulation

The patient and her spouse received psychoeducation about trauma reactions and PTSD. Her symptoms were explained as recognised responses that can follow severe trauma rather than signs of personal weakness, moral failure, loss of faith, or irreversible mental deterioration. The psychoeducation addressed common trauma symptoms, sleep disturbance, triggers, avoidance, safety behaviours, treatment options, recovery expectations, and indications for urgent reassessment.

The advice from non-medical providers that she should avoid recalling or narrating the traumatic experience was addressed cautiously. Indiscriminate suppression of trauma-related thoughts may reinforce avoidance; trauma processing should instead occur gradually within a safe, structured, consent-based and evidence-supported intervention.

Safety planning and restoration of autonomy

A collaborative safety plan identified that the threat from the kidnappers had ended, law-enforcement agencies were involved, and the patient did not remain at risk of retaliation or re-abduction. Other measures addressed secure transportation, emergency contacts, identification of trusted support persons, and practical measures to reduce realistic exposure to harm.

Temporary accompaniment was permitted where necessary. However, treatment also emphasised graded restoration of independence to prevent prolonged overprotection from reinforcing trauma-related avoidance and perceived incapacity. Activity scheduling, sleep-supportive measures, controlled breathing, grounding, and basic arousal-regulation strategies were encouraged.

Psychological treatment

The patient was referred for individual trauma-focused cognitive behavioural therapy with a qualified therapist. The source report described a plan for at least 12 sessions over 16 weeks.

Family and faith-sensitive support

With the patient's consent, her spouse participated in psychoeducation and practical support. He was encouraged to provide reassurance and assistance without communicating helplessness or reinforcing permanent dependence.

At the patient's request, an imam working as pro bono chaplain provided prayers and spiritual encouragement. The clinical team clarified that spiritual support was supplementary and did not replace medical or psychological treatment. The religious involvement was framed around compassion, hope, social connection, and the

patient's own beliefs. It avoided interpretations suggesting that her symptoms resulted from weak faith, sin, spiritual punishment, possession, or moral failure.

Follow-Up and Outcomes

The patient reportedly experienced progressive improvement in sleep, fear, headaches, nightmares, social interaction, and community participation. She gradually resumed visits outside the home and became increasingly able to undertake activities independently.

Discussion

This case describes a clinically coherent trauma-related presentation following kidnapping. Intrusive memories, trauma-related nightmares, avoidance, persistent threat perception, sleep disturbance, negative mood, autonomic arousal, and marked functional restriction were all reported. These symptoms affected the patient's mobility, family life, social participation, and perceived personal safety.

Table 1. Provisional clinical timeline

Time point	Reported clinical status	Management
Kidnapping	Threat, forced confinement, loss of control, and reported physical or psychological mistreatment	Details of immediate medical assessment and safeguarding response were not supplied
Following release	Intrusive memories, nightmares, avoidance, persistent fear, hyperarousal, sleep disturbance, depressive symptoms, and restricted independent movement	Self-medication with non-prescribed sleeping medication and analgesics
Initial clinical assessment (day 0)	Severe insomnia, recurrent nightmares, intrusive symptoms, avoidance, autonomic anxiety, depressed affect, and substantial functional impairment	Clinical assessment, psychoeducation, safety planning, paroxetine 20 mg daily, referral for trauma-focused psychotherapy, and consented family and religious support
Two weeks (day 14)	Improved sleep and reduced headache and fear; residual palpitations and one reported nightmare	Medication and psychosocial interventions continued
One month later (day 42)	Symptoms described as substantially reduced	Biopsychosocial treatment and graded functional recovery reinforced
Subsequent months (day 98)	Progressive return to social visits and community activities; increasing independence	Follow-up, continued treatment, and restoration of ordinary roles
Later follow-up (every 2 month for 6 times i.e. 168 day)	Sustained remission reportedly achieved	Paroxetine gradually tapered and discontinued; routine follow-up ended
Termination (day 266)	Sustained remission maintained; no significant residual symptoms; full functional restoration achieved	Formal termination of treatment; review and reinforcement of relapse prevention and coping strategies; self-management protocol reinforced; discharge with open-door re-entry provision if needed

The depressive features were clinically important. Self-blame, loss of interest, crying, appetite reduction, and functional decline may occur within PTSD but may also indicate a comorbid depressive disorder. Comorbid depression can increase illness burden and may influence suicide risk, treatment selection, and recovery. The absence of a documented structured suicide assessment therefore represents an important reporting limitation.

The multimodal management was broadly compatible with contemporary PTSD care, provided that the treatment components were delivered as reported. Manualised trauma-focused psychotherapy is generally preferred as first-line treatment. Pharmacotherapy may be appropriate where a patient prefers medication, access to psychotherapy is limited, depressive or anxiety symptoms are prominent, or medication is used within an individualised shared decision-making process.[4,5]

Paroxetine was a clinically defensible pharmacological option. Nevertheless, its use in a woman of reproductive age requires documentation of pregnancy and breastfeeding status, reproductive counselling, adverse-effect monitoring, adherence, and discontinuation planning. The current report does not provide these details.

The description of both trauma-focused CBT and EMDR requires clarification. Each is a structured treatment with defined procedures, clinical competencies, and treatment doses. Listing both without explaining their sequence risks presenting treatment as an unspecified mixture of techniques. The report should state precisely which intervention was delivered, by whom, for how long, and why.

The patient's spouse may have contributed to practical safety, treatment adherence, emotional reassurance, and gradual re-engagement with daily activities. Family involvement should, however, preserve patient autonomy. Excessive accompaniment or restriction may unintentionally reinforce avoidance, communicate incapacity, and delay restoration of independent functioning.

The involvement of an imam as a pro bono chaplain was potentially culturally congruent because it occurred at the patient's request. Evidence concerning spiritually integrated psychotherapy suggests that respectful incorporation of patients' religious or spiritual beliefs may improve acceptability and outcomes for some individuals.[6] This evidence should not be interpreted as demonstrating that informal religious support alone treats PTSD.

Faith-sensitive care should therefore remain patient-led, clinically bounded, and ethically supervised. Religious leaders should not receive confidential information without explicit permission. Their contribution should avoid blame, coercion, fear-based explanations, or advice to discontinue evidence-based care.

The reported improvement cannot be attributed confidently to any single intervention. Recovery may have reflected trauma-focused treatment, medication, family support, spiritual support, restoration of safety, natural recovery, or

interactions among these influences. A single case cannot establish effectiveness or comparative benefit.

The case nevertheless has potential educational value. Kidnapping-related trauma may first present in primary care through sleep complaints, headaches, palpitations, breathlessness, or fear of mental deterioration. Clinicians should enquire sensitively about traumatic exposure, assess medical and psychiatric differentials, evaluate safety and suicide risk, and facilitate access to evidence-based trauma care.

Ethical and Confidentiality Considerations

Case reports involving kidnapping require particularly careful protection of confidentiality. Removing a patient's name or replacing it with initials is insufficient when combinations of age, location, date, travel route, family structure, occupation, institution and public events could permit re-identification. The report was reviewed against CARE guidance on patient information, clinical findings, timelines, diagnostic assessment, interventions, follow-up, patient perspective and informed consent.[7]

Conclusion

This case describes recovery in a young Nigerian woman who developed PTSD symptoms and clinically significant depressive features following kidnapping. Coordinated assessment, psychoeducation, safety planning, trauma-focused psychological care, medication, family involvement, and voluntary faith-sensitive support were associated with progressive symptomatic and functional improvement.

The principal clinical lessons are the importance of recognising trauma-related symptoms in primary care, assessing psychiatric and medical differentials, restoring autonomy gradually, and integrating culturally meaningful support without replacing evidence-based treatment.

References

1. Shalev A, Liberzon I, Marmar C. Post-traumatic stress disorder. N Engl J Med. 2017;376(25):2459–2469. doi:10.1056/NEJMra1612499.
2. Ressler KJ, Rothbaum BO, Schnurr PP, et al. Post-traumatic stress disorder. Nat Rev Dis Primers. 2026;12:27. doi:10.1038/s41572-026-00701-1.
3. Kessler RC, Aguilar-Gaxiola S, Alonso J, et al. Trauma and PTSD in the WHO World Mental Health Surveys. Eur J Psychotraumatol. 2017;8(sup5):1353383. doi:10.1080/20008198.2017.1353383.
4. Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for management of posttraumatic stress disorder and acute stress disorder. Version 4.0. Washington, DC: US Department of Veterans Affairs and US Department of Defense; 2023.
5. National Institute for Health and Care Excellence. Post-traumatic stress disorder. NICE guideline NG116. London: NICE; 2018.
6. Captari LE, Hook JN, Hoyt W, Davis DE, McElroy-Heltzel SE, Worthington EL Jr. Integrating clients' religion and spirituality within psychotherapy: a comprehensive meta-analysis. J Clin Psychol. 2018;74(11):1938–1951. doi:10.1002/jclp.22681.
7. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D; CARE Group. The CARE guidelines: consensus-based clinical case report guideline development. J Clin Epidemiol. 2014;67(1):46–51. doi:10.1016/j.jclinepi.2013.08.003.

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