



SCARS ON THEIR SOULS: PTSD and Veterans of Ukraine



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Kyiv - 2023

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GLOBSEC Kyiv Office is also very grateful to Frank Ledwidge, Alex Donelly, and Ed Lycett for their advisory role in the project.

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Co-funded by
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EXECUTIVE SUMMARY

1. The whole population of Ukraine for twenty months has been in a raw state of existence and continues to be exposed to life-threatening events. Many have sleepless nights because of the regular terror of missile and drone attacks. The majority of the population lives under constant threat with a considerable part of the country occupied by Russian forces many have experienced the worst atrocities of war with barbaric behaviour of occupants, while being exposed to tortures and forceful “russianization”. These circumstances provide the basis for Ukrainians to be particularly exposed to all war-related traumas and to develop an array of mental health issues at an unprecedented scale, including post-traumatic stress disorder (PTSD). The Ministry of Health of Ukraine (MHU) is already predicting that 3-4 mln people will need to receive drugs to manage mental health problems resulting from the war. Some 15 million will require other kinds of psychological support to balance their fragile emotional state.
2. Ukraine will be facing an enormous challenge to get the whole society prepared for dealing with the different kinds and scale of war traumas. It will need to be ready to integrate all the traumatized people to enable the country to recover. Special responsibilities in this regard will be placed not only on medical personnel or infrastructure. Social workers, teachers, policemen, ordinary Ukrainians — all should be educated to provide first-line assistance to traumatized people. Ukrainian society in general should build a capacity to respond to their needs effectively and to strengthen the psychological resilience of the nation in general.
3. We have to be prepared that real numbers of PTSD cases in Ukraine could be much higher than expectations of ‘something around 20%’, especially given the difficulties in measuring the real picture caused by so many non-reported cases or poor diagnostics, as demonstrated by the experience of countries like the US and UK. Therefore, Ukraine needs to develop an efficient approach and system for the management of PTSD, ranging from accurate and better identification/diagnosis and treatment to combatting public biases and stigma.
4. After the war Ukraine will become a standard-setting country in many areas, given the expertise it has been developing with the support of international partners during the war; for example: modern combat strategy and tactics; the ability to make and build on economy resilience; fast recovery from damage to critical infrastructure; efficiency of emergency rescue teams recovering people from under the remnants of destroyed buildings; advanced demining techniques and technologies etc. War has provided Ukraine with a unique opportunity to not only build, but to lead in medicine and treatments, given the experience obtained in urgent surgery on battlefields, prosthetics needs, healing war-related traumas, and be in a position to extend this further and become an example of best-practice globally.
5. The biggest difference of this conflict in comparison to most others in recent European history is that ordinary everyday people have been called to fight, given brief training in warfare and then sent to the front line. They are not professional soldiers; many had other professional lives prior to this conflict. Ordinary people have had to leave behind lives they once knew, therefore they are much more vulnerable to the exposure of war than professionally trained servicemen that the US and UK deploy for their military missions. Intense fighting and constant exposure to danger naturally lay them open to exhaustion and repeated trauma. With rotations of combatants taking place intermittently, there are still many fighting on the front line from the very first days of the war.
6. Military personnel are at a higher risk of developing PTSD due to the very nature and intensity of their exposure to combat situations in comparison to the general population. With this in mind, even if the war in Ukraine ends tomorrow, Ukraine will be facing a figure of 1.8 million veterans. The need to provide the most up-to-date assessment and diagnosis is paramount to drive treatment pathways of care to begin to offer them the most comfortable reintegration into a peaceful life once the war is over. The experience of countries like the US, UK, Western Balkans and even Israel could be of limited use for Ukraine owing to the unprecedented scale, intensity and duration of the current war with Russia.
7. The Ukrainian government has already taken steps to deal with not only the immediate needs of military and economic sustainability

sufficient to go through the war and achieve full victory over the enemy, but also to begin working on longer-term issues like reconstruction and planning for the post-war period, including quality of human capital. However praised, all these efforts still lack proper coordination and comprehensive strategies at a national level, which could be agile in the changing environment of the ongoing war.

8. Since the outbreak of armed hostilities in Eastern Ukraine in 2014, the issue of PTSD and other war-related traumas among combat veterans and civilians, who were within or close to the zones of combat actions, started to draw closer attention. About 80% of the military involved in combat operations in Eastern Ukraine during the Anti-Terrorist Operation (ATO), and later in the Joint Forces Operation (JFO), found themselves in a state of combat stress, which later transformed into about 25% suffering PTSD of varying severity. 20-30% of military personnel, who received psychological traumas during combat actions, were not able to solve psychological problems without external assistance. Nevertheless, the issue of PTSD in Ukraine was not properly addressed prior to February 2022.
9. Besides PTSD, war causes other mental health disorders. Military personnel will also face problems with depressive spectrum disorders, various types of addictions, phobias, dissociative disorders (depersonalization, derealization, dissociative amnesia), behavioural disorders, anxiety disorders, and suicidal behaviour. In the Ukrainian context, these will be aggravated by multiple brain injuries caused by kinetic blasts, which would make treatment more complex.
10. One of the greatest challenges for Ukraine is the gap between the enormous, identified and evolving needs on one side and the current level of available psychosocial resources on the other. To meet the needs of such a scale and high intensity among the combatants and the widest range of war-affected population, a holistic, practical, inclusive and different approach to psycho-social support and to mental health is required.
11. The development of post-traumatic stress disorder or other mental and emotional imbalances is an extreme reaction, and the risk of its manifestation can be significantly reduced and minimized, when if all who are in contact with survivors of a potentially traumatic event are equipped with the tools and skills to provide effective support in the initial stages. Based on Israeli practical experience, the most viable and effective approach is to create a widespread network of non-stigmatized psycho-social support networks on the ground, at the community level.
12. Existing practices of PTSD classification cause a great deal of confusion, as some countries (like the US) use DSM-V, whereas in most European countries ICD-11 serves as a reference material. PTSD and Complex PTSD (CPTSD) are known in European practice as *Type-1* and *Type-2* traumas, which would require different approaches for treatment. Recent reviews highlight the lack of consensus regarding the trajectory of PTSD, the diversity of approaches in the diagnosis and treatment and inconsistencies in defining response to PTSD treatments as problematic. Given the disparity between both the DSM-V and ICD-11, it is vitally important that a unified approach is applied.
13. Complex PTSD results in a permanent change in brain chemistry, continual arousal of dissociative states, dysregulated neuropathophysiological processes affecting the brain, gut, endocrine, and neuroendocrine, and changes to DNA sequencing (ref research inserted), leading to a fragmented immune system autoimmune diseases, poor physical health outcomes, premature death and suicide ideation. Complex PTSD can lead to high-risk behaviours and has been linked to comorbid psychiatric disorders and physical health problems, addiction, and self-harm. It, therefore, requires wider assessment and an eclectic treatment regime by those qualified in the field of trauma.
14. In its practice Ukraine uses ICD classificatory, however in modern practice, it still refers to ICD-10 as a national-wide recommended document. ICD-11 is in use with not a big group of Ukrainian psychiatrists. This creates serious confusion when it comes to the right statistics and even treatment, given the difference between PTSD and CPTSD. The reasons for not adjusting the current classification to modern ICD standards nationwide lie in Ukrainian bureaucracy, which is slow to make respective amendments to a number of internal regulatory acts. As a result, many practitioners and profile institutions keep using older ICD-10, where CPTSD is not yet in place. This administrative glitch should be corrected as soon as possible, as CPTSD is highly likely to be a prevailing type of PTSD in Ukraine.
15. It is important to ensure that PTSD is diagnosed and treated in a timely fashion, to reduce patients' suffering and improve their mental and physical health. Although PTSD can have

long-term effects, early and adequate treatment can help prevent or mitigate such effects. Left unaddressed, PTSD can become chronic and lead to incremental health issues, a decline in performance and quality of life. Rehabilitation is also important because it helps patients recover after treatment and prepare for a full-fledged life by coping with the trauma sequela and getting back to normal activities.

16. There is a consensus among many professionals that various treatments for PTSD have so far shown limited success, with existing psychological therapies demonstrating success in outpatient treatment for about one-third of them. A treatment is considered successful if a patient reaches positive remission and is able to interact with society. In most international practice, the first line of treatment comprises different kinds of psychological therapies. The use of medical prescriptions is always considered at a second stage when symptoms remain or get worse.
17. Vast scientific evidence challenges the current ideology of PTSD. It supports the need to provide both neurophysiological assessment and respond with a wider eclectic treatment regime to slow down disease progression and provide optimum recovery. It challenges the current overuse of talking therapies as front-line treatment for PTSD. Increasing knowledge in the clinical correlation of pathological disease progression will provide a greater understanding of innate systems of immune pathways linked to PTSD, and will enable to apply early treatment and reduce disease progression.
18. Despite having not been incorporated into worldwide practices of PTSD treatment on a large scale yet, an approach of looking at PTSD through the lens of neurobiology is worth considering, given the apparently low efficacy of traditional methods of PTSD diagnosis and treatment. Merely assessing the psychological symptoms of PTSD and responding with psychological treatment is futile given that PTSD has more of a biological underpinning than any other mental health disbalance that drives psychological symptoms. One suggested approach is to use biomarkers tests, to identify the existence of inflammation in a patient's body, that could provide a more accurate assessment and a further line of treatment (which is always individual), as the existing practice of diagnosis remains reliant on subjective, observational assessment and fails to consider underlying neuropathophysiological changes that occur due to dysregulated metabolic states.
19. A polytrauma approach needs to be applied for those who are diagnosed with CPTSD to apply accurate assessment, diagnosis and treatment and cross reference with triage of related injuries, including ongoing monitoring of constellation of health-related immune diseases linked to the disorder that increases over time.
20. Treatment for PTSD in Ukraine is similar to internationally recognized traditional practices. Approaches to treatment are based on the unified clinical protocol of primary, secondary (specialized) and tertiary (highly specialized) medical care (UCPMC) "Response to severe stress and adjustment disorder", which MHU has developed in line with the effective requirements of evidence-based medicine. CBT, CT, CPT and PE are used as a method of first choice. Other methods in use are narrative exposition (NET) and EMDR. Medical treatment is based on a prescription of anti-depressants of SSRI class. New experimental methods of treatment and rehabilitation are being developed now in Ukraine, eg. VR360 technology.
21. The major challenges relating to proper diagnosis and treatment of PTSD in Ukraine are: (1) insufficient education of specialists; (2) difficulties in diagnostics; (3) problem denial; (4) lack of public apprehension; (5) limited accessibility of psychotherapeutic care; (6) insufficient financing for public health care; (7) non-compliance with the therapeutic process; (8) stigmatizing trauma and different cultural profiles; (9) specific challenges for veterans and the military; (10) comorbidity with other mental disorders; (11) loss of access to therapy; (12) duration of therapy and relative effectiveness; (13) unqualified specialists.
22. There is a need to see more leadership from the Ministry of Veteran Affairs of Ukraine (MVAU) both in driving veteran policies, and establishing communication among the ministries. Nowadays, it also looks like different veteran associations tend to cooperate on their initiatives with different governmental institutions, not necessarily the MVAU. This is partially due to confusion with respect to a leadership role when it comes to war trauma mental disbalance (WTMD) and the mental health of veterans in Ukraine, that is aggravated by multiple coordination inter-agency networks for mental health issues, which have come into existence over the last year: The Interagency Coordination Council on Mental Health Care and Psychological Support for Individuals Affected by Russian Aggression against

Ukraine, Coordination Center for Mental Health, Support Centers for Civilians Network within the Regional State (Military) Administrations.

23. The physical and psychological health of veterans/ex-servicemen are not separate things, but WTMD has been merged within the suggested common policy on mental health, both at national and regional levels. The current initiative of the MVAU to establish an institution for a 'Veteran Assistant' in every local territorial community could be considered as a useful, but not sufficient link between a veteran and the system of medical and social care. Given the potential number of veterans in Ukraine after the current war, it deems advisable to consider an extension of the competence of the MVAU over veteran affairs with WTMD treatment included, like it is organized in the USA, where the Veteran Affairs Department of the Ministry of Defense is also charge of the National PTSD Center and a network of polytrauma centers across the country, and receives respective financing for this type of activities from the federal budget.
24. It is difficult to assess the efficacy of governmental plans in Ukraine to establish a coherent system of medical and rehabilitation centers, specializing in traumas, as well as on perspective needs in resources (medical personnel, infrastructure and financial support). Yet, some estimate that Ukraine would need to double the figures of specialists available from the current 4095 psychiatrists, 1067 psychologists and 473 psychotherapists. Prior to the full-scale war with Russia many people, after receiving a degree as a psychiatrist/military psychologist/medical psychologist/psychologist, were not motivated to work in their speciality area, due to dissatisfaction with the social package (high psycho-emotional stress, low salaries, neglect of self-regulation, work/rest schedule and, as a result, rapid burnout). Ukraine did not have many trained personnel to deal with war traumas and those willing to work in the profession after the full-scale invasion had to obtain the necessary knowledge and qualifications in a very limited timeframe. Access to respective educational programs and training had been limited, which was caused by a shortage of correspondent training courses in Ukraine and limited knowledge of military psychology, as well as by a simple lack of knowledge of the English language to access international courses.
25. A serious problem for the quality of services provided arises from the 'fashion to become a psychologist' in war times, which is widespread in Ukraine these days. Sometimes people begin non-certified practice upon completion of these fast-track courses only. This trend is very dangerous and harmful, as unprofessional service could only aggravate mental disbalance in a patient and lead to re-traumatization. With due respect to people's sincere wish to help others coping with traumas, they do not fully understand the level of responsibility for consequences and potential costs of mishandling a situation. This is a problem that the Ukrainian government has to pay serious attention to.
26. Nowadays a variety of factors affect the quality and accessibility of WTMD-related services in Ukraine, with the main ones being: (1) a significant shortage of psychologists in military units in hospitals; (2) a lack of necessary knowledge and skills among specialists; (3) undue use of psychological protocols by specialists; (4) trauma specialists in hospitals of general care; (5) lack of coordination in the transfer of patients between military medical units / hospitals / civilian medical institutions / rehabilitation centers / family doctors / social support centers.
27. Partial psychological rehabilitation was introduced for ATO participants after 2014–2015 and was compulsory for all ex-combatants. At the same time, in 2017 the level of supply of this service to ATO veterans accounted for only 0,1% of the needs. The situation has been partially improved in recent years with the enlargement of medical capacities to treat veterans, who suffered from WTMD. In 2018 the Government of Ukraine increased financing for rehabilitation services for veterans, which enabled it to enlarge capacities for treatment and slightly improve infrastructure. A national Center for Mental Health and Rehabilitation of Veterans based on the War Veterans' Hospital "Lisova Polyana" was opened in September 2019 with some other centers followed.
28. Against a background of significant financial support provided to Ukraine by its international partners to strengthen the resilience of a war-torn country, assistance for mental health and trauma treatment, as well as support for veteran policies remains strikingly small. Initiatives on psychological rehabilitation and treatment of veterans should be expanded further with a view to the prospective integration of Ukraine into the EU, when Ukrainian veterans become part of EU human resources. Some of them might even migrate to European countries to get reunited with their families who had to flee

Ukraine in the early days of the full-scale war. It seems reasonable to consider the possibility of using more financial instruments of the EU and NATO to work in the area.

29. Recently a number of draft legislative acts have been introduced in Ukraine to regulate the provision of medical and psychological care and support for patients with signs of acute psychological trauma of direct impact or their mixed nature, associated with the experience of negative consequences, more complex consequences of war, irreversible losses, injuries, etc. These also stipulate criminal responsibility for non-certified specialists, who provide psychological services to the population. The initiatives are considered to be the right move in a direction to streamline and organize a chaotic process of psychological services in Ukraine. An open issue remains as to which state agency will become the authority responsible for the certification and accreditation of specialists.
30. The surge in interest in the topic of PTSD in Ukrainian society has led to heated discussions about the scale of the affected population and the potential after-effects on the health of the nation. At the same time, the lack of public professional discussions and research on the topic creates an anchoring of negative stereotypes in society and hardens unhealthy stigma. It would be justifiable to say that there is still much ignorance about PTSD among the population of Ukraine, and even among professional medical staff.
31. Countries are trying to resolve the stigma attached to PTSD with special public awareness campaigns to establish a more positive image of veterans who obviously need the help and support of society to adapt to a peaceful life upon return from their combat missions. These days most tend to frame PTSD as 'invisible wounds of war', a 'temporary disorder of recovery', or a 'healthy reaction to life-threatening circumstances', and to break away from 'PTSD as an 'uncurable illness and strong mental disorder'. There is a real need for nationwide advocacy campaigns in Ukraine to set a positive frame for PTSD as a temporary mental disbalance that can be effectively treated, especially with timely diagnosis. Society should be informed about its nature and consequences and become mature and responsible enough to face this phenomenon as one of the wounds of the war that needs to be healed.
32. Experience in other countries shows that social environments can play a major role in triggering the emotional conditions of mentally vulnerable veterans. The Ukrainian government and society are well aware of this societal effect. Therefore, both are quite active in developing opportunities for veterans to realize themselves in new professions and find a new sense of purpose. Different research and the personal experience of veterans provide enough evidence that professions like paramedics, rescuers, deminers, emergency services and other adrenaline-high professions, as well as military psychologists and psychotherapists, would be very suitable for former combatants. They also can demonstrate themselves very well as private entrepreneurs and para-sportsmen.
33. The MVAU responded to address the needs of veterans in a more systemic way. In summer 2023 it elaborated a *Strategy of Transition from Military Service to a Peaceful Life by 2032*. In this Strategy, one of the main focuses was placed on opportunities for professional training and re-training of veterans in new professions, academic work, veteran entrepreneurship etc. In the summer of 2023, the Ministry also launched a pilot project of the *Centers for Veteran Development* (with a focus on professional training and further employment) altogether with the veteran assistants' network in 5 regions of Ukraine (Dnipro, Vinnytsia, L'viv, Mykolayiv and Kyiv), which a view to expand the practice onto all 21 regions of the country in 2024.
34. Many countries, which have faced similar challenges of accommodating ex-combatants into peaceful life, acknowledge that providing a veteran with mere pension allowances (however high) could be destructive and lead to increased negative side effects like alcohol and drug abuse, domestic violence and criminal activities and so on. Also, social and economic uncertainty, with vague perspectives for employment after the war could aggravate concerns about the future and deepen feelings of depression and anxiety, which is likely to be the case in Ukraine if there are no clear-cut pathways for a peaceful life. With the general level of anxiety about the future in Ukraine remaining rather low (33% against 58% of positive confidence in the future), this mood might change with time, especially if there is no definite government strategy to address the issue in place. These pathways have to be developed and set already now during the ongoing war.
35. Housing for veterans remains one of the most acute problems in Ukraine. Existent funding does not cover all the needs of veteran families, which has been aggravated by the scale

of destruction of private houses and even residential blocks as a result of heavy shelling. As of April 1, 2023, there has been a queue of over 32 000 veteran families waiting for housing under the government benefit scheme (5,5 bln UAH from the state budget capable of covering the needs of 2 843 families). The Ukrainian government is also currently working on a new program for compensations of mortgage rates (7%) for housing “e-Oselya”/”There is a house”.

- 36.** Unlike more individualist Western cultures, in Ukraine, family and religion play important roles in the system of values and could be effectively used as efficient accommodating factors when it comes to healing the psychological wounds of war. Like in Israel and the Western Balkans, Ukrainian families are also more likely to show sympathy and understanding of war traumas, as they partially experience the same because of the Russian attacks on civilians. Within this group of closer relatives, a particularly vulnerable one is that of relatives of missing and captured servicemen, who are living through everyday anxiety about the destiny of their loved ones. They are more likely to develop PTSD symptoms than those who still communicate with their relatives fighting on the front line. On the other hand, the mentioned category is also more active in public campaigns that contribute to disseminating information and raising awareness of the costs of war internationally.
- 37.** By the end of the war a significant part of the Ukrainian society will have direct experience of war through their family ties. They need to be prepared how to deal with a relative, who is returning home after the war, and how to accommodate him better in a peaceful environment. The rich experience of other countries teaches us that family members being estranged from this experience in most cases fail to understand the inner conflict in a soldier and may not be able to cope with the new reality. As a result, we see higher levels of domestic and sexual abuse, divorces and separations, which makes all suffer.
- 38.** Still little attention is given in Ukraine to combatants’ families when it comes to making them prepared for the return of their loved ones. Despite a number of government initiatives to work with combatants’ family members, their scale is insufficient because of limited resources and a shortage of qualified professionals to provide this kind of training. The situation is particularly acute in rural areas, which, however, have provided the highest number of soldiers during mobilization.
- 39.** In the Ukrainian context, religion and spirituality will definitely be one of the most noticeable effects of post-traumatic growth due to the general cultural affinity to religion and a strong faith in God. This will especially be the case for those families, who lost their loved ones in the war and will be seeking ways of coping with grief of loss. Here there is a potential for Ukrainian religious confessions to play a significant part in restoring their role in society and to help those vulnerable accommodate themselves to the new reality.
- 40.** The veteran community in Ukraine is very vibrant and sometimes could be seen as being strikingly united. The veteran movement started to form during the 2014–2015 war with Russia with 400 registered charities in 2016 and 750 in 2017. Since the beginning of the current war, their number has grown exponentially. Some veteran /combatant groups like the Azov Patronage Service have developed into a coherent eco-system of taking care of their comrades’ needs from first aid on the front line to psycho-rehabilitation, employment and family support. Others like the NGO “Space of Opportunities” actively engage with local authorities and municipalities to build a network of veteran entrepreneurs educated in modern project management to set up their own businesses.
- 41.** Deliberate avoidance of seeking treatment for clear WTMD issues is a cross-cultural factor. Despite the difference in the cultural mindset of the role of a psychologist in someone’s life, which is more normal for Western cultures and less fashionable in Ukraine, military veterans and active servicemen across continents alike tend to decline such treatment for almost the same reasons which include: (1) they do not want to be seen ‘weak’ ones who are having mental health issues; (2) they do not want their career to be permanently impacted because they sought help; (3) fear that a certain diagnosis can make them non-deployable or forced to change military occupation, or even see them removed/retired from service. All of these concerns could be addressed by proper public campaigns that reframe negative stereotypes of mental assistance from ‘illness’ into more positive ‘mental hygiene’. People need to get used to considering constant psychological checking after receiving complex war traumas as something routine, but necessary for wellbeing.
- 42.** In Ukraine, the Western Balkans and Israel it is much easier to deal with public stereotypes of war veterans, who are in most cases

considered as glorious defenders of their motherlands. The situation is more difficult for countries like the US and the UK, where there is at best an abstract understanding of soldiers 'duty to defend their countries in distant territories'. Yet, with the passing of time, Ukrainian society might be showing more visible signs of indifference to veterans' deeds and needs, thus, creating more risks of social tension and polarization. In twenty-one months of the war, Ukraine still has not developed a sense of total defense, where each citizen considers himself as a defender of the country on its own front. Owing to the size of the country's territory, there is less visceral awareness of war in Western regions (except for air raid periods) than in the East. Because the nation still has not developed a state of an active war in every Ukrainian soul, developing proper attitudes to and appreciation for servicemen and the veterans' cohort becomes a visible challenge.

43. At least one of the factors like de-commissioning humiliation, long queues for medical services, shortage of specialists in local areas, or unqualified psychotherapy counselling was named as being relevant to the experience of sample countries in the research with Israel

being the least troublesome (with de-commissioning humiliation being the only significant factor). The UK gained a top score for long waits for treatment (sometimes the waiting list is up to 18 weeks), slow bureaucracy and lost papers, shortage of qualified staff, answer machines on hotlines etc.

44. Contrary to positive expectations within Ukrainian society that suicides and crime won't be major problems for Ukrainian veterans, statistics of other countries and previous experience from the war in Ukraine of 2014–2015 indicate that the Ukrainian government still needs to consider these risks seriously to outline a number of preventative initiatives to mitigate the risks. On the positive side is the fact that culturally Ukraine is not a country with excessive rates of depression. On the other hand, figures of suicides committed by veterans and servicemen are very difficult to count, especially these days when information about losses is classified. Even with a smaller number of cases of Ukrainian ex-servicemen going to jail for criminal offences, the practice of other countries, especially the US and UK, shows that the kind of crimes committed by ex-servicemen are often of the most serious category: murders, rape and various other abuses.

INTRODUCTION

With the ongoing war waged by Russia in Ukraine 20 months on, the support by allied nations around the world to protect Ukraine's freedom has shown and continues to show overwhelming support. Much-needed equipment has inevitably helped to maintain a strong fighting force at the front line. However, an army does not march on military resources alone; its biggest asset is its people who need the mental capacity to maintain and respond to the worst atrocities of war. The need to support the mental health and well-being of those who have risen to the cause needs equal consideration if we are to continue to maintain a fighting force on the front line. Consideration also needs to be given to maintaining the mental capacity of those who will be responsible for rebuilding Ukraine for future generations to come. Many of them are already feeling deep loss due to displacement of family members, loss of loved ones, shattered communities, broken lives, education cut short, and the existence and uncertainty of what the future holds, all of which are the hallmarks of war.

The Ukrainian government has already taken steps to deal with the immediate needs of military and economic sustainability sufficient not only to go through the war and achieve full victory over the enemy, but also to begin working on longer-term issues like reconstruction and planning for the post-war period, including quality of human capital. In this regard, a number of initiatives are being developed such as how to return displaced Ukrainians, back to their homeland (IDPs), to consider needs of those who are living in liberated or temporarily occupied territories, Ukrainian military servicemen and veterans. However praised, all these efforts are still lacking proper coordination and comprehensive strategies at a national level, which could be agile in the changing environment of the ongoing war.

By presenting this paper, GLOBSEC would like to contribute to development of Ukraine's future viable strategic tools for sustainable policies. We want to invest today in laying down the foundations for a healthy tomorrow. With this in mind, GLOBSEC has undertaken a review of international research and launched a series of papers on war-related traumas. The purpose of this particular work is to provide the Ukrainian government with policy recommendations on establishing a viable and efficient

integral eco-system for tackling post-traumatic stress disorder (PTSD) and other war trauma mental disbalance (WTMD)¹ in veterans and to lay down the foundations of this system already these days. It considers policy recommendations for the Ukrainian government based on the valuable knowledge of our highly qualified international experts.

The rationale for selecting this particular subject and focus is self-evident. Modern conventional warfare in Ukraine is unprecedented in its scale, intensity and duration. The biggest difference of this conflict in comparison to most others in recent European history is that ordinary everyday people have been called to fight, given brief training in warfare and then sent to the front line. They are not professional soldiers; many had other professional lives prior to this conflict. Ordinary people have had to leave behind lives they once knew, therefore they are much more vulnerable to the exposure of war than professionally trained servicemen that the US and UK deploy for their military missions. The whole population of Ukraine for twenty months has been in a raw state of existence and continues to be exposed to life-threatening events. Many have sleepless nights because of the regular terror of missile and drone attacks. The majority of the population lives under constant threat, with a considerable part of the country occupied by Russian forces: many have experienced the worst atrocities of war with barbaric behaviour of occupants, being exposed to torture and forceful "russianization". These circumstances provide the basis for Ukrainians to be particularly exposed to all war-related traumas and to develop an array of WTMD issues including PTSD at an unprecedented scale.

Direct consideration needs to be given to those who are currently fighting for our country on the front line. Intense fighting and constant exposure to danger naturally lay them open to exhaustion and repeated trauma. With rotations of combatants taking place intermittently, there are still many fighting on the front line from the very first days of the war. With this in mind, even if the war in Ukraine ends, tomorrow Ukraine will be facing a figure of 1.8 million veterans. The Ministry for Veterans Affairs of Ukraine estimates that the number of veterans and their family members may reach five million people (which in different estimates accounts for 10-20% of

¹ Here and further we deliberately use new frame of 'disbalance' instead of 'disorder' as part of our proposal to get to a more positive perception of temporary abnormal psycho-condition caused by war traumas in order to beat stigma of PTSD (for more detailed explanation, please consider respective Section in this research 'Putting a Framing Right').

the total population). But the war is not over yet and will likely not be in the immediate future. The real number of veterans in Ukraine will most certainly be much higher.

The war in Ukraine has also caused unprecedented challenges with the displacement of healthcare professionals and the destruction of medical facilities across the country. A **Health Needs Assessment** (HNA) conducted by WHO (2022), found that 1 in every 3 members of the population in Ukraine had difficulty accessing medical treatment. The Ministry of Health of Ukraine (MHU) is already **predicting** that 3–4 million people will need to receive drugs to manage mental health problems resulting from the war, and about 15 million will require other kinds of psychological support to balance their fragile emotional state.

The first paper in this series considers PTSD in its complex nature, with new insights of research that grew out of the Iraq and Afghanistan conflict taken into consideration. The main focus of this study will be placed on Ukrainian veterans and the system of veterans' care in Ukraine around the PTSD phenomenon, which will be assessed from the point of future needs of servicemen who nowadays urgently require a level of decompression to maintain a fighting force on the front line and to reduce risks of complex PTSD development. Those responsible have a moral duty to pay back with gratitude, respect and honour to those who have fought and continue to fight on the frontline to protect our freedoms. The need to provide the most up-to-date prevention resilience tools, assessment and diagnosis is paramount to drive treatment pathways of care, as well as further rehabilitation, to begin to offer them the most comfortable reintegration into peaceful life once the war is over. With this paper, we endeavour to assess how prepared the system is to welcome and return gratitude to those, who have risked or currently risking their lives to guard our present and future and to reintegrate them into the Ukrainian society.

There is a need to consider and analyze whether Ukraine has sufficient capacity and resources to handle the issue of veteran treatment efficiently and professionally. This comes from understanding of some poor legacy of the medical and social care inherited from the Soviet Union, which has not advanced much during 30 years of independence of Ukraine. Before the full-scale war begun in February 2022 Ukraine had not become a social welfare state, with medical and social services receiving insufficient funding from the state budget. As will be shown in the report, the issue of PTSD was not properly addressed prior to February 2022, even though Ukraine has in a war with Russia

since 2014, and already then many combatants had suffered from different types of psychological disbalance. Other factors like medical reforms in 2016-2018, COVID-19 and the significant outflow of Ukrainians since February 2022 have contributed to a substantial decrease in the number of psychiatrists, psychotherapists and other medical professions, thus, causing a shortage in professional cadres to address PTSD and other war-related health problems in Ukraine from that time on.

Tackling PTSD is the most complex and challenging issue as it is about:

1. both mental and physical well-being;
2. comfortable social environment (affordable and sufficient state services);
3. promoting a caring society and demonstrating sound diligence and good practice;
4. identifying the best opportunities to heal war wounds (in the most comprehensive meaning of this);
5. proper and best use of scarce resources by being accountable and transparent;
6. promoting and engaging in best practice;
7. continuing to build relationships and collaborate with international partners through the work.

It is important that after the war Ukraine will become a standard-setting country in many areas, given the expertise it has been developing with the support of international partners during the war; for example: modern combat strategy and tactics; the ability to make and build on economy resilience; fast recovery from damage to critical infrastructure; efficiency of emergency teams to save people under remnants of destroyed buildings; advanced demining techniques and technologies etc. We believe that war has provided Ukraine with a unique opportunity to not only build but to lead in medicine and treatments, given the experience obtained in urgent surgery on battlefields, prosthetics needs, healing war-related traumas and be in a position to extend this further and be an example of best-practice globally

METHODOLOGY OF RESEARCH

Upon reviewing the international platform of those already providing services for military personnel/veterans and their families, as well as the literature obtained and discussions that have taken place our expert team has come to the conclusion that there is no consistent replicable or reliable service model to consider as a 'ready-made' example for Ukraine. Equally interviews with those who were either involved in delivering services or had received treatment provided a stark insight into the difficulties and poor outcomes, despite a considerable amount of within-state budgets being applied.

It has been acknowledged by many international experts in our research team and throughout our numerous interviews in the US, UK, Croatia, Bosnia and Herzegovina (BiH) and Israel that the experience of their respective countries could be of limited use for Ukraine owing to the unprecedented scale and duration of the current war with Russia. Even Israeli experts say that all the experience they obtained in addressing PTSD could be very limited in terms of Ukraine's needs, as the longest war with similar intensity was that of the Second Lebanon War in 2006 (for 33 days only compared to over 555 days of the Russo-Ukrainian war by now).

The need to make a comparative study with a focus on Ukraine was, therefore, all the more important. In this respect, the study is based on lessons learned from the countries that have the longest experience in addressing PTSD in their military servicemen and veterans. Other criteria that have been used for countries' selection are as follows:

1. long history of active participation in international military conflicts/wars;
2. the largest communities of combatants/veterans about the percentage of the general population;
3. intra-territorial war (i.e., a war has happened on the territory of the country) in order to consider a wider effect of war traumas to include civilian population (relevant for general sympathy);
4. national practices to tackle PTSD, which have received international recognition and are used by other countries as indicative manuals (scientific research, treatments, rehabilitation practices, preventive tools etc.).

For selection, we picked countries, that match, at least, two of the criteria listed above and came up with the following countries to compare with Ukraine: the USA, UK, Israel, and Western Balkans (Croatia and BiH). GLOBSEC has invited representatives of these countries, who have relevant experience in medical treatment, policy-making and personal experience of going through PTSD treatment (veterans) to join our research team and to bring the best knowledge into our research.

In our analysis, we looked mostly at lessons learned in terms of exposed bottlenecks and weak spots, which we would like to bring to the attention of the Ukrainian government, while formulating a respective national strategy for dealing with PTSD for military servicemen/veterans, together with perspective solutions that are currently being elaborated in the countries in question in response to lessons learned. We also considered the strongest elements of national policies (what worked well) and suggested those of them applicable to Ukraine's case).

Within our research, we used open data analysis, personal interviews by GLOBSEC with former and current government officials, medical experts (psychiatrists, psychotherapists, psychotherapeutics), academics, veterans' associations and individual veterans from all listed countries, as well as official responses to GLOBSEC's formal requests to the Ministry of Veteran Affairs and the National Service of Health of Ukraine. Altogether there have been over 50 interviews conducted.

We also studied the current situation in Ukraine from the point of a country's specifics, current scientific discourse, treatment (including experimental) and supportive rehabilitation practices, as well as resource sufficiency to address PTSD and WTMD.

Data imperfection. It needs to be said, however, that our team had to operate on imperfect data for analysis, which may impact the correctness and accuracy of our assessments. Firstly, we were able to access only figures representing officially registered cases, whereas it is acknowledged across all the countries under analysis that many of veterans still do not report their worsened psychological conditions to doctors. Most figures we used were obtained from different resources, which sometimes

conflict even within one country.² Also, some of the data (e.g. on the number of suicide cases) include not only veterans but actual servicemen in the US, UK or Israeli armies, which is sometimes very difficult to disaggregate. Another element of uncertainty comes from the unknown real number of Ukrainian servicemen, who will become veterans after the war is over, as this data in times of the ongoing war is classified. Also, many veterans from the previous

war of 2014–2015 have changed their status and become mobilized as servicemen/combatants again since February 2022, which makes the current assessment more difficult. Therefore, our projections on the number of veterans once the war is over were made on the assumption of potentially 2 million Ukrainian service personnel (including 200 000 more to the given figures of 1,8 million), who will obtain veteran status after the war.

² For instance, in its **11th Report on Mental Health and the Armed Forces, Part One: The Scale of Mental Health Issues** from July 2018, the Defence Select Committee of the UK Parliament openly points this contradiction in data on actual statistics of PTSD affected veterans in UK, which were provided by the Government (namely, the Ministry of Defence), independent scholars and medical services.

I. MAKING THE CASE FOR PTSD AND OTHER WAR RELATED TRAUMAS IN UKRAINE: NEITHER OVER-DRAMATIZE, NOR UNDER-ESTIMATE

The war that Russia waged in Ukraine in February 2022, the intensity of combat, the level of atrocities seen and lived through by Ukrainians and overshadowed by regular air raids has given a surge of attention to issues of war-related psychological traumas in Ukraine. This interest did a good service for raising awareness in the Ukrainian society to the problem, with the most efficient and positively perceived nation-wide campaign under the patronage of the First Lady of Ukraine Mrs Olena Zelenska. On the other hand, it has also given rise to speculation over the potential scale of the problem and the affected population, with a lot of people tending to over dramatize it and paint the future negatively. It also contributed to a 'fashion' among many Ukrainians of becoming a specialist in trauma/PTSD or setting up a rehabilitation center, without having even the most basic professional knowledge of how to deal with these issues.³

While working on the problem, we came across different subjective projections ranging from ten⁴ to one hundred⁵ percent of the affected population. The Ministry of Health of Ukraine gave their own estimations of around 5 million Ukrainians, who may be in need for medical assistance related to mental health after the war, at the same time denying that PTSD levels will be higher than 20% of population. We also have been hearing calls to stop over dramatizing the situation, especially with potential PTSD estimates, and to give more emphasis in teaching people preventive strategies of resilience in traumatic events. While the latter proved to be a very useful and powerful instrument, which, inter alia, contributed to a striking decrease in the level of PTSD in Israel from 20% in 1973 to 1-2% today, it could only be partially helpful in current situation in Ukraine, as all of Ukrainians have already had their first shocking experience in early days of war and throughout these 20 months, leading now to cumulative trauma experience, which is not over yet.

From these considerations, we already have to deal with traumas in the immediate future and to use preventive tools to achieve sustainable psychological resilience in the medium and long term.

With this work GLOBSEC would like to set up the appropriate framework for addressing PTSD and other war-related traumas: not to over-dramatize, but to access the reality in a mature way. PTSD will undoubtedly be a problem for a significant part of the population in Ukraine and we cannot allow ourselves to downplay the challenge. For example, in Western Balkan countries measurements of PTSD in different groups of population even decades after the war demonstrated numbers as high as over 30% (in a number of studies the figure reached over 50% of mental disbalance in control groups across different spectrum of the society). We have to be prepared that real numbers of PTSD cases in Ukraine could be much higher than desirable expectations of 'something around 20%', especially given difficulties in measuring a real picture caused by many non-reported cases or poor diagnostics as shown by experience of countries like the US and UK. What Ukraine needs to achieve is to set up an efficient approach and system of managing PTSD, ranging from accurate and better identification/diagnosis and treatment to combatting public biases and stigma.

The specifics of 'Ukrainian case' are characterized by severe conflict of perceptions, that the whole society has to accommodate with: past positive stereotype of Russia being a friendly/neutral neighbor and evidence of their barbaric extermination practice towards Ukrainians these days. This conflict of perceptions forces an entire reconsideration of reality, which is sometimes very difficult to comprehend especially by older generations of Ukrainians. This is aggravated by the transitional nature of mindset formation: genocode of the nation has just being formed now, as well as a sense of a national identity;

³ Most notorious in this sense is a wide-spread practice of obtaining 'diplomas' or 'certificates' on short psychological courses (one to seven days) from both Ukrainian and international experts with not verified qualifications, which will give those trained (often without respective medical background) a right to claim themselves being ready-made specialists to deal with severe war-related traumas in the population. Professional psychotherapists confess they receive a lot of clients these days, who are coming to them after treatment by these 'freshly-baked' amateurs.

⁴ Projected mostly by medical personnel and specialists

⁵ Projected mostly by politicians and general population

the gradual transition from post-Soviet past to a new mentality of a free and independent nation had not been fully completed in first 30 years of independence, as most of identity symbols had been taken formally, without true sense of their meaning. On top of that the culture of the country remains rigid when it comes to seeking psychological and especially psychiatric assistance, which bears the legacy of negative stereotypes about ‘punishment therapy’ in psychiatric clinics during the Soviet era. Recent public opinion **survey** in Ukraine conducted by Rating Sociologic Group and the International Republican Institute (IRI) shows that only 20% of Ukrainians across the country would like to receive psychological support during the war, out of whom almost 2/3 would prefer to see a specialist individually and 1/3 would go to group activities that unite people.

Naturally, PTSD is not the only known war trauma, and military servicemen/veterans are not the only group in Ukraine that will be exposed war traumas’ experience. Our expert team has identified the following at-risk groups, who would require some form of psychological support or treatment:

- Demobilized combatants, veterans and their families (from 2014 war and 2022 war);
- Families with members lost in wars of 2014 and 2022;
- Prisoners of war (POWs), captured and tortured by Russians (men and women);
- Emergency service employees, who participated in exhumation of mass graves in liberated territories;
- Professional rescuers;
- Volunteers, who worked on the occupied territories and helped in clearing territories after occupation;
- Civilians, who were captured, detained and tortured under occupation (adults, teenagers and children);
- Civilians, who were under general occupation (adults, teenagers and children);
- Refugees and internally displaced people (IDPs);⁶
- Other groups of population of Ukraine (general population regularly exposed to air raids, shelling etc.)

These groups will have their own specifics when it comes to PTSD symptoms and clinical picture (especially children). Ukraine will be facing an enormous challenge to get whole society prepared for dealing with the different kinds of war traumas and ready to integrate all the traumatized people to enable the country to recover. Special tasks in this regard will be placed not only on medical personnel or infrastructure. Social workers, teachers, policemen, ordinary Ukrainians — all should be educated to provide first line assistance to traumatized people. Ukrainian society in general should build a capacity to respond to their needs effectively and to strengthen the psychological resilience of the nation in general. These tasks and analysis of the mentioned target groups’ specifics goes beyond the scope of this paper, but will be addressed in future GLOBSEC papers on the subject.

⁶ Some of the studies on Western Balkans experience show that refugees and IPDs are more likely to develop PTSD and other mental disbalance symptoms than even servicemen, combatants and veterans.

II. PTSD AND CPTSD IN A FAMILY OF OTHER WAR TRAUMAS

War creates factors for the formation of psychological disbalance in military personnel and civilians. The main mental difficulties in the case of military personnel arise from the factors of real combat, which leads to the exhaustion of a combatant's psyche or leads to its overstimulation.

The most well-known of these disorders is PTSD. Many people talk about this disorder, and when someone mentions mental trauma caused by war, PTSD will be the first thing comes to their minds. Besides PTSD, war causes other mental health dysregulations. Military personnel will also face problems with depressive spectrum disorders, various types of addictions, phobias, dissociative disorders (depersonalization, derealization, dissociative amnesia), behavioural disorders (including anxiety disorders and suicidal behaviour). In the Ukrainian context these will be aggravated by multiple brain injuries caused by kinetic blasts, which would make treatment more complex.

In recent years other military-related trauma diagnoses have gained recognition, like military sexual trauma and moral injury/survivors' guilt.⁷

- **Military Sexual Trauma (MST)** describes the effects veterans of all genders experience after being subjected to sexual assault or sexual harassment while serving.[lxxviii]
- **Moral Injury and Survivors Guilt** can emerge as a response to a traumatic incident that shatters deeply ingrained morals or values. The ensuing emotional turmoil can lead to conditions like PTSD, depression, and other disorders where emotions such as guilt, shame, betrayal, and anger take center stage, even though these emotions might manifest without a formal diagnosis. PTSD is currently regarded as a serious

debilitating psychiatric disorder characterised by re-experiencing of the trauma event through flashbacks, hyperarousal, avoidance and numbing.⁸ The origin of PTSD dates back to World War I when it was first considered as a neurological injury and treated as such with hospital admission for those who had suffered trauma on the front line.⁹ At the start of World War II Freudian influences changed the direction of trauma, placing it in the field of psychiatry with a paper *The Report of the War Office Committee on Shell Shock (1922)*. However the need to provide a fighting force on the front line was of greater importance with very little attention given to treating trauma victims during World War II and those who returned home received minimal support. It would be some years later, at the end of the Vietnam war in 1975, when veterans in the US lobbied government and forced an independent study that recognised trauma as a psychological injury with the need to provide treatment and compensation in line with those who had received physical injuries.^{10,11}

In 1980 trauma appeared for the first time in *The Diagnostic Manual of Mental Health Disorders III (APA 1980)*, defined as Post Traumatic Stress with a focus on psychological symptoms. This research underscored the connections between the trauma of war and its impact on post-military civilian life. The criteria for diagnosing PTSD were subsequently refined in subsequent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), such as DSM-III-R (1987), DSM-IV (1994), DSM-IV-TR (2000), to align with ongoing research.

A notable discovery that emerged over time was the relatively common occurrence of PTSD. Since that time changes in classification have continued across both *The Diagnostic and Statistical*

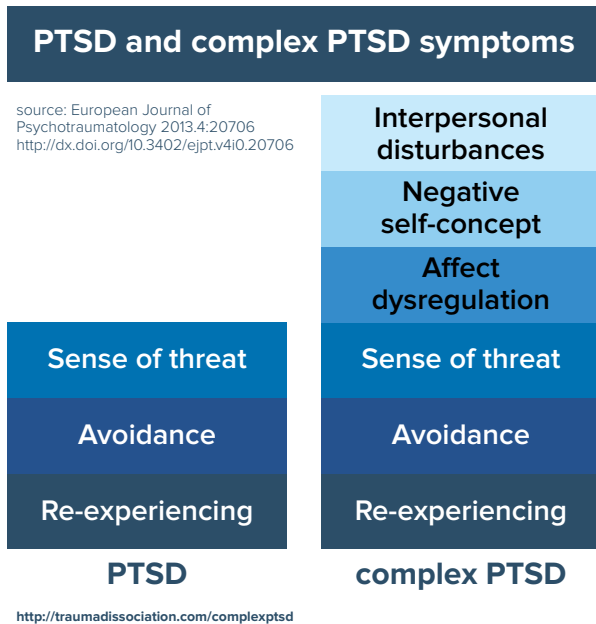
⁷ While the bulk of existing research has concentrated on military veterans it's important to note that moral injury and survivor's guilt can extend beyond the confines of a military setting.

⁸ Lindqvist, D., Mellon, S. H., Dhabhar, F. S., Yehuda, R., Grenon, S. M., Florys, J. D., Bierer, L. M., Abu-Amara, D., Coy, M., Makotkine, I., Reus, V. I., Bersanito, F. S., Marmar, C. R., & Wolkowitz, O. M. (2017). Increased pro-inflammatory milieu in combat related PTSD — A new cohort replication study *Brain Behav Immun*, 59, 260-264.

⁹ Myers, C. (1915). A contribution to the study of shell shock: Being an account of three cases of loss of memory, vision, smell, and taste, admitted into the Duchess of Westminster's War Hospital, Le Toutquet. *The Lancet*, 185(4772), 316-320.

¹⁰ Kulka, R. A., Schlenger, W. E., Fairbanks, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., and Weiss, D. S. (1988). Contractual report findings from the National Vietnam Veterans Readjustment Study: Volume I: Executive summary, Description of finding, and technical appendices. National Vietnam Veterans Readjustment Study

¹¹ For more on historical context on PTSD, please, see Annex I to this report.



*Manual of Mental Disorders V (DSM-V)*¹² and *The International Classification Diseases (ICD-11, 2022)*, with disagreement in the way PTSD and Complex PTSD (CPTSD) were categorized across both manuals.^{13,14} This difference in classification causes a great deal of confusion even today, as some of countries (like US) use DSM-V, whereas in most European countries ICD-11 serves as a reference material. PTSD and CPTSD are known in European practice as Type-I and Type-II traumas, which would require different approaches for treatment.

► **Acute Stress Disorder and PTSD under DSM-V**

US (Veteran Affairs Department (VA)) currently defines PTSD as a “clinically significant condition with symptoms that have persisted for more than one month after exposure to a traumatic event and have caused significant distress or impairment in social, occupational, or other important areas of functioning”.¹⁵ The period of one month is different from the traditional view of PTSD under the DSM-V and is meant to differentiate PTSD from what the World Health Organization calls Acute Stress Disorder (ASD).

In the first incidence those exposed to a trauma event will experience:

Acute Stress Disorder — Clinicians at this phase will stand back as the body resources will attempt to recover and return a person to heamostasis, a term known as ‘watchful waiting’.

If symptoms persist beyond one-month a diagnosis of *Post-Traumatic Stress Disorder (Type I Trauma)* is given. A clinician at this phase may offer first line treatment psychotherapy Cognitive Behavioural Therapy, Trauma Focused CBT, or EMDR for one trauma events with medication to aid sleep and drop initial arousal states.

ASD and PTSD share many of the same symptoms, however the key difference in a PTSD diagnosis is the occurrence and/or persistence of the necessary symptoms beyond one month from the traumatic event. The core concept appears to be that PTSD can manifest at nearly anytime in a person’s life regardless of proximity to an event.

► **PTSD and C-PTSD as defined in ICD-11**

Given the prevalence and uniqueness of PTSD experienced amongst military populations, the provision of accurate assessment, diagnosis and effective treatment is of utmost importance as outlined in this report. Recent reviews highlight the lack of consensus regarding the trajectory of PTSD, the diversity of approaches in the diagnosis and treatment and inconsistencies in defining response to PTSD treatments as problematic. Defining the difference between PTSD and CPTSD can add to this confusion with catastrophic results. Given the disparity between both the DSM-V and ICD-11 it is vitally important that a unified approach is applied.

► *Complex PTSD (Type II Trauma)*

Complex posttraumatic stress disorder (CPTSD) has been included as a diagnostic category in the ICD-11, consisting of six symptom clusters: the three PTSD criteria of reexperiencing, avoidance, and hypervigilance, in addition to three disturbances of self-organization:

- Problems in affect regulation (such as marked irritability or anger, feeling emotionally numb).

¹² Reclassification of PTSD from an Anxiety Disorder to a novel category Trauma- and Stressor-Related Disorders is considered as an important conceptual shift introduced in DSM-V. Rather than being primarily associated with anxiety, PTSD has become recognized to have links with other mood states, such as depression, as well as expressions of anger or recklessness.

¹³ DSM-V(APA 2013) only recognizes PTSD and regards it as complex with comorbid dissociation, whereas ICD 11 (2022) recognizes both PTSD and Complex PTSD as separate diagnosis with additional and separate criteria for both.

¹⁴ Courtois, C. (2008). *Complex Trauma, Complex Reactions: Assessment and Treatment*. Psychotherapy: Theory, Research, Practice, Training, S(1), 86-100; Kiyimba, N., Buxton, C., Suttleworth, J., & Pathe, E. (2022). *Discourses of psychological trauma*. Cham, Switzerland: Palgrave MacMillan.

¹⁵ <https://www.ptsd.va.gov/index.asp>

- Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event.
- Difficulties in sustaining relationships and in feeling close to others.

Traumas which are drip fed in over longer periods have the biggest impact such as: sexual, physical, emotional, verbal abuse, those tortured, held captive, witnessing repeated trauma events as in the case of military personnel those exposed to repeated trauma of high intensity, being under constant threat are regarded as C-PTSD (Type II Trauma). This would also apply for those living in a combat environment being exposed to constant threat of trauma, traumatic loss of loved ones, extraction from family life (those displaced).

Complex PTSD results in a permanent change in brain chemistry, continual arousal of dissociative

states, dysregulated neuropathophysiological relating to brain, gut, endocrine, neuroendocrine, changes to DNA sequencing (ref research inserted), leading to a fragmented immune system autoimmune diseases, poor physical health outcomes, premature death and suicide ideation. C-PTSD can lead to high-risk behaviours and has been linked to comorbid psychiatric disorders and physical health problems, addiction, and self-harm.

Complex PTSD therefore, requires wider assessment and an eclectic treatment regime by those qualified in the field of trauma (official and recognized qualifications, not those who assume knowledge from working within the field or believe being linked to the military and having experienced trauma; this does not account for them working within it). This would cause 'sanctuary trauma' those who you go to make you worse, as they do not know or are not qualified in how to treat you.

III. CHALLENGING THE IDEOLOGY OF PTSD: NO MORE MENTAL DISORDER, BUT NEUROBIOLOGICAL DYSREGULATION. ALTERNATIVE APPROACHES TO ASSESSMENT, DIAGNOSIS AND TREATMENT REQUIRED?

Significant research has been published globally for military personnel and veteran populations of the Iraq and Afghanistan conflicts that links PTSD to auto immune disease leading to poor physical health outcomes, which goes beyond simplification of PTSD as a pure mental health disorder. Despite having not been incorporated into world-wide practices of PTSD treatment on a large scale yet,¹⁶ an approach of looking at PTSD through lenses of neurobiology is worth considering, given low the efficiency of traditional methods of PTSD diagnosis and treatment.¹⁷

CASE BOX: INTERNATIONAL RESEARCH THAT LINKS PTSD TO POOR PHYSICAL HEALTH OUTCOMES

Mellon et al (2019), considered combat veterans of the Iraq and Afghanistan conflicts who had a formal diagnosis of PTSD and found clear **changes in proinflammatory biomarkers** that linked PTSD to poor physical health outcomes. Auto immune diseases relating to PTSD were, irritable bowel syndrome, cardiovascular disease, multiple sclerosis, gastrointestinal disease, skin irritations, fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, diabetes, asthma, musculoskeletal disorders, ischemic heart disease, kidney disease and mitochondrial disease. Demonstrating that PTSD changes underlying dysregulated neuro-pathophysiological networks that eventually causes heightened

levels of auto immune disease and poor physical health outcomes.

O'Donovan et al (2016), conducted a cohort study of 666,269 veterans of the Iraq and Afghanistan conflicts again with a formal diagnosis of PTSD. Their study found **increased risk of auto immune disease** for both men and women, with no disparity between sex and listed auto immune disease relating to rheumatoid arthritis, cardiovascular disease, thyroiditis including inflammation of the bowel. The research recommended early detection of poor physical illness as part of the screening process pre and post deployment for military personnel.

Groer et al (2015), provided data that demonstrated **significant biomarkers** for deployed soldiers with **heightened levels of inflammation**, that confirmed the risk of developing poor physical illness and disease progression over time. The research noted an increased risk in health costs, loss of productivity, ongoing suffering over a person's service with the need to urgently upgrade treatment and redesign care services to respond to proinflammatory markers of PTSD and monitor long term physical illness linked to the disorder.

Lindqvist et al (2017) measured pro inflammatory biomarkers for 61 male veterans and found **increased markers of inflammation** in PTSD active-duty personnel compared to

¹⁶ Studies of this new approach to PTSD started nearly a decade ago, but have not been not fully explored and completed due to lack of research base and financial investments into this particular scientific angle as well as prevalence of traditional theories of PTSD being a mental disorder.

¹⁷ Hoskins, M., Pearce, J., Bethell, A., Dankova, L., Barbui, C., Tol, W. A. (2015) *Pharmacotherapy for post-traumatic stress disorder: systematic review and meta-analysis*. The British Journal of Psychiatry, 206(2), 93-100; Forman-Hoffman, V., Middleton, J. C., Feltner, C., Gaynes, B. N., Weber, R. P., Bann, C. (2018) *Psychological and pharmacological treatments for adults with posttraumatic stress disorder: a systematic review update*; Watkins, L. E., Sprang, K. R., & Rothbaum, B. O. (2018) *Treating PTSD: A review of evidence-based psychotherapy interventions*. Frontiers in behavioral neuroscience, 12, 258; Shiner, B. R., Gui, J., Rozema, L., Cornelius, S. L., Dufort, V., Schnurr, P. P., & Watts, B. V. (2021) *Patient and clinical factors associated with response to medications for posttraumatic stress disorder*. The Journal of Clinical Psychiatry, 82(6), 37305; Levi, O., Ben Yehuda, A., Pine, D. S., & Bar-Haim, Y. (2022). *A sobering look at treatment effectiveness of military-related posttraumatic stress disorder*. Clinical Psychological Science, 10(4), 690-699.

a non-PTSD control group. Their research showed a need to consider alternative methods of treatment to respond to auto immune disease including changes in lifestyle, diet and pro inflammatory supplements to support a person's immune system to help reduce the risk of disease progression.

Schultebrucks et al (2021), conducted a longitudinal study examining 473 case files of active-duty soldiers who had undergone lab testing for metabolic changes in relation to endocrine and inflammatory biomarkers over a period of several months. The research found active-duty personnel tested positive for **higher levels of endocrine and inflammatory biomarkers** which questioned their fitness to deploy. Their research confirmed the need to test soldiers pre and post deployment to mitigate the risk of developing PTSD and monitor poor physical health outcomes.

Miller et al (2017), considered 16 male veterans of older age who had been clinically diagnosed with PTSD and had received lab testing of pro-inflammatory biomarkers comparing them with 16 male veterans who did not have a diagnosis of PTSD of similar age. Data comparison showed a direct correlation of **higher pro inflammatory biomarkers** in later life for PTSD sufferers which demonstrated increased disease progression over time and demonstrated the need to monitor poor physical health outcomes post discharge and apply ongoing treatment as a result of being diagnosed with PTSD (Miller et al., 2017).

Bam et al (2016), considered war veterans of the Iraq and Afghanistan conflicts who had a formal diagnosis of PTSD and looked at **gene pathology**. Their research found distinct marked differences across complex networks relating to DNA sequencing due to chronic inflammation linked to a person's immune system, causing accelerated aging, cancer and premature death. The significance of Bam et al (2016), research is that it shows how molecular factors determine the risk and subsequent development of PTSD and how immune related diseases are passed down through each generation. Equally how first line approaches to

treatment need to respond to dysregulated metabolic systems of defense linked to the immune system.

Dyball et al (2019), research conducted by the Kings Centre for Military Health Research (UK), completed a systematic review of the literature that linked PTSD to **cardiovascular disease** for male veterans of the Iraq and Afghanistan conflicts. The review confirmed a direct increased risk of cardiovascular disease for those who had a formal diagnosis of PTSD and as a result recommended screening for PTSD UK military personnel and veterans with ongoing health advice post discharge.

LINKING PTSD WITH PRO INFLAMMATORY BIO-MARKERS AND AUTO IMMUNE DISEASE

Research listed above during the Iraq and Afghanistan conflicts has shown a direct link between PTSD and auto immune disease which correlates to research conducted within civilian populations over the past three decades.¹⁸

It demonstrates that merely assessing the psychological symptoms of PTSD and responding with psychological treatment is futile given PTSD has the largest biological underpinning than any other mental health disorder that drives psychological symptoms.¹⁹ In this respect the research provides scientific evidence that challenges the current ideology of PTSD, especially in relation to the DSM V (APA, 2013) and ICD 11 (2022).²⁰ It supports the need to provide both neurophysiological assessment and respond with a wider eclectic treatment regime to slow down disease progression and provide optimum recovery, which challenges the current overuse of talking therapies as front-line treatment for PTSD. It calls for a staged approach to treatment and refocus assessment to include blood biomarkers to accurately diagnose and treat PTSD, with the need to provide ongoing care and support to monitor long-term physical health outcomes linked to the disorder.

In this respect research conducted during the Iraq and Afghanistan conflicts has shown the need to reconsider PTSD etiology and move away from

¹⁸ MacFarlane et al (1994), Physical Symptoms in Post-Traumatic Stress Disorder; Boscarino J, A (1996), Post Traumatic Stress Disorder exposure to combat trauma and lower plasma cortisol among Vietnam veterans: findings and clinical implications; Ironson et al (1997) Post-Traumatic Stress symptoms, intrusive thoughts, loss and immune function after Hurricane Andrew; Buckley et al (2001) A meta-analytical examination of basal cardiovascular activity in post-traumatic stress disorder; *full list of reference can be provided for this period.*

¹⁹ MacFarlane et al (2017), The need to take a staging approach to the biological mechanisms of PTSD and its treatment. *Psychiatry Rep*, 19,10.

²⁰ American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Health Disorders (5th Ed)*; International Classification of Diseases Eleventh Revision (ICD -11). Geneva World Health Organisation.

purely regarding it as a mental health disorder given the distinct link between PTSD and proinflammatory biomarkers that leads to auto immune disease.

Recognition of auto immune disease is not new and dates to 1900 when Enrilch and Morenorth (1900)²¹ discovered that the system that defends us also can turn in on itself through a form of self-suicide. There are over eighty known systematic auto immune diseases linked to PTSD, the majority of which have no definite cure and require lifelong care.²² Research found that once a person has one auto immune disease, they are more likely to attract another.²³ However, identifying which physical illness is likely to be more prevalent for those diagnosed with PTSD is still not yet available, as a metabolic signature for PTSD is yet to be identified.²⁴ As a result, studies to reduce inflammatory responses linked to immune systems are now at the forefront of research with clinical management strategies aligned to treatment.²⁵ Increasing knowledge in clinical correlation of pathological disease progression would no doubt provide a greater understanding of innate systems of immune pathways linked to PTSD to apply early treatment and reduce disease progression. This advanced approach requires inclusion of lab testing for neuroendocrine and inflammatory biomarkers to understand underlying epidemiological links between PTSD and auto immune disease as suggested within the research presented within this paper. It also requires cross collaboration with international partners who are at the forefront of this work to develop an international data repository to better understand the epidemiological link between PTSD and auto immune diseases, which is strongly recommended.

The ability to measure metabolic systems of defense and map out disease progression has benefits across other areas of health including mental health disorders as well as PTSD, in preventing and promoting treatment approaches that support the immune system. The approach has already demonstrated a higher level of efficiency compared to traditional practices within current veteran mental health services, evaluated across international platforms.²⁶ The US Veterans Association latest publication *Improving Access to High Quality*

Mental Health Care for Veterans (2023)²⁷ lists several ongoing difficulties in providing mental health services for US veterans including treatment, increasing numbers and capacity to respond, retaining qualified clinicians, complex presentations and the length of time it takes to adopt changes.

The importance of adopting a new paradigm shift and moving away from out-of-date mainstream mental health models of treatment that continue to show remedial results will no doubt challenge the current ideology. It will require a period to re-educate clinicians to recognize poor physical health outcomes as part of a diagnosis of PTSD and pollinate across multidisciplinary specialists to create new polytrauma pathways of care linked to the work of international scientist and clinicians in the field, who are at the forefront of research and treatment. Therefore, a new comprehensive strategy addressing both physical, mental and social well-being is needed to respond to those traumatized by war which correlates to WHO's definition of health (2023)²⁸ which is: "*not merely the absence of disease or infirmity, but a state of complete physical, mental and social well-being*"

ADOPTING A POLYTRAUMA APPROACH TO PTSD

War is not black and white and has many shades of grey, as weapon systems become more sophisticated so do the types of complex injuries endured by returning military personnel and veterans as seen during the Iraq and Afghanistan conflicts. As a result a new approach addressing multiple traumas has been introduced in US and **Polytrauma Rehabilitation Centres** were established through the U.S Department of Veterans Affairs to address such complex injuries including those diagnosed with a triage of injuries PTSD, TBI and pain management problems classed as polytrauma.²⁹

In this regard the same approach needs to be applied for those who are diagnosed with CPTSD to apply accurate assessment, diagnosis and treatment and cross reference with a triage of related injuries similar to those registered during the Iraq

²¹ Enrilch and Moregenroth (1900), The Concept of 'horror autootoxicus' first expressed: On Heamolysis: Third Ed, In Himmelweit, F (Eds), The Collected Papers of Paul Enrich (1st Ed., 205-212). Pergamon.

²² Lerner et al (2015), The world incidence and prevalence of autoimmune disease is increasing. *International Journal. Celiac Dis*, 3,151-155.

²³ Ibid.

²⁴ Karabastsiakis et al (2015), Metabolic profiling in post-traumatic stress disorder. *Journal of Metabolic Psychiatry*, 3(1), 2.

²⁵ <http://www.tbimedlegal.com>

²⁶ <https://millenniumhealthstore.com>

²⁷ *Improving Access to High-Quality Mental Health Care for Veterans: Proceedings of a Workshop* (2023). ISBN 978-0-309-7-833-3

²⁸ World Health Organisation (2023). Constitution. <https://www.who.int/about/governance/constitution>

²⁹ <https://www.polytrauma.va.gov/system-of-care/care-facilities/index.asp>

and Afghanistan conflicts, including ongoing monitoring constellation of health-related immune diseases linked to the disorder that increase over time as noted within research. Trauma is multi layered and multi-faceted, recovery entails deciphering an enigma code of dysregulated complex metabolic systems of defense. What is required is a multidisciplinary approach where a group of specialists come together to provide first-line treatment based on the most up-to-date research as evidenced

within this report, before applying psychological tools. A polytrauma model of application therefore aligns with the same principles of a polytrauma rehabilitation center developed in the US given complexity between associated physical and mental health comorbidities to unravel the Rubik's Cube of trauma and trauma related injuries. Such a unit would need to include military and veteran specific pathways of care, and extend across to family and civilians traumatized to incorporate all.³⁰

³⁰ Mandy Bostwick MSc, MA, ISSTD — Polytrauma Treatment Model for Post-Traumatic Stress Disorder.

IV. GETTING FRAMING RIGHT: PTSD — INVISIBLE WOUNDS OF WAR, DISORDER OF RECOVERY, MENTAL DISORDER, MENTAL DEATH PENALTY OR HEALTHY REACTION TO LIFE-THREATENING CIRCUMSTANCES?

Regardless of national cultural mindset, almost every country under analysis (with the possible exception of Israel because of its ‘family culture’ that already embraced veterans as integral part of the society) is faced with the problem of correcting stigma about PTSD. All have resorted to special public awareness campaigns to break this stigma and to establish a positive image of veterans who obviously need the help and support of society to adapt to a peaceful life upon return from their combat mission.

Most countries framed PTSD in soldiers and civilian population with terms like ‘invisible wounds of war’, ‘temporary disorder of recovery’, or a ‘healthy reaction to life-threatening circumstances’. They have tried to break the stigma of PTSD being a mental disorder like an incurable illness that is considered to be something like a ‘mental death penalty’.

However the actual results of these campaigns in terms of changing perceptions of the society are very difficult to measure, all of our experts say that Ukraine should definitely envisage in its governmental strategies comprehensive nation-wide communication strategies to get the framing right and to encourage the society as a whole to take care of veterans as an intrinsic part of national culture.

The country, which has developed most of public awareness campaigns about veterans and PTSD issues, is the US. Most sound of these initiatives have been conducted by governmental agencies like VA, DOD, U.S. Department of Health and Human Services (HHS), however, some of the other campaigns have been launched by different society groups and private business as well.

At the height of the ‘Global War on Terror’, the mental health of U.S. veterans and service members began to gain significant media attention largely due to the issue of veteran suicide. Before arriving at that view of PTSD, there was strong

stigma (or misconception) that PTSD was a permanent diagnosis, that veterans were somehow permanently broken and could not get better even if they wanted to. This sense of hopelessness also worked to prevent many veterans from seeking or continuing treatment. The US government considered that views on veteran trauma be couched in positive messaging programs both to the affected and to the general public. The goal was that those suffering from PTSD know there is hope and that the public do not view them as dangerous, broken, or otherwise outcasts from general society.

With this in mind the US government initiated a number of different public awareness campaigns, most notorious of them being:

1. **Real Warriors Campaign (RWC)**, which the DoD instituted RWC in 2009: a large-scale “multi-media public health awareness campaign designed to encourage service members, veterans, and their families coping with invisible wounds to reach out for appropriate care or support”. Goals of the campaign were: (1) reduce misperceptions and combat myths of mental health concerns and treatment through education; (2) foster a culture of support for psychological health—i.e., that seeking help is a sign of strength; (3) restore faith in the Military Health System; (4) improve support systems (e.g., friends, family) for services members and veterans with mental health concerns; (5) empower behaviour change among service members and veterans.
2. **Make the Connection (MTC)** — a VA public awareness campaign designed to promote mental health to veterans and their supportive networks through education and outreach, and to motivate and facilitate help-seeking among veterans with mental health needs. Launched in 2011, MTC includes personal testimonials from fellow veterans that describe helpseeking

experiences, emphasizing recovery and conveying positive treatment outcomes. Information on symptoms, conditions, and treatment options is organized by life experiences and challenges rather than primarily focusing on diagnosis or illness. Set goals to achieve: (1) foster positive conversations about mental health and engage veterans in sharing stories of mental health challenges and recovery with other veterans; (2) reduce barriers to help-seeking, such as stigma, and improve attitudes and beliefs related to mental health conditions and use of treatment services among veterans; (3) Educate veterans and their supportive networks by presenting accurate information on common life events, mental health symptoms, and conditions in nonclinical, easy-to-read language; (4) promote help-seeking by increasing awareness of VA and community resources among veterans and their supportive networks.

3. **National Recovery Month Sponsored by SAMHSA (HHS).** Recovery Month is held every September and aims to educate Americans about mental health and substance use issues. Recovery Month's primary goal is to communicate to the general population that people with mental health and substance use issues can recover—by modeling the achievements and successes of individuals who have recovered—and that treatment can play a vital role in helping people lead healthy and productive lives.
4. **“Face the Fight,”** a multimillion-dollar new initiative launched June 2023 to halve the suicide rate among veterans by 2030. Coalition of corporations, foundations, nonprofits and veteran-focused organizations have launched Face the Fight™ to raise awareness and support for veteran suicide prevention. The aspiration is to cut the veteran suicide rate in half by 2030.

Established by USAA and The USAA Foundation, with the Humana Foundation and Reach Resilience, an Endeavors Foundation, as founding partners, the mission of the initiative is to break the stigma of seeking help, increase the conversation about the problem and complement the efforts of VA, DOD and many others to stop veteran suicide.

One of the most noticeable UK public support campaigns was *The Don't Bottle It Up* campaign launched 2011 by MOD and was the Army's first ever campaign to tackle the stigma surrounding mental health issues. The first phase of the campaign was very much about trying to break the stigma around

combat stress, whereas phase two concentrated on bringing awareness to the occupational and emotional factors that cause stress and can lead to depression.

There are also veterans' hotlines that were set up in the US and UK, which received extensive publicity to raise awareness about these tools to support veterans and to encourage veterans to seek assistance via these hotlines:

- US — *Veterans Crisis Line (VCL)* is a free, confidential service available 24 hours a day, that provides specialized care to veterans in crisis and resources to their families and friends.³¹ VCL provides immediate crisis intervention and, when necessary, connects veterans with local services, such as VA suicide prevention coordinators or emergency services. The call center was established as a partnership among VA, SAMHSA, and SAMHSA's National Suicide Prevention Lifeline. The goal of the VCL campaign is to increase awareness and use of VCL among veterans in crisis.
- UK — *Big White Wall*, an online early intervention service for people in psychological distress with veterans having a special channel line.

³¹ VCL can be accessed by telephone and using text and online chat platforms. A proportion of responders on the crisis line are veterans themselves, further personalizing the experience for callers.

V. COUNTING PTSD RATES. WHAT THE FIGURES TELL US

Military personnel are at a higher risk of developing PTSD due to the very nature and intensity of training and exposure to combat situations, in comparison to the general population.³² At the end of the Afghanistan conflict, the US reported up to 23% of military personnel receiving a diagnosis of PTSD³³ in comparison to 4-5% UK military personnel.³⁴

Table: PTSD rates in US veterans in different Service Eras³⁵

Service Era	PTSD in the Past Year	PTSD at Some Point in Life
Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF)	15 out of 100 (15%)	29 out of 100 (29%)
Persian Gulf War (Desert Storm)	14 out of 100 (14%)	21 out of 100 (21%)
Vietnam War	5 out of 100 (5%)	10 out of 100 (10%)
World War II (WWII) and Korean War	2 out of 100 (2%)	3 out of 100 (3%)

Source: US VA DOD

CASE BOX: US PTSD MEASUREMENTS ACCORDING TO SERVICE ERA

Currently, the VA and the Department of Defense (DOD) divide veteran PTSD prevalence into four main Service Eras: 1.) World War Two and Korea; 2.) Vietnam War; 3.) Desert Storm; and 4.) Operations Iraqi Freedom and Enduring Freedom or the Global War on Terror (GWOT). [vii] Each of these eras' corresponding veteran population has its own specific data on PTSD prevalence.

For example, the World War Two and Korean War Service Era represents approximately 1.1 million veterans as of the VA's 2020 projection. [viii] Within this population, the VA reports that 3 out of 100 of these veterans experienced or will experience PTSD at some point in their life.[ix] This represents the low end in terms of total population and of PTSD prevalence. By contrast, the

Vietnam Era represents a much larger population with approximately 5.8 million veterans as of the VA's 2022 projection model.[x] The VA reports a much higher corresponding PTSD prevalence in this population of 10 out of 100 experiencing PTSD at some point in their life.[xi] The VA notes that PTSD rates are likely much higher in this population, but due to the limited surviving population previous studies with different survey methods may have had different results.[xii]

The trend continues to increase in the remaining Service Eras. The Desert Storm Service Era veterans, specifically those who did not serve after the 9/11 Terror Attacks, number approximately 2.6 million.[xiii] Of these, 21 out of 100 will experience PTSD at some point in their life.[xiv] Finally, the GWOT Service Era veterans number approximately 3.4 million and have the highest prevalence of PTSD at 29 out of 100 experiencing it at some point in their lives.[xv]

³² Schultebrucks, K., Qian, M., Abu-Amara, D., Dean, K., Laska, E., Siegel, C., Gautam, A., Guffanti, G., Hammamieh, R., Misganaw, B., Mellon, S. H., Wolkowitz, O. M., Blessing, E. M., Etkin, A., Ressler, K. J., Doyle, F. J., Jett, M., & Marmar, C. R. (2021). Pre-deployment risk factors for PTSD in active-duty personnel deployed to Afghanistan: A machine-learning approach for analyzing multivariate predictors. *Molecular Psychiatry*, 26, 5011-5022; Boggs-Bookwalter, D., Roenfeldt, K. A., LeardMann, C. A., Yeon-Kong, S., Riddle, M. S., & Rull, R. P. (2020). Posttraumatic stress disorder and risk of selected autoimmune disease among US military personnel. *BMC Psychiatry*, 20(23), 1-8.

³³ Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N. Engl. J. Med*, 351, 13-22.

³⁴ Fulton, J. J. Calhoun, P. S., Wagner, H. R., Schry, A. R., Hair, L. P., Feeling, N., & Beckham, J. C. (2015). The prevalence of posttraumatic stress disorder in Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) Veterans: A meta-analysis. *Journal of Anxiety Disorders*, 31,98-107; MacManus, S., Bebbington, P., Jenkins, R., Brugha, T. (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey*. Leeds: NHS Digital.

³⁵ The data in this table is from Veterans alive at the time of the study. As such, it does not include Veterans in any service area who have died and may have had PTSD.

The VA clarifies that although PTSD is generally more prevalent in veterans, the highest rates are disproportionately related to subsets of the overall veteran population. It is key to note that not every U.S. veteran has deployed to a combat theater or experienced combat. Those who do are three times more likely to experience PTSD than veterans who have not deployed in the same service era.[xvi] Likewise, higher rates of PTSD are also found in veterans who experienced military sexual trauma which is essentially sexual harassment or sexual assault while serving in the military. Together these risk factors help provide context to the overall PTSD rate. Finally, there is also some overlap between PTSD and suicide. In 2020, the VA reported that of those who veterans who died by suicide 24.4% were diagnosed with PTSD.[xvii]

Being in the conditions of recurrent military conflicts, Israel has been faced with the issue of psychological trauma of the military since the 1973 war. Since then, Israel has become one of the leading countries in the treatment of PTSD, having created its own unique experience that has brought excellent results for their country. According to statistics in Israel, the rate of PTSD among veterans of the 1973 war was 20%. To date, this percentage has improved significantly and the percentage of PTSD among veterans in Israel has reached 1-2%, which is one of the lowest rates in the world. Main factors of such striking results attribute to intense development in Israeli's culture an approach of preventive resilience techniques and methods of immediate assistance in coping with traumas. It perfectly laid down into a national mindset of a 'family culture', with care about a neighbor as a signature mark. Israel also became notorious for its vigorous introduction of military psychologists in every military unit, so that a culture of speaking to a psychologist in case there is a problem has become closely incorporated in a serviceman's routine, which later continues once a person becomes a veteran. Servicemen have also been taught to detect first signs of strong emotional disbalance in their comrades and to report this quickly to senior commanders. This early detection has helped a lot to

deliver a timely professional care to prevent further development of psychological disfunction (more on Israeli's approach see sub-section on Pre- and Post-Resilience Support Measures).

PTSD IN EX-SERVICEMEN IN UKRAINE

The prevalence of post-traumatic stress disorder in Ukraine was unknown until 2014, as the problem was not widely recognized. No specific research on the conditions of Afghanistan war veterans (1979-1989)³⁶ was conducted in Ukraine independently. Yet, it is commonly known that the problem of psychological health among former combat veterans was not given due attention, as it was believed that a Soviet soldiers could not have such a problem. This attitude gave rise to the "Afghan syndrome" phenomenon, with **35-40%** of war veterans being in need for urgent psychological assistance (according to various sources, from 150 to 400 thousand people).

The Chernobyl disaster of 1986 could be viewed as a first step to recognize PTSD phenomenon in Ukraine, and a series of scientific research were conducted looking into the development of PTSD and its impact on the health of accident liquidators. Later PTSD research was developed in studies on the Sknyliv tragedy³⁷ and numerous accidents on coal mines in Donbass.³⁸ Notwithstanding, the phenomenon was not studied in-depth and the methods of PTSD treatment used in Ukraine before 2014 were limited, with the most common being drug therapy and psychotherapy.

► Situation in the period 2014 – early 2022

Since the outbreak of armed hostilities in Eastern Ukraine in 2014, the issue of PTSD and other war-related traumas among combat veterans and civilians who were within or close to the zones of combat actions, started to draw closer attention. The first attempts are being made to **assess** the situation and **revise** approaches to dealing with PTSD in Ukraine.³⁹

³⁶ AFU soldiers were part of the Soviet Union's contingent

³⁷ The Sknyliv air show disaster occurred on Saturday, 27 July 2002, when a Ukrainian Air Force Sukhoi Su-27UB piloted by Volodymyr Toponar (of the Ukrainian Falcons) and co-piloted by Yuriy Yegorov crashed during an aerobatics presentation at Sknyliv airfield near Lviv, Ukraine. The accident killed 77 people and injured 543, 100 of whom were hospitalized.

³⁸ The 2007 Zasyadko mine disaster was a mining accident that happened on November 18, 2007 at the Zasyadko coal mine in the eastern Ukrainian city of Donetsk. By November 30, 101 miners were reported dead. At the time of the explosion, 457 miners were in the complex.

³⁹ For example, in 2014, a group of Ukrainian academic psychiatrists from the International Academy of Ecology and Medicine of Ukraine, led by Prof. Postrelko, conducted a research to determine the peculiarities of onset of mental and addictive disorders among military personnel, including those who suffered contusion damage to the brain. The research was conducted at the Regional Psychiatric Hospital #2. As of 2019 alone, 534 ATO and JFO participants were treated and examined in the war veterans department of the Kyiv Regional Psychoneurological Hospital #2, which is 100 times more than in 2014. Patients mostly complained of apathy, anxiety, sleep disturbance, headaches, constant irritability, low mood and appetite, memory loss for current events, conflicts with others, indifference, fatigue, emotional and physical exhaustion, impulsive and self-destructive behavior, and attempts to alleviate their painful condition by alcohol and drug intake.

According to the Ministry of Veterans Affairs of Ukraine, as of August 2021, there were more than 410,000 people in Ukraine having the status of combat veterans. The situation with treatment of post-traumatic stress disorder (PTSD) among those who fought in Ukraine from 2014 to early 2022 remained difficult, however, the number of diagnosed PTSD cases was increasing, while the level of knowledge and actual medical practice in treating this disorder remained low. Thus, about 80% of the military involved in combat operations in Eastern Ukraine during the Anti-Terrorist Operation (ATO), and later in the Joint Forces Operation (JFO), found themselves in a state of combat stress, which later transformed into about 25% of post-traumatic stress disorders (PTSD) of varying severity. It has been established that 98% of combat veterans needed qualified support and assistance due to the impacts of combat stress factors.⁴⁰ **26%** of servicemen, who participated in combat actions in the east in 2014–2015, developed signs of post-traumatic disorders. Research and Scientific Center on Humanitarian Issues of the Armed Forces of Ukraine reported that over the period 2014–2017 **80%** of ATO combatants displayed symptoms of psychological trauma and **20-30%** of military personnel, who received psychological traumas during combat orders, was not able to solve psychological problems without external assistance. A common problem among the military after they returned from the zone of combat operations was that they didn't feel they were understood, accepted, and they felt as if the state was ignoring their interests.

It has been assessed that the duration and intensity of conflict are the main factors responsible for the psychological condition of combatants. In 2014–2017 ATO combatants were deployed for 8 months in to combat zone, spent 2 months in a situation of permanent dislocation and two months on training fields. These figures are noteworthy to be compared with the intensity and duration of the current conflict, both of which are much higher than in 2014–2017. Given the correlation of PTSD and other mental dysregulation in conditions of lower intensity and duration, we can extrapolate figures for potential exposure to PTSD and other combat traumas in currently serving personnel.

► **Changes in the situation since February 2022 after Russia's full-scale invasion of Ukraine**

Since the start of Russia's full-scale military invasion in February 2022, the number of both the military and civilians seeking qualified mental health care

has increased many-fold. According to the **Ministry of Health of Ukraine**, as a result of armed hostilities and other wartime-related traumatic factors, about 15 million people will need psychological assistance, with 3-4 million of them seeking medication treatment. Yet, an accurate estimate remains complicated due to ongoing war and continuing traumatic experiences.⁴¹

CASE BOX: NEW STUDIES ON PTSD IN LIBERATED TERRITORIES IN KYIV REGION

After the de-occupation of Kyiv region territories in March 2022, a group of Ukrainian academic psychiatrists of the International Academy of Ecology and Medicine of Ukraine, led by Prof. V. M. Postrelko began to develop new methods of research/diagnostics, treatment and rehabilitation of PTSD among the military and civilians.

The efforts were undertaken within the following categories:

- Group I — 2014 and 2022 war veterans and active military personnel: males and females aged 18 to 59 who were directly involved in active combat operations.
- Group II — civilians: males aged 18 to 68 who were under occupation and were involved in exhuming bodies of the dead.
- Group III — civilians: females aged 18 to 68 who were under occupation and suffered various types of violence.
- Group IV — civilians: males and females aged 5 to 16 years (children and adolescents).

Initially, group II, III, and IV patients complained of having experienced a severe stressful event in the form of tortures, beatings, rape, denial of access to drinking water and food, and depression involving active suicide attempts. Emphasized separately as stress-inducing factors was involvement in exhumation of dead bodies.

Some patients among the adult population observed that they started to take alcohol and other psychoactive substances to alleviate symptoms caused by stress. A significant factor is that these patients developed the addiction syndrome to alcohol and other psychoactive substances very quickly, with withdrawal syndrome developing quickly, and alcohol palimpsests being observed.

⁴⁰ Monography Kravchenko, Tymchenko, Shybokov

⁴¹ The statistics made available either rely on very small sample groups or are generated based on forecast trends, which does not reflect the real picture across the country.

VI. PRACTICES OF DIAGNOSES, TREATMENT, REHABILITATION, PRE- AND POST-RESILIENCE SUPPORT MEASURES

International practice in diagnosing PTSD refers either to DSM-V or ICT-11 with the former being used predominantly in the US and latter in Europe. In all countries in question diagnosis could be made by a psychiatrist only. Further to this reference to international classificatory a psychiatrist made his assessment also with the help of self-reported screening tools, the most common of them being: (1) The Post Traumatic Stress Disorder Checklist; (2) the Clinical Administered PTSD Scale — CAPS 5 (a structured interview approach based on the DSM-V criteria), or the Trauma Symptom Inventory-2 (TSI-2) (a questionnaire that considers psychological symptoms including dissociative states). Suggested approach of using biomarkers' tests to identify existence of inflammation in a patient's body could provide with more accurate assessment and further line of treatment (which is always individual), as existing practice of diagnosis remains reliant on subjective, observational assessment and fails to consider underlying neuropathophysiological changes that occur due to dysregulated metabolic states.

It is important to ensure PTSD is diagnosed and treated timely, to reduce patients' suffering and improve their mental and physical health. Although PTSD can have long-term effects, early and adequate treatment can help prevent or mitigate such effects. Left unaddressed, PTSD can become chronic and lead to incremental health issues, decline in performance and quality of life. Rehabilitation is also important because it helps patients recover after treatment and prepare for a full-fledged life through coping with the trauma sequela and getting back to normal activities.

In the US the VA and the DOD have been working together since 2004 in the Evidence-Based Practice Work Group (EBPWG) to determine the best treatment practices for service members and veterans.[xxxv] In 2023, they published a new set of Clinical Practice Guidelines to help further define and explain the current trends in PTSD treatment. These guidelines are recommendations and updates based on systematic review but are not meant to redefine the standard of care for medical practitioners who must always consider a patient's needs before providing treatment. Finally, in addition to the Guidelines, the VA provides their core diagnoses and treatment protocols on their website as part of the National Center for PTSD.

CASE BOX: PTSD DIAGNOSTICS – US EXPERIENCE

The diagnostic framework for PTSD encompasses four distinct clusters of symptoms: re-experiencing the traumatic event (also termed intrusion); avoidance of situations reminiscent of the trauma; negative alterations in beliefs and emotions; and a heightened state of arousal (also referred to as hyperarousal or over-reactivity to stimuli). It's noteworthy that many individuals may encounter some of these symptoms following a traumatic experience. However, an official diagnosis of PTSD requires the presence of all four symptom clusters persisting for at least one month and causing notable distress or functional impairment in day-to-day life.[lxxvii]

Once it is established that the symptoms remain over one month time, the VA uses a series of seven criteria (A-H) to confirm the diagnosis of PTSD. Criterion A requires exposure to actual or threatened death, serious injury, or sexual violence either directly, witnessing to another, learning of an occurrence to a close family member, or experiencing repeated or extreme to adverse details of traumatic events (like collecting human remains after an accident).[xliv] If an individual has experienced any of these events, they must also exhibit specific symptoms from Criteria B–E.

Criteria B-E are referred to as symptom clusters and have multiple possible manifestations of symptoms.[xliii] These include but are not limited to the following: Recurrent, involuntary, and intrusive distressing memories of the traumatic event; Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s); Inability to recall an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs); Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.[xliv] These examples are only one of the possible manifestations of each Criterion's five or six possible symptoms to establish a diagnosis.

The final three criteria put the aforementioned symptoms into context. Criterion F formally requires that these symptoms must persist for at least one month after the traumatic event. [xlv] While Criterion G and H ensure that the manifestation of the symptoms lead to clinical impairment of the individual and are not the product of another drug or substance, respectively. [xlvi] Together these seven criteria represent the fundamental basis the VA utilizes to diagnose PTSD.

During the Iraq and Afghanistan conflicts the UK military psychiatry aligned to the Ministry of Defence added confusion with additional precursor to the diagnosis: Post Traumatic Stress Reaction, Combat Related Stress and Combat Stress Reaction emerging.⁴² Such diagnosis was considered temporary, non-medical with the need to treat casualties on the front line in order to maintain a fighting force promoting resilience programs in response.⁴³

In its practice Ukraine uses ICD classificatory, however in modern practice it still refers to ICD-10 as national-wide recommended document. ICD-11 is in use with not a big group of Ukrainian psychiatrists. This creates serious confusion when it comes to right statistics and even treatment, given difference of PTSD and CPTSD. Reasons for not adjusting the current classification to modern ICD standards nation-wide lay in slow Ukrainian bureaucracy, which need to make amendments to a number of internal regulatory acts in Ukraine. As a result many practitioners and profile institutions keep using older ICD-10, where CPTSD is not yet in place. This malfunction should be corrected as soon as possible, as CPTSD is highly likely to be a prevailing type of PTSD in Ukraine.

CASE BOX: TREATMENT AND REHABILITATION

Treatment and rehabilitation of post-traumatic stress disorder (PTSD) are two separate but essential aspects of assistance to people suffering from this mental disorder. Ordinary people sometimes get confused, mixing these two parts in one.

Treatment for PTSD is aimed at relieving symptoms and eliminating or mitigating the manifestations of the disorder. It may include medication therapy, psychotherapeutic methods, or combination of both. The goal of treatment is

to reduce anxiety, eliminate repetitive traumatic memories, improve the quality of sleep, managing hyper-erethism, and improve the patient's general condition. Medication treatment for PTSD, as mentioned above, may include antidepressants, anxiolytics, and other medications that help cope with symptoms of the disorder.

PTSD rehabilitation is the process of restoring functionality, and improving the patient's quality of life after a traumatic event and treatment. It embraces a wide range of activities aimed at helping a patient cope with the effects of trauma and reintegrate into the society. Rehabilitation programs may include professional help in finding a job, social support, training in stress and anxiety management. Rehabilitation helps patients regain skills and improve functionality, making it easier to cope with daily routine and reintegrate into the society.

TREATMENT

There is a consensus among many professionals that various treatments for PTSD have so far shown *limited success*, with existing psychological therapies demonstrating success in outpatient treatment for about one-third of patients. A treatment is considered successful, if a patient reaches positive remission and is able to interact with a society. In Israel a marker of 'being able to work' is used to access whether a treatment has shown positive results. In most international practice first line of treatment is different kind of psychological therapies; usage of medical prescriptions is always considered at a second stage when symptoms remain and getting worse.

CASE BOX: NON-MEDICAL METHODS OF PTSD TREATMENT IN USE IN INTERNATIONAL PRACTICE:

- 1. Cognitive Behavioural Therapy (CBT):** CBT is one of the most common and proven effective treatments for PTSD. It focuses on changing negative thoughts and behaviours related to traumatic events.
- 2. Cognitive Processing Therapy (CPT):** teaches a person how to change the upsetting thoughts and feelings you have had since your trauma. This can be done individually or in groups and can use a mix of

⁴² Jones, N., Jones, E., Robbins, I., Wessely, S., Greenburg, N. (2017). Combat Experiences and their Relationship to Post-Traumatic Stress Disorder Symptom Clusters in UK Military Personnel Deployed to Afghanistan. *Behavioral Medicine*. 44(2). 131 – 140.

⁴³ Jones, N., Whelan, C., MacFarlane, A., Harden L., Burdett, H., Greenburg, N. (2018). Resilience-based intervention for UK military recruits: A randomized controlled trial. *Occupational and Environmental Medicine* 76(2).

oral and written processing sessions to help change the veteran's thought pattern.

3. **Prolonged Exposure Therapy (PE/PET):** this method is based on gradual and controlled exposure of patients to events or objects related to their trauma in order to reduce fear and anxiety reactions.⁴⁴
4. **Eye Movement and Desensitization and Reprocessing (EMDR):** this method involves making rapid eye movements by a patient, which accompany reconstruction of traumatic events and processing of negative flashbacks.⁴⁵
5. **Rational-emotive behaviour therapy according to A. Ellis:** REBT is an approach in psychotherapy that considers false, irrational cognitive attitudes (convictions, beliefs, ideas, not the past experience of an individual, but also the ways and possibilities of overcoming them peculiar to each person) as the main cause of mental disorders.
6. **Somatic Experiencing (SE) according to P. Levine:** this is a method of healing psychic trauma focused on sensations in the body. Levine noticed that despite facing life-threatening situations on a daily basis, animals do not seem to show signs of long-term psychic trauma, such as chronic anxiety, PTSD, or disconnection. Peter Levine studied the neural response to stress and trauma, and how animals naturally cope with physiological states of increased load, and then proposed to have this therapeutic approach integrated in practices applicable to humans.
7. **Neuro-Linguistic Programming (NLP):** when it comes to short-term psychotherapy, NLP can be successfully applied. The use of this method enables a prompt and long-term improvement of a patient's psycho-emotional, behavioural, psychosomatic condition.
8. **Hypnotherapy.** Using hypnosis (essentially a state of deep relaxation), we can recover

positive pathways in the brain, and develop new ones, which will promote long-term and healthy mental behaviour.

9. **Personality-Focused Treatment (PFT)** enables change in the victim's attitude towards the traumatic situation, and accepting responsibility, if not for the situation itself, then for his/her attitude thereto.
10. **Art Therapy:** Art Therapy offers an opportunity to not only express oneself in a creative manner, but also learn one's own self better, and express one's inner world through art. The combination of verbal and non-verbal expression helps to process and reframe traumatic experiences.
11. **Animal therapy (cane-therapy, hippo-therapy)⁴⁶** directed at release of oxytocin in a human's body
12. **TRE (Trauma Relax Exercise) methodology** (David Bercelli) simple yet innovative series of exercises that assist the body in releasing deep muscular patterns of stress, tension and trauma. It safely activates a natural reflex mechanism of shaking or vibrating that releases muscular tension, calming down the nervous system. When this muscular shaking/vibrating mechanism is activated in a safe and controlled environment, the body is encouraged to return back to a state of balance.

Treatment of PTSD should involve various factors and focus on the individual needs of each patient. A combination of medication therapy and psychotherapeutic approaches often yields better results than using one of the methods. It can be a time-consuming process, and its effectiveness will depend on correct assessment of complex condition of a patient. At its core, PTSD treatment should aim at assisting patients to cope with trauma sequela, reduce suffering, and improve quality of life. Collaboration with experienced professionals, including psychiatrists, psychotherapists, and other healthcare professionals, plays a key role in ensuring the therapy and rehabilitation of patients suffering from PTSD are successful.

⁴⁴ is meant to help veterans deal with memories or thoughts about traumatic events they have avoided. PE is intended to work towards dealing with the details of the trauma, essentially facing the fear, to help decrease PTSD symptoms.

⁴⁵ moves fixed unprocessed memories from the right frontal lobe across to the amygdala completing the trauma loop. The veteran will pay attention to either a back-and-forth movement or sound while recalling a memory with goal being to process the event.

⁴⁶ In March 2019, Lviv Veterans Service Center launched a project called "Riding to the Future" for ATO/JFO veterans suffering from post-traumatic stress disorder. The project is based on Equine Therapy (a treatment method using the most long-standing companions of humans, horses, as the major therapeutic agent). Involvement of ATO/JFO participants in equine-assisted therapy sessions and their subsequent training as instructors is an effective way to offer not only therapeutic intervention, but also social adaptation of veterans to peaceful life.

CASE BOX: MEDICAL TREATMENT OF PTSD

Medical treatment of post-traumatic stress disorder (PTSD) includes the use of various drug classes aimed at relieving PTSD symptoms and improving a patient's overall mental state. Medication tactics can be individual-specific and depend on severity of symptoms, presence of co-existing mental disorders, and personal make-up of each patient. Here are some of the main classes of medications that can be used for PTSD:

1. **Antidepressants:** selective serotonin and norepinephrine reuptake inhibitors (SSRIs and SNRIs) are a class of medications often used to treat PTSD. They can help reduce symptoms of anxiety, restlessness, insomnia, and recurring traumatic memories.
2. **Anxiolytics:** this class of medications help reduce anxiety and fear. They can be used in short-term situations or as antidepressant adjuncts.
3. **Antipsychotics:** in some cases, when PTSD is accompanied by severe psychotic symptoms, antipsychotic medications may be used.
4. **Antiepileptic medications:** some antiepileptic drugs, such as pregabalin and topiramate, can be effective in controlling anxiety and hyperarousal in PTSD.
5. **Specific medications for treating nightmares and insomnia:** specific medications can be used to treat nightmares and insomnia in PTSD to help improve sleep quality.

It is important that drug therapy for PTSD be tailored to personal make-up of each patient, consider possible side effects of medications and their interactions with other drugs. Treatment should be supervised by a physician who will adjust the dosage and use of medications for these to align with the run of the disease and the patient's response to drug therapy.

The current US model for PTSD treatment is based on Patient-Centered Care. Patient-Centered Care considers the patient's needs and preferences in a whole/holistic and spiritual (they just added this one in) approach to implementing a treatment protocol that is simultaneously in line with the necessary standard of care. [xlvi] The overall goal is to

not only treat the specific mental health issue, but to optimize the veteran's overall health. [xlix]

The VA's main treatment tools for veteran PTSD are psychotherapy and medication. Psychotherapy, or talk therapy, are "trauma focused" and work on helping the veteran deal with the incident and what impact it had on them.[i] This treatment plan usually lasts between 8 to 16 sessions with a provider and usually implement one of three specific therapies: Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure (PE).[ii] These three psychotherapy options represent the main treatment protocols but the VA may use any number of evidence based therapies to provide care.

In addition to talk therapy, the VA may also use medications to help treat PTSD. The VA currently utilizes three main antidepressant medications to help treat PTSD symptoms: Sertraline (Zoloft) — SSRI; Paroxetine (Paxil) — SSRI; and Venlafaxine (Effexor) — SNRI.[lviii] These medications are believed to treat PTSD by rebalancing the neurochemicals in the individual's brain.[lix] The VA does not currently recommend the use of benzodiazepines for PTSD treatment due to the potentially harmful side effects.[x] Overall, the use of medications is subject to the provider's relationship with the veteran and any changes, limitations, or increases are based on their discretion.

The current treatment model for PTSD is fundamentally intended to treat the condition. It is not meant to be a lifelong protocol that only manages symptoms and results in addiction or further deterioration of the individual's overall health. The goal is to get a better quality of life for the veteran and to specially help them move past the trauma and PTSD. However, as demonstrated above, it fails to consider permanent neurophysiological changes that occur and autoimmune disease that leads to poor physical health outcomes linked to PTSD.

COMPLEMENTARY AND INTEGRATIVE HEALTH (CIH) OPTIONS FOR PTSD

The VA acknowledges a variety of wellness practices for treating PTSD in addition to pharmaceutical and psychotherapy modalities.⁴⁷ Through its Integrative Health Coordinating Center, the VA offers acupuncture,⁴⁸ biofeedback,⁴⁹ clinical hypnosis,⁵⁰ guided imagery,⁵¹ massage therapy,⁵²

⁴⁷ https://www.ptsd.va.gov/professional/treat/txessentials/complementary_alternative_for_ptsd.asp#two

⁴⁸ <https://www.va.gov/WHOLEHEALTH/professional-resources/Acupuncture.asp>

⁴⁹ <https://www.va.gov/WHOLEHEALTH/professional-resources/Biofeedback.asp>

⁵⁰ https://www.va.gov/WHOLEHEALTH/professional-resources/Clinical_Hypnosis.asp

⁵¹ https://www.va.gov/WHOLEHEALTH/professional-resources/Guided_Imagery.asp

⁵² https://www.va.gov/WHOLEHEALTH/professional-resources/Massage_Therapy.asp

meditation,⁵³ Tai Chi,⁵⁴ and yoga.⁵⁵ Although in wide use in military and civilian contexts, research on the efficacy of CIH treatments is still emerging. It is worth noting that many of these options are easy to implement immediately following a traumatogenic event and can be facilitated by non-medical personnel.

A CIH modality showing promise is Written Exposure Therapy (WET).⁵⁶ One recent study found that WET is non-inferior to Cognitive Based Therapy in PTSD symptom change.⁵⁷ Another study found that WET was noninferior to Prolonged Exposure Therapy in PTSD symptom change.⁵⁸ Both studies reported lower attrition rates for WET than talk therapy and shorter treatment durations, suggesting that WET is economical, efficient, and may lower barriers to therapy for patients. In Syracuse, NY, co-author Lenny Grant founded the Resilience Writing Project, which uses writing to process trauma for medical, social work, and community members, and can confirm the ease of implementation and efficacy of this modality.

The first stage in the system of PTSD treatment in **Israel** is the *1st line of support concept*. The concept is based on development of capacity of every person (first responders, educators, medical personnel, social workers, administrative support personnel, volunteers) to provide first emotional support to another person.

The second concept in rehabilitation of veterans is based on *restoration of disrupted continuities and return to civilian functions* as soon as possible. All the rehabilitation is done in the community — there are no military hospitals, no military resorts and after a day spent in rehabilitation center (usually only for those going through physical rehabilitation) a veteran returns home to his family, job, business and regular environment.

Most of a veteran's psycho-social rehabilitation lies in the hands of a social worker (also case manager), who also works with a family of a veteran, in coordination with social workers in hospital and in education institutions. In Israel social workers supporting veterans are trained to recognize markers of PTSD and protocols of referral.

PTSD is diagnosed only by psychiatrists, who are specialists in this field. Treatment of diagnosed

veterans is conducted by multi-disciplinary teams — a medical expert, a psychotherapist specializing in post-traumatic disorders and a rehabilitation specialist. In addition to internationally accepted methods and protocols of trauma-focused therapy, rehabilitation process might include mindfulness, outdoor, breathing exercises, animal assisted therapy, art therapy and other supporting tools as supplementary resources. The main tools of PTSD treatment for Israeli veterans are — CBT and See Far CBT, EMDR, TF CBT and PE.

Recommended treatment by the **UK** National Institute for Clinical Excellence (NICE, 2012) recommends Cognitive Behavioural Therapy (CBT), Eye Movement and Desensitising Processing (EMDR)⁵⁹ as front-line treatments with the use of prescription drugs mainly SSRI's to reduce psychological symptoms (NICE, 2012). This dismissing completely the metabolic matrix that underpins psychological symptoms and long term poor physical health outcomes.

A review of the literature following the Iraq and Afghanistan conflicts has shown poor outcomes of treatment recorded for UK NHS Talking Therapy formerly known as Improving Access to Psychological Therapies (IAPT model). The IAPT treatment model was later adopted under the banner of Op Courage the NHS veteran's mental health service in the UK. In a paper Therapies (2012) the IAPT model was reported to having a 83-86% failure rate for low level anxiety and depression with high dropout rates.

There are some reasonable complains when it comes to efficiency of the existing route of treatment in the UK. If a veteran refers to a specialized charity for assistance with PTSD symptoms, in the first instance they ask him to go back to their GP (General Practitioner) and be referred back into the NHS Military referral pathway OP Courage. A veteran will be assessed by a mental health nurse (not necessarily qualified in trauma) and referred for Cognitive Behavioural Therapy to manage his symptoms (nottreatment of his symptoms). He/she will receive between 6 and 12 sessions and be discharged regardless of whether this has worked or not. If there is a long waiting list (currently running at 18 months), a veteran can go back to the charitable sector he called and they will pay for him to link with a therapist available in his area, not necessarily a specialist in trauma as

⁵³ <https://www.va.gov/WHOLEHEALTH/professional-resources/Meditation.asp>

⁵⁴ https://www.va.gov/WHOLEHEALTH/professional-resources/Tai_Chi.asp

⁵⁵ <https://www.va.gov/WHOLEHEALTH/professional-resources/Yoga.asp>

⁵⁶ https://www.ptsd.va.gov/professional/treat/txessentials/written_exposure_therapy.asp

⁵⁷ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787933>

⁵⁸ <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2808302>

⁵⁹ In 2018, EMDR was removed from NICE as a front-line treatment for combat soldiers due to re-activating trauma genetic states which led to many veterans entering the criminal justice system).

not many of them exist in the UK.⁶⁰ However, if he/she is deemed too complex they will not be able to help him/her.

Treatment for PTSD in **Ukraine** is similar to internationally recognized traditional practices, however, new methods are currently being elaborated and tested. It is regulated by the unified clinical protocol of primary, secondary (specialized) and tertiary (highly specialized) medical care (UCPMC) **“Response to severe stress and adjustment disorder. Post-traumatic stress disorder” MH of Ukraine**, developed in line with the effective requirements of evidence-based medicine. It addresses the specifics of diagnosing and treating patients PTSD in Ukraine from the perspective of ensuring the continuity of medical care.⁶¹ By its form, structure and methodological approaches to application of the requirements of the evidence-based medicine, the UCPMC is compliant with the **“Methodology for the development and implementation of medical standards (unified clinical protocols) of medical care based on evidentiary medicine”**.

CBT, CT, CPT and PE used as a method of first choice. Other methods in use are narrative exposition (NET) and EMDR. Medical treatment is based on prescription of anti-depressants of SSRI class.

CASE BOX: PATHOLOGICAL TRIANGLE: PTSD-BRAIN INJURY-ALCOHOLISM

Some studies conducted in Ukraine since 2014 have revealed that the risk of developing PTSD may increase for veterans or people who have experienced traumatic events (e.g., shell shock or blast injury). It has been also observed that patients with PTSD had higher tendency for **alcohol abuse** in an attempt to cope with their emotional and psychological difficulties.⁶²

In 2022-2023, academic psychiatrists in Ukraine registered many cases of the military personnel seeking assistance while complaining of depression, sleep disturbances, and hallucinatory experiences. The clinical surveys revealed the presence of PTSD, brain injury, and alcohol and

drug addiction. This phenomenon was defined by Prof. V.M. Postrelko as a “pathological triangle”. However, as of August 2023, there are no comprehensive statistical data on the PTSD-brain injury-alcoholism pathological triangle.

The pathological triangle comprising the post-traumatic stress disorder (PTSD), brain injury, and alcoholism is kind of an interlink between these conditions, which can interface and exacerbate the symptoms of each other. The triangle being complex and multifaceted, comprehensive data analyses and research are needed to drive its further study.

Treatment of such a pathological triangle requires an integrated approach and comprehensive treatment, including psychotherapy this as we have said above needs a different approach for PTSD, as well as appropriate rehabilitation and support programs to deal with alcohol addiction. Early diagnosis and timely treatment of each condition helps to prevent the others from exacerbation, and improve the patient’s overall mental and physical health. Yet, it is important to note that not all cases of PTSD, contusion, and alcoholism are inter-related, and each of these conditions can develop independently.

EXPERIMENTAL METHODS OF PTSD TREATMENT

1. *Neurofeedback (NFB)*: This method uses electroencephalography (EEG) or other biofeedback to help patients monitor their neurophysiological activity and reduce PTSD symptoms.
2. *Pharmacotherapy*: Research is underway on various medications for their applicability in PTSD treatment, including new approaches to the use of antidepressants, anxiolytics and other drugs.
3. *Psychedelic-assisted therapy*: Uses in treatment (mainly CBT) psychedelic drugs, such as psilocybin, MDMA, LSD, and ayahuasca, to treat mental disorders.

⁶⁰ According to the British Psychology Trauma Guidelines (2016), in the UK all specialists working with trauma should be respectively qualified ‘to MSc Psychological Trauma or PhD Level in this specialist field to assess and provide treatment’. It lists three levels of competencies for those working with victims of trauma, including the importance of ‘having in-depth knowledge of existing science-based practices for assessment and treatment of traumatic stress’. The Association of Clinical Psychologists UK in its Standards for Psychological Rehabilitation in Major Trauma (2022) stipulates that ‘clinical psychologists should be core members of the MTC multidisciplinary team (MDT)’

⁶¹ It was the first time when UCPMC development involved representatives of various ministries and agencies, which enabled the introduction of unified standardized approaches, and consideration of the specifics of providing medical care to certain groups/communities, in accordance with the legislation of Ukraine. The UCPMC was developed based on the adapted clinical guideline **adapted clinical guideline “Post-Traumatic Stress Disorder”**

⁶² People suffering from PTSD and alcohol addiction can find themselves in a misleading situation: alcohol can temporarily alleviate some of the symptoms of PTSD, but end up exacerbating them in the long run. Such links between conditions can lead to a chronic and severe pathological condition.

For now, integrative approaches that combine traditional and experimental methods are considered to be the most promising methods of PTSD treatment. For example, a combination of CBT and pharmacotherapy can work more effectively than any of these methods alone. Application of new approaches based on the use of virtual reality or artificial intelligence technologies is also possible, to reinforce the results of therapy.

CASE BOX: VR TECHNOLOGIES AS AN EXPERIMENTAL THERAPY/SUPPORTING REHABILITATION IN PTSD TREATMENT IN UKRAINE

In June 2022, a group of Ukrainian academic psychiatrists of the International Academy of Ecology and Medicine of Ukraine, led by Prof. V. Postrelko, started application of hypnotherapy methods using virtual reality glasses. There were individual rehabilitation programs developed for each patient. As of August 2023, 47 people (37 military personnel and 10 civilians) were examined and treated. The treatment methodology is still under research, but the preliminary results available are positive (test treatment was also conducted for the British ex-servicemen).

The preliminary research has established that virtual reality (VR) can be successfully used to treat anxiety disorders, including phobias and post-traumatic stress disorder. A wide range of intensity of specific effects of the study is indicative of high capacity of VR, but also points to the need for a more in-depth insight into the underlying driving mechanisms. Given the benefits of VR effects, the need for its further dissemination should be stressed. Improvements in the technology and procedures may have the best effect in the future.

The early results of the methodology have shown its effectiveness not only for treatment and rehabilitation of existing mental disorders, but also for prevention thereof by relieving stress, especially among the military personnel engaged in front-line operations.

PSYCHOTHERAPY AND PSYCHO-CORRECTION FOR PTSD

Psychotherapy is aimed at treating PTSD, while psycho-correction is aimed at correcting certain behaviors that do not correspond to the optimal behavioral model. However, the modern view of psychologists in Ukraine does not offer clear distinction between the concepts of psychotherapy and psycho-correction. This causes confusion when some people understand psycho-correction as a package of measures for treatment/rehabilitation of a person, while others — as a tool for correcting behavioral patterns of a healthy person.⁶³

Psychological correction (psychocorrection) in PTSD overlaps the process of PTSD psychotherapy and uses the same techniques as PTSD psychotherapy (CBT, EMDR,⁶⁴ Exposure Therapy).

In the case of veterans, psycho-correction can be used after PTSD treatment to correct behavioral patterns, as well as during PTSD treatment to reinforce the results of psychotherapy.

PTSD-related psycho-correction can be streamlined to address the following aspects of veterans' behaviour:

- Correction of attitudes towards others (aggressiveness towards others, empathy issues, ability to empathize and understand the condition of civilians);
- Correction of the system of values (building a rational view of one's psychophysiological state, individual needs and capabilities);
- Correction of self-attitude, the concept of "Self" (objective assessment of one's own self and condition);
- Acquiring socialization skills;
- Correction of self-destructive behaviour.

► Challenges in addressing PTSD in Ukraine

There is a number of challenges relating to diagnosis and treatment of post-traumatic stress disorder in Ukraine, which can make it difficult to provide effective care to patients.

⁶³ At this stage of research into this subject, psychocorrection is almost equated with psychotherapy, for which reason there are almost no specific studies in the field of PTSD psychocorrection, while the available ones are often in conflict with each other. At the same time, the foreign scientific literature does not raise the issue of PTSD psychocorrection in an aspect other than psychotherapy, and psychocorrection itself is often called psychological intervention and is defined as any non-medical intervention, although in fact it doesn't have any clear definition either, and is interpreted in the same way as psychotherapy.

⁶⁴ Thus, EMDR can be conditionally called a therapy technique for mild PTSD, because its most common application is when a person sees an unpleasant image or picture that periodically pops up — then we use EMDR to relieve the sensations of this image, but this method has a number of contraindications (contusion, TBI, baroacoustic trauma, epilepsy), as well as cases when a given flashback itself is useful for the brain.

Some of these challenges include:

- 1. Insufficient education of specialists:** poor quality of education and insufficient training of medical and psychotherapeutic specialists in the field of PTSD diagnosis and treatment can lead to undiagnosed cases and improper treatment.
- 2. Difficulties in diagnostics:** diagnosing PTSD can be difficult, as some symptoms may overlap other mental disorders. This can lead to misdiagnosis or delayed treatment.
- 3. Denial of the problem:** some patients may deny having a problem or feel ashamed to seek help because of the stigma associated with mental disorders. This can delay diagnosis and treatment.
- 4. Lack of public apprehension:** misunderstanding by the society of PTSD and mental health in general can lead to insufficient support, and individuals not seeking assistance from a psychotherapist. Some people may believe that PTSD is a weakness or that they can cope with it on their own.
- 5. Limited accessibility of psychotherapeutic care:** some regions or some social groups may have limited access to qualified psychotherapists, which makes PTSD treatment challenging.
- 6. Insufficient financing for public health care:** insufficient funding for PHC can limit availability and downgrade the quality of psychotherapeutic care for patients with PTSD.
- 7. Non-compliance with the therapeutic process:** some patients may discontinue treatment in the early stages, or fail to follow doctors' recommendations, which can reduce the effectiveness of the therapy.
- 8. Stigmatizing trauma and different cultural profiles:** some cultures view seeking psychotherapy or acknowledging mental health problems as a taboo, or stigmatize it. This can lead to waiving medical attendance, and poor help-seeking culture in some societies.
- 9. Specific challenges for veterans and the military:** people who did military service or participated in armed conflicts may face additional challenges in diagnosing and treating PTSD. Some may fear being stigmatized, or of potential consequences for their service, making it difficult to seek attendance.
- 10. Comorbidity with other mental disorders:** patients with PTSD often have concomitant mental problems, such as depression, anxiety disorders, or substance abuse. This complicates diagnosis and requires comprehensive treatment.
- 11. Loss of access to therapy:** in some cases, changes in insurance systems, geographical remoteness from specialists, or other circumstances can result in losing access to psychotherapy or discontinued treatment.
- 12. Difficulties in applying therapy to children:** diagnosing and treating PTSD in children can be particularly challenging, as its symptoms and manifestations in children may differ from those in adults. In addition, intervention in children's mental world requires special skills and approaches.
- 13. Duration of therapy and relative effectiveness:** treatment for PTSD can take a long time, and its results may vary from patient to patient. Some patients may feel surprised or disappointed if they do not see immediate improvement or do not achieve the results they expect.
- 14. Unqualified specialists.** Some individuals who are certified for psychotherapeutic activities in a particular method, have no basic classical education, which in its turn can significantly aggravate a patient's condition and compromise the public sentiment towards the general community of practitioners.

PRE- AND POST- RESILIENCE SUPPORT MEASURES (ISRAEL EXPERIENCE)

One of the greatest challenges for a country that is going through a prolonged and severe emergency, such as the current Russian invasion of Ukraine or as endless terror attacks waves in Israel is the gap between the enormous, identified and evolving needs and the current level of psychosocial resources available.

Israeli and international experience shows that following potentially traumatizing events, no matter how painful and overwhelming they may be, most people regain their mental well-being naturally over time, relying on basic support from loved ones and inherent coping resources. The development of post-traumatic stress disorder or other mental and emotional disorders is an extreme reaction, and the risk of its manifestation can be significantly reduced and minimized if all who are in contact with survivors

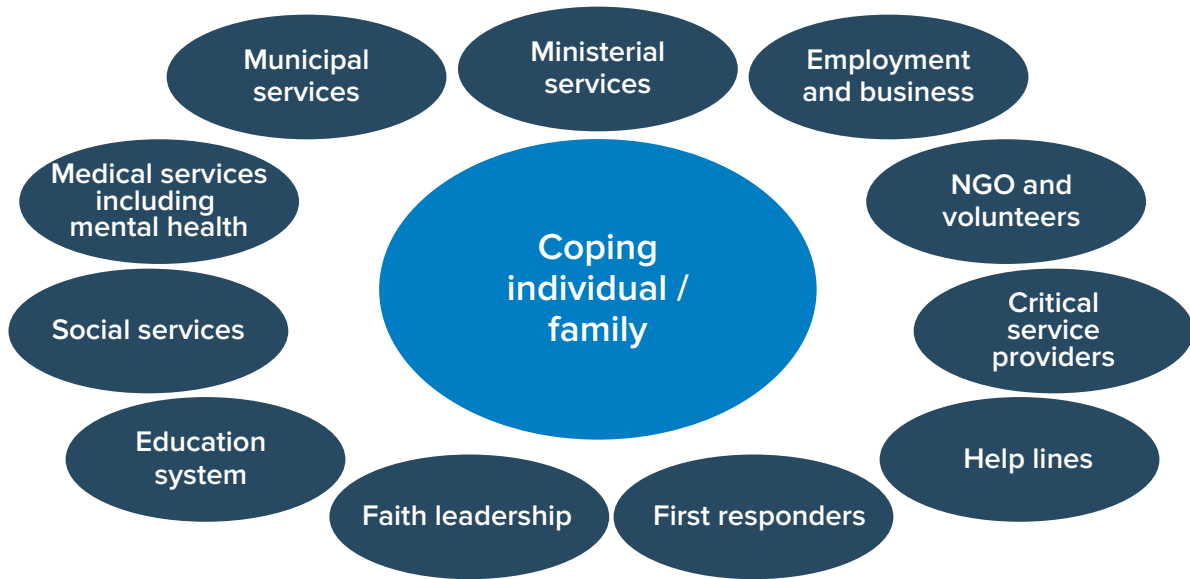


Fig. 1: Eco-system of psycho-social support. Source: Israel Trauma Coalition

of a potentially traumatic event are equipped with tools and skills to provide effective support in the initial stages. Thus, the vast majority of trauma survivors will not require professional intervention from mental health professionals at later stages.

To meet the needs of such a scale and of high intensity among the population and the widest range of war-affected populations⁶⁵ a holistic, practical, inclusive and innovative approach to psycho-social support and to mental health is needed.

Based on Israeli practical experience, the most viable and effective approach to fill this gap is to create a widespread network of non-stigmatized psychosocial support on the ground, at the community level. Psycho-education, training of every person capable of helping another (not only mental health professionals, but also teachers and employment clerks, nurses and volunteers, policemen and parents, social workers and postmen; so to say, everyone who's job involves interaction with persons and families) is the key to a more successful and faster rehabilitation and return to normal life for individuals, families and communities of survivors of traumatic events.

To reduce the number of people in need of professional mental health help, Israel relies on the concept of a timeline starting from the moment of the event that might become traumatic. On each time period in which post-traumatic and other types of disorders can develop, different tools are used to reduce the level of traumatization and / or for short-term trauma-focused psychotherapy (for example, TF CBT etc).

When psychosocial and emotional support comes from within the community itself, it enables both individual and community coping mechanisms, reducing the risk of developing post-traumatic stress disorder and freeing up mental health professionals to handle more complex tasks and work with cases of psychopathology and PTSD.

The core principles of the Israeli approach to prevention and mitigation of posttraumatic disorders and to the development of resilient persons, families, communities and resilient nation:

1. Everyone can be trained to help another.
2. Utilize inclusive language and tools that avoid stigmatization.
3. Adopt a holistic approach encompassing the individual, family, community, and society.
4. Identify and address all spheres of vulnerability.
5. Establish a "first line of defense" comprised of supporters capable of providing emotional support.
6. Prioritize the well-being and support of those who provide assistance.
7. Implement a cascade model that involves training individuals to become trainers themselves.
8. Embrace the PIE framework — Proximity, Immediate response, and realistic Expectations.

⁶⁵ Entire communities, displaced and returning home, demobilized and injured soldiers returning to their communities, families who have lost their loved ones, families who have lost their homes and businesses, survivors of sexual abuse and rape, orphaned children and many others

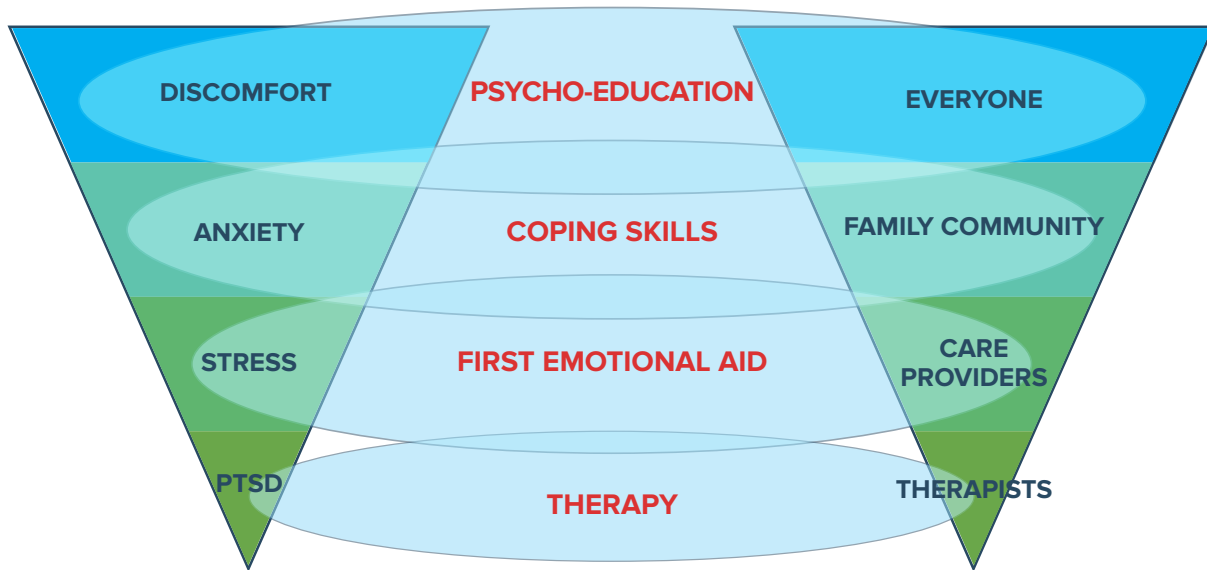


Fig. 2: Needs, tools and supporters funne. Source: Israel Trauma Coalition

POST TRAUMATIC GROWTH (PTG)

Post traumatic growth (PTG) is the phenomenon of growing after trauma or hardship.

PTG can be experienced as an increased appreciation for life, a greater sense of personal strength and self-understanding, or a renewed appreciation for intimate relationships. Experiences of PTG have been found to have implications for psychological outcomes, with several studies reporting an inverse association between high levels of PTG and fewer PTSD symptoms. Moreover, self-reported experiences of PTG have been linked with improved health behaviours, such as a reduction in drug and alcohol consumption. However, as some studies report a positive association between PTG and PTSD symptoms or no relationship between PTSD and improved well-being, the impact of PTG on adjustment remains unclear. However, the following are deemed to be areas that allow a person to move into post traumatic growth after an event.

1. **A new sense of opportunities after trauma.** Trauma and loss shake us to our core and challenge us in ways that we might not have imagined as possible. As a result, many survivors begin to see new possibilities in life and the opening of new doors of opportunity.
2. **New value in relationships** The process of coping with trauma requires relationships — friends, family, therapists, support groups, etc. As humans, we are neurobiologically wired to regulate our emotions through relationships. The experience of utilizing support after trauma increases these connections and helps us remember how important they are.

3. **New sense of personal strength** Surviving trauma and asking for help to cope with its aftermath requires incredible strength. Trauma survivors demonstrate extraordinary courage, resilience, vulnerability, trust, hope, and compassion, among other strengths. When an overwhelming event force us to utilize all the strengths we have (and often develop new ones), we are much more aware of them going forward. “If I survived that trauma, I could survive anything”.
4. **Greater appreciation for life** Trauma, by its nature, threatens our safety, security, and often our lives. Trauma and loss remind us how precious life is and how fragile it can be. It can help us see the big picture and reconsider our priorities in life.
5. **Deepening of spiritual/religious views** Because trauma is so often experienced through relationships and involving other human beings, many trauma survivors turn to spirituality or religion for strength, hope, and inspiration. Trauma is an existential crisis that challenges us to make sense of it, often through spiritual, religious, or existential belief systems.

These five domains of post-traumatic growth are sometimes simplified further into three categories: 1) Quality of Life, 2) Perception of self, & 3) Experience of relationships and others

Provision of timely, appropriate, and effective treatments and support networks that are aligned across organizations, service providers, and service users is critical to the well-being of military personnel and veterans which has shown to aid PTG in most cases.

DECOMPRESSION

Decompression models are long standing within military environments, particularly at times of war. The theory behind decompression derives from the Vietnam conflict with the need for military personnel to undergo a period of psychological adjustment before returning home or back to the front line. According to Major Maree Riley, an officer involved in Australian Defence Force, decompression needs to happen in a “third location”, which is neither the operational theatre nor home for rest with comrades who have experienced the same. A review of the literature revealed the same in that the morale and effectiveness of military personnel is dependent on his or her membership of a tight-knit social group and hence it is important to ensure that reintegration back into society takes place within the same social group just as much as operational exposure/combat⁶⁶

United Kingdom

Following the Falklands War in 1982, United Kingdom military personnel returned from their deployments in one of two ways: entirely by sea or by a combination of sea and air travel. Those who returned entirely by sea had journeys that were one week longer than those who split their mode of travel. Press reports at the time suggested that those who spent longer getting home had better psychological outcomes than those who made the trip more quickly. Although outcome data to substantiate the claim has never been published and in this respect the narrative has entered legend and is widely cited in support for providing decompression time between a war zone and home station.

During the Iraq and Afghanistan conflicts the UK set clear parameters for decompressing their troops, by publishing ‘Standing Orders’ that set out the concept and importance of decompression which was mandatory for all in a report titled: Land Post-Operational Stress Management (POSM) the concept of decompression and purpose of decompression is outlined.

- **“Concept of Decompression.** *Decompression is an enabler for recovery. It is a process by which personnel who deploy together, unwind together. It is designed to place individuals into a formal, structured and monitored environment in which to rest, relax and reflect*

after a period on operations; by doing so individuals will start to re-adjust to a normal and routine peace-time environment. It affords an opportunity for personnel to begin to rationalise their experiences and set them in context.

- **Decompression** must occur in a formal, structured and monitored environment, away from the area of operations immediately before recovery to the home base. Here, personnel are provided with a location in which to **rest, relax and reflect** before returning to a normal, routine, home environment. It should normally take place with those with whom they have served.
- Decompression is **mandatory** for all personnel who serve a minimum of 31 consecutive days in a theatre of operations for which DcN has been deemed necessary.

The Front-Line Commanders who retain full command of their personnel whilst they are deployed on operations were responsible for its delivery.⁶⁷

United States

To capitalise on the potential benefits of a decompression period, paired with support services, the U.S. Air Force established the Deployment Transition Centre (DTC) at Ramstein Air Base in Germany in July 2010. The DTC provided airmen returning from combat missions with an opportunity to decompress and share lessons learned before returning to their home stations. A review of the decompression model is given below:

“Unfortunately, many well-intended and well-liked decompression programs prove to be ineffective. In many ways, the history of mental health prevention efforts could be summarized in the same way. It has proved extraordinarily challenging to reach the right people, at the right time, and with the right intervention to prevent the negative consequences of trauma exposure. Considering these challenges, it is not surprising that few preventative decompression programs have been found to have benefits on post-deployment PTSD, depression, binge drinking, and social conflict. However, these evaluations are key for promoting ongoing program modification or program development that can improve outcomes for those who serve their country on difficult or dangerous deployments.”⁶⁸

⁶⁶ Grinker RR, Spiegel, JP Motivation for combat-morale. In: *Men under Stress*. Edited by Grinker RR, Spiegel, JP Philadelphia, PA, Blakiston, 1945.

⁶⁷ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/428920/LFSO_3209_Redacted.pdf

⁶⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5644773/>

Although there is no common definition of what works for those who enter decompression there are some important points to consider from the literature.

Decompression programs need to be:

1. Structured, time limited and informal.
2. Needs to be carried out in a safe environment with good living accommodation and amenities.
3. In a 'third location' this could be accomplished by spending a short period at a staging post on the way home or perhaps a longer period back in a base location.
4. Needs to be with those who experienced the same and who spent time together on the front line.

5. Provide rest, recover and recuperation and assessment of those who have been involved in high intense operations.

Given the lack of knowledge as to the balance of risks and benefits, and the absence of any definitive evidence that decompression is associated with improved mental health outcomes, or conversely that lack of decompression is associated with the reverse, research has shown decompression should remain a matter of discretion (Hacker Hughes et al., 2008). Where decompression can fit seamlessly with the life of a unit, it may well indeed convey some benefits. Where it is imposed for little purpose, it runs the risk of doing the opposite.⁶⁹

⁶⁹ Hacker Hughes et al (2008), The Use of Psychological Decompression in Military Operational Environments, *Military Medicine*, Vol 173, Issue 6. <https://academic.oup.com/milmed/article/173/6/534/4557676>

VII. INSTITUTIONAL FRAMEWORK (POLICY MAKING AND COORDINATION)

As veterans after leaving military service become civilians, all their further affairs are being handled by civilian ministries — Ministry of Veteran Affairs (MVAU), Ministry of Health (MHU), Ministry of Social Policy (MSPU), National Service for Health of Ukraine (NSZU).

The Ministry of Veteran Affairs of Ukraine is the main governmental body, responsible for the formation and implementation of social protection policy for war veterans (those from Revolution of Dignity 2014 included), members of their families and those families, who lost their members in combat actions.⁷⁰ It is in charge of social protection (psychological rehabilitation), social and professional adaptation, employment, recreational treatment and housing. In terms of psychological health, the Ministry is responsible for protecting rights of veterans and their families for medical care. On issues of prevention, treatment and rehabilitation the Ministry must act in cooperation with the Ministry of Health of Ukraine. It is also responsible for handling a Common State Register of Veterans.

The Ministry of Health of Ukraine is main governmental body responsible for formation and implementation of state policy of healthcare, with healthcare of veterans being part of it.⁷¹

The National Service for Health of Ukraine is responsible for governmental policy on state financial guarantees for medical services according to program of State Guarantees for Medical Services for Population. It is coordinated by the Cabinet of minister of Ukraine through the Ministry of Health of Ukraine.⁷²

The Ministry of Social Policy of Ukraine is responsible for the formation and implementation of state policy in social care, inter alia, social and professional adaptation of servicemen and war veterans (one-time payment).⁷³

As is seen from brief description of functions, MVAU is the main body in charge for veterans,

however, on medical issues it should coordinate its policy with those of the MHA. MVAU has in its disposal 5 rehabilitation centers, but it can neither deal with the medical component alone, nor be in charge of a complex medical-rehabilitation process of a veteran. This division of functions resembles very much the system of medical care of veterans, which is in existence in the UK, where the National Health Service (NHS) defines a process of veteran treatment. In Israel the main player in addressing veteran's quality of life and rehabilitation is conducted by Ministry of Defense. This is different from US model, with Department of Veteran Affairs having a **National PTSD Center** and nation-wide network of Polytrauma Centers under its supervision.

Having a separate track for medical treatment of veterans is a discussable issue. From one hand, making a specific case for veterans might be subject to critics of discrimination in rights.⁷⁴ On the other hand, UK practice of dealing with veterans through NHS has been criticized by the UK veterans themselves, who found it difficult to see an understanding of veterans' specifics in combat-related traumas in medical personnel they had to deal with. Given the size of potential veteran and families' population in Ukraine, it looks advisable to consider option of moving all veteran-related affairs under the responsibility of the MVAU, who should be working more closely with the Ministry of Defense (like in the US model).

Ukrainian veterans, interviewed by GLOBSEC, almost unanimously pointed out that they would like to see more leadership from the MVAU both in driving veteran policies, and establishing communication among the ministries. Nowadays, it also looks like different veteran associations tend to cooperate on their initiatives with one of the named institutions, not necessary the MVAU. Those who are working with MHU, MSPU or NSZU explained their choice by 'this institution being more responsive to our initiative'. However, given the nature of competence, it would be advisable to see more authority of the MVAU-MOU link in running veteran affairs.

⁷⁰ Cabinet of Ministers Decree #1175 from December 27, 1998 (amended by Decree #276 from April 15, 2020).

⁷¹ Cabinet of Ministers Decree #1175 from March 25, 2015 (amended by Decree #90 from January 24, 2020).

⁷² Regulation on National Service for Health of Ukraine #1101 from December 27, 2017.

⁷³ Cabinet of Ministers Decree #423 from June 17, 2015.

⁷⁴ And in 2020, European Commission **criticized** B&H for favoring veterans against other people with disabilities. "Bosnia and Herzegovina does not have a uniform definition of disability, nor a database of persons with disabilities. Support is limited and varies depending on the origin of the disability, as persons with war-related disabilities (war veterans and civilian victims of war) enjoy priority over other persons with disabilities. Such a status-based discriminatory approach must end."

Institution	Priority Project	Essence
MHU	Mental Health Care in the Structure of Medical Care	to increase the capacity of primary and specialised healthcare to provide accessible, timely, high-quality and free mental health services to all those who need them.
MDU	Recovery: Creating a Psychological Rehabilitation System for the Personnel of the Armed Forces of Ukraine	aims to provide psychological recovery for military personnel and their families, those who have been released from captivity, including through establishing specialised centers.
MVAU	Transition from Military Service to Civilian Life (in terms of psychological assistance)	involves a digital solution (creation of a mobile application) to support veterans and their families during their return to civilian life.
MSPU	Creation of Resilience Centers in Ukraine	aims to provide psychosocial support to community residents, first-line contact professionals, and volunteers.
MESU	Psychosocial Support and Psychological Assistance at all Levels of Education	involves implementing psychological resilience skills at all levels of education, from preschool to higher education. It is also planned to transform the psychological service within the education system.
MIAU	Crisis Psychological Assistance and Support to Individuals in Emergency Situations	develops an algorithm for providing crisis psychological assistance and support to individuals in emergency situations. This algorithm would involve professionals from various fields (social, education, medical, etc.) and address the need for ongoing support beyond the immediate event, ensuring proper follow-up and assistance.
MYSU	Youth Centers and Active Parks — Part of the Mental Health Ecosystem	One of the components is to provide psychological support services for adults, children and adolescents through the SpivDiia platform

Confusion with respect to division of competence is exacerbated by multiple coordination inter-agency networks for mental health issues, which have come into an existence over the last year:

1) Interagency Coordination Council on Mental Health Care and Psychological Support for Individuals Affected by Russian Aggression against Ukraine (ICC)

Established by the Cabinet of Ministers **Resolution** No. 539 from 7 May 2022. ICC serves as a platform for making decisions related to developing and implementing the Ukrainian Mental Health Program. The Council is chaired by the Vice-Prime-Minister of Ukraine for Reintegration of Temporarily Occupied Territories Ms Iryna Vereshchiuk. Proposals and recommendations of the Interagency Coordination Council may be adopted by a decision of the Cabinet of Ministers of Ukraine. Organisational, informational, material and technical support of the Interagency Coordination Council is provided by the Ministry of Health.

In May 2023 MHU, MDU, MVAU, MSPU, Ministry of Education and Science (MESU), Ministry of Internal Affairs (MIAU), and Ministry of Youth and Sports (MYSU), all being members of ICC presented **seven different projects** to restore the mental health of Ukrainian citizens. While projects are different in their focus groups, they nevertheless overlap each other to a certain extent.

2) Coordination Center for Mental Health adjacent to the Cabinet of Minister of Ukraine (CCMH)

Established by the **Resolution** of the Cabinet of Ministers of Ukraine No. 301 of 30 March 2023 to coordinate efforts and facilitate collaboration among ministries, institutions, organizations, local government bodies, non-governmental sector, international partners and donors, as well as the expert and scientific community, in the development and implementation of the Ukrainian Mental Health Program «How Are U?» initiated by the First Lady of Ukraine Ms Olena Zelenska. CCMH is headed by Ms Oksana Zbytneva, CEO NGO

“Barrier Free”. The proposals and recommendations of the Center are of advisory nature. CCMH is supported by extra-budgetary funding.

3) Support Centers for Civilians Network within the Regional State (Military) Administrations (SCC)

The Government adopted **Resolution No. 470** “ On Coordination Centers for Civilian Support” dated 9 May 2023 and approved the relevant Standard Regulations. The centers aim to ensure effective interaction and coordination with executive authorities, law enforcement and other government structure, local self-government, and civil society organizations and to establish an efficient mechanism for administering local needs, resources, and services, including providing housing and promoting employment for the affected population, as well as providing psychosocial, medical and legal assistance. Formally, SCC are established within the regional state (military) administrations,⁷⁵ but they report on their activities to the Cabinet of Ministers of Ukraine through the Ministry for Reintegration of Temporarily Occupied Territories (under VPM Iryna Vereshchiuk). Organizational and financial support of SCC is provided by regional state (military) administrations.

In practice a decision of the government to establish SCC in regional administrations has been met with mixed reaction on the local level. While praising the very initiative to pay attention to specific needs of the affected population (including psychological health), quite a few administrations have been complaining about the lack of respective financial resources and professionals/specialists, who might be able to provide respective services (especially on mental care).

From an analysis of competences given to ICC, CCMH and SCC it becomes clear that there might be significant confusion of competences and interaction among them:

1. Ukrainian Mental Health Program «How Are U?» initiated by the First Lady of Ukraine Ms Olena Zelenska is an overarching program for mental health of Ukraine, but decisions of CCMH are of advisory nature only. The connecting body here is the MHU, as the head of CCMH is appointed by the Minister of Health.
2. ICC is a collective governmental body under VPM for Reintegration of Temporarily Occupied Territories, where MHU is on equal footing with the other ministries, however responsible for organizational and material support of ICC’s activities.

3. Functions and competences of ICC and CCMH are very much similar, with major difference that activity of CCMH is directed onto implementation of Ukrainian Mental Health Program «How Are U?».
4. SCC have similar competences as ICC but on a regional and local level, but their activities are run within regional state (military) administrations subordinated to the President of Ukraine.
5. All these structures are very open to cooperate with public associations, civil society and veteran unions, but the latter found it very confusing to understand ‘who is in charge’ and describe the whole process of cooperation with the government to be rather chaotic. All GLOBSEC respondents for this research were unanimous in view that ‘there should be a streamlined and clear coordination mechanism on national level with one body in charge of the whole process’.

Also, as it is clear from the infrastructure setting, that the physical and psychological health of veterans/ex-servicemen are not separate things, but have been merged within the suggested common policy on mental health both on national and regional levels. The current initiative of the MVAU to establish an institution for a ‘veteran assistant’⁷⁶ in every local territorial community could be considered as a useful link between a veteran and the system of medical and social care. However, for the time being it is not clear how this new infrastructure element would fit into the established coordination networks.

⁷⁵ which in times of martial law are directly subordinated to the President of Ukraine

⁷⁶ A person, who will be helping a veteran to get accommodated into a peaceful life after decommissioning

VIII. RESOURCE ASSESSMENT (PROFESSIONAL, INFRASTRUCTURE, FINANCIAL INCLUDING DONORS' ASSISTANCE)

As matters stand, it is difficult to assess the efficacy of governmental plans to establish a coherent system of medical and rehabilitation centers, specializing in traumas, as well as on perspective needs in resources (medical personnel, infrastructure and financial support). Also, in times of martial law in Ukraine much information remains unavailable for public access.

RESOURCE SUFFICIENCY 1. DOCTORS AND SPECIALISTS

Ukraine has a number of qualified doctors, psychiatrists and psychotherapists who specialize in treating military personnel and individuals suffering from PTSD. However, the availability of specialists may be limited, especially in some regions of the country. National Service of Health of Ukraine (NSZU) reports that as of August 2023 in Electronic System of Healthcare of Ukraine there were 4095 psychiatrists, 1067 psychologists and 473 psychotherapists registered nationwide.⁷⁷ Their breakdown differs from region to region, with the most staffed regions being Kyiv, Lviv, Dnipro, Kharkiv, Odesa and Poltava (see respective chart on next page).

Given the projected number of the Ukrainian population potentially exposed to mental health issues, Ukrainian medical experts interviewed by GLOBSEC estimate that Ukraine would need to double the figures of specialists available.

Since the start of the full-scale invasion, virtually all members of scientific, academic research and practical psychological associations, departments, laboratories, services, educational institutions and private centers in Ukraine have been actively engaged in volunteer psychological assistance and have been internalizing new essential knowledge and skills. One of the major challenges undermining their work is that before the war Ukraine has not had many trained personnel to deal with war traumas and all these specialists had to obtain the necessary knowledge and qualifications fast enough in a very limited timeframe. Access to respective educational programs and training had been limited (caused by a lack of correspondent training courses in Ukraine and limited knowledge of military psychology, as

well as by simple lack of knowledge of English language to access international courses).

Nowadays a variety of factors affect the quality and accessibility of mental healthcare services in Ukraine, with main of them being:

- no psychologists in military units in hospitals;
- lack of necessary knowledge and skills among specialists;
- undue use of psychological protocols by specialists;
- no psychologists in hospitals;
- lack of coordination in the transfer of patients between military medical units (battalions) / hospitals / civilian medical institutions / rehabilitation centers / family doctors / social support centers.

A shortage of specialists in the field can also be explained by the factor that prior to the full-scale war with Russia many people, after receiving a degree as a psychiatrist/military psychologist/medical psychologist/psychologist were not motivated to work in their specialty area, due to dissatisfaction with the social package (high psycho-emotional stress, low salaries, neglect of self-regulation, work/rest schedule and, as a result, rapid burnout).

Another serious problem for the quality of services provided arises from the 'fashion to become a psychologist' in war times, which is widespread in Ukraine these days. Psychologist has become one of top three trending profession in higher education, but people want to make it 'fast baked': coming from professions largely unrelated to medicine (like teacher, lawyer, tax inspector etc) they complete 1-week fast-track courses with unofficially certified trainers, they apply for a master degree in psychology to get into practice as soon as possible. Sometimes it gets even worse, when people begin non-certified practice upon completion of these fast-track courses only. This trend is very dangerous and harmful, as unprofessional service could only aggravate mental disorder in a patient and lead to re-traumatization. It could also be life-threatening for a 'doctor' himself,

⁷⁷ Those medical establishments that have officially concluded contracts with NSZU.

Professional Staff for Mental Health Care in Ukraine (2023)

Region	Service providers under contracts			Service providers under contracts for mental healthcare packages		
	Number of regular staff in the position of Psychiatrist	Number of regular staff in the position of Psychologist	Number of regular staff in the position of Psychotherapist	Number of regular staff in the position of Psychiatrist	Number of regular staff in the position of Psychologist	Number of regular staff in the position of Psychotherapist
Vynnytska	91	53	5	72	28	2
Volynska	70	11	7	53	4	5
Dnipropetrovska	189	49	31	139	23	11
Donetska	71	33	9	33	1	3
Zhytomyrska	68	49	5	42	10	3
Zakarpatska	62	20	11	39	4	2
Zaporizka	80	30	11	42	19	1
Ivano-Frankivska	87	34	11	73	13	7
Kyivska	90	34	1	60	8	1
Kirovohradska	59	32	10	45	9	5
Luhanska	50	11	6	0	0	0
Lvivska	210	30	33	188	13	23
Mykolaivska	40	13	8	31	8	5
Kyiv	239	92	28	195	17	14
Odeska	151	53	14	113	16	8
Poltavska	115	24	17	85	10	3
Rivnenska	65	33	6	43	12	3
Sumska	91	22	27	79	18	16
Ternopilska	89	23	15	49	5	7
Kharkivska	163	31	43	102	11	18
Khersonska	60	9	6	34	1	3
Khmelnyska	66	28	6	47	11	3
Cherkaska	70	23	4	62	12	3
Chernivetska	75	45	7	50	15	2
Chernihivska	56	16	5	36	8	2
Total	2385	791	324	1710	276	149

Source: The National Health Service of Ukraine, August 2023, Letter of 14.08.2023 No.28116/6-15-23

if a PTSD affected (ex)combatant suddenly attacks a 'doctor', being in a deep state of dissociation that a 'doctor' has not been able to detect due to low (if any) qualification.⁷⁸ With due respect to people's sincere wish to help others coping with traumas, they do not fully understand the level and deep responsibility and potential costs of mishandling a situation. This is a problem that the Ukrainian government has to pay serious attention to.

Ukrainian veterans interviewed for the 2020 **study** underlined that it is important for them to receive support from professionals who deeply understand veterans' experience and problems they face after they come back home. Conversely, veterans hold prejudices against psychologists who have no such experience. It was emphasized that civilian psychologists lack experience counselling veterans. They said that, prior to working with veterans,

psychologists should undergo additional training that would enable them to understand the specifics of veterans' life situation, world view, and experience in combat operations.

RESOURCE SUFFICIENCY 2. CLINICS AND MEDICAL FACILITIES

According to Ukrainian legislation after completing service in the AFU military servicemen change their status into civilians and are no longer in a position to receive treatment in military hospitals. After demobilization ex-serviceman turn to civil psychiatric clinics when PTSD symptoms become apparent.⁷⁹

Partial psychological rehabilitation was introduced for ATO participants after 2014–2015 and was compulsory for all ex-combatants. At the same

⁷⁸ This is not an abstract assumption. These days in Ukraine there had been a lot of cases of mishandling combat patients that provoked their aggressive defence in response.

⁷⁹ If case this person does not receive proper treatment and commits suicide, this case will not be reported as a suicide committed by a veteran, which makes proper counting of suicides among veterans difficult.

time, **according** to then Military Prosecutor of Ukraine Anatoliy Matios, in 2017 the level of supply of this service to ATO veterans accounted for only 0,1% from the needs. In February 2017 regional social protection services stopped providing psychological rehabilitation for ATO participants and the state budget allocations for this were reduced from 49,9 mln UAH to 21,9 mln UAH (down by 56,2%).

The situation has been partially improved in recent years with the enlargement of medical capacities to treat veterans, who suffered from mental disbalance. In 2018 the Government of Ukraine increased financing for rehabilitation services for veterans up to 109 mln UAH, which enabled to enlarge capacities for treatment and slightly improve infrastructure. A national Center for Mental health and Rehabilitation of Veterans based on the War Veterans' Hospital "Lisova Polyana" was opened in September 2019⁸⁰ with other centers to follow.

NSZU reports⁸¹ that in 2023 psychiatric assistance in Ukraine is being provided by communal and private entities. Inward psychiatric assistance or counselling is provided in 92 communal and 2 private entities; outward psychiatric treatment is provided by mobile multidisciplinary groups of 69 communal and 1 private entities; primary care (assistance and treatment) is provided by 520 communal, 37 private entities and 29 private practitioners. Rehabilitation services are given by 264 units for in patients and 410 units for out patients. These facilities are of common use for all civil population with decommissioned servicemen included.

Veterans, however, could also apply to be treated⁸² in special rehabilitation centers for veterans, which MVAU has in its possession. As of August 2023, MVAU is in charge of 5 centers of social and psychological rehabilitation in **Borodyanka**, Ivankiv, Kyiv-Svyatoshyn, Slavutych and Korosten', where a veteran can receive rehabilitation therapy individually, with family members and in groups. MVAU has also expressed its strong interest in considering establishment of 5 new rehabilitation centers, that could each be specified in rehabilitation methods and practices used in the US, UK, Israel, Croatia, Ukraine (experimental methodic) with a view of potential further scaling up the model, which will demonstrate to be most efficient for rehabilitation of Ukrainian veterans. Recently the MVAU

has also developed a complex strategy "Path to Rehabilitation and Resurgence of Defender", by which it suggests measures to ensure consistency in medical services after injury/ies and longer-term assistance in psychological, physical rehabilitation alongside with professional and social adaptation and legal support.

RESOURCE SUFFICIENCY 3. FUNDING

Funding for health care, including mental health care, constitutes an important aspect of the country's resilience in war times. Yet, in Ukraine this area has always been largely underfunded, especially when it comes to development and support of mental health care. In 2019 spending on healthcare in Ukraine amounted for 2,4% of GDP against 5-7% recommended by WHO or 16,7% in the US, 11,1% in Germany, 9,8% in UK, 7,4% in Czech Republic, 4,86% in Poland,⁸³ out of which only around 2,5% were spent on mental care. In June 2020 Expert Committee of World Psychiatric Association made an **appeal** about a crisis of psychological health in Ukraine as a result of improper reforms in the medical sphere in 2016-2018, which led to drastic fall in financial support and outflow of many specialists in the field.

In 2023 healthcare in Ukraine was financed for **206,8 bln UAH**, which constitutes 7,8% of all budget expenditures and is almost aligned with WHO recommendations.⁸⁴ According to NSZU, expenditures on primary psychological care constituted for 19 800 800 UAH; inward psychiatric care — 3 623 191 800 UAH; outward psychiatric care provided by mobile multidisciplinary teams — 105 120 000 UAH.

In 2023 state budget of Ukraine **allocated** around 6 838,6 mln UAH for state veteran policy (only 0,25% of state budget expenditures), major part of which goes for support of housing needs of veterans and their families (5,5 bln UAH) with 540 mln UAH being spent on psychological rehabilitation needs (0,02% of state budget expenditures). It comes together with a separate budget program 1501040 "Measures on Psychological Rehabilitation, Social and Professional Adaptation and Recreational Treatment for Veterans" with 1 733 939,2 thousand UAH.

According to Programs for State Guarantees for Medical Services a veteran and his family members

⁸⁰ Initially started with capacity to receive 20 inward patients, by mid 2023 the Center has grown up to receive over 200 inward patients.

⁸¹ The National Health Service of Ukraine, August 2023, Letter to GLOBSEC of 14.08.2023 No.28116/6-15-23.

⁸² no medical treatment, but rehabilitation only

⁸³ Goroshko, A., Shapoval, N. & Lai, T., 2018. Can people afford to pay for healthcare? New evidence on financial protection in Ukraine. WHO Regional Office for Europe.

⁸⁴ Medical care for veterans and their families is not separately specified

are entitled to receive a package of enlisted medical services for free, with some of mental care services included. Medical services and medicaments, which are not included into a package, could be covered at the expense of other state budget programs.

► International assistance

Against a background of significant financial support provided to Ukraine by its international partners to strengthen resilience of a war-torn country, health care and mental care, as well as support to veteran policies remains strikingly small.

In December 2022 MHU and **World Bank signed** a credit agreement on a project of strengthening the system of healthcare and preservation of life (HEAL), under which MHU will receive 100 mln USD in credit resources and 10 mln USD in grant from Global Finance Fund. This is an initial phase of 500 mln USD project on psychological care and rehabilitation needs in Ukraine. World Bank also supports implementation of two big projects on healthcare in Ukraine in amount of 681,1 mln USD.

During the visit of the **European Commission Vice-President for Promoting our European Way of Life, Mr Margaritis SCHINAS** to Ukraine on June 15-16, an **Arrangement for Cooperation on Health** was signed, which stipulates for further expanded cooperation on both urgent and long-term health priorities, mental health and psycho-social assistance included. This also implies perspective access of Ukraine to financing under EU4Health program.

In 2021 the Swiss Agency for Development and Cooperation (SDC) has contributed CHF 3'295'000 in a 4 year project **Sustaining Health Sector Reform in Ukraine** within a framework of a wider project **Mental Health for Ukraine (MH4U)** to support Concept of Mental Health Development in Ukraine by 2030.

In March 2023 MVAU **launched** 4.8 mln EUR project "Resilience Path" together with **International Organization on Migration (IOM)** and the Ministry of Foreign Affairs of **Germany**. The project envisages two main components: (1) development of institutional potential of MVAU, local authorities and veteran organizations (including creation of 25 centers for veteran development); (2) mental health and psycho-social support to veterans and their families. newly initiated second phase of veterans reintegration programming, IOM Ukraine together with the EU's Instrument Contributing to Stability and Peace will continue responding to the needs of

Ukrainian communities through targeted protection assistance and social cohesion initiatives. Previously IOM together with MVAU were **engaged** in two EU supported projects on sustainable reintegration of veterans, supporting their successful transition to civilian life through assistance to veterans, family members, and their communities (2018-2020 and 2020-2022).

In June 2023 it was **announced** that Ukraine would be launching a cooperation with **Canada** on experience and knowledge sharing on PTSD treatment in veterans. This idea was discussed at the highest political level between the First Lady of Ukraine Mrs Olena Zelenska and Canadian Prime Minister Justin Trudeau. The project will be implemented under the auspices of All-national mental health program **'Ty yak?/How are you?'**

Initiatives on psychological rehabilitation and treatment of veterans should be expanded further with a view to prospective integration of Ukraine into the EU, when Ukrainian veterans will become part of EU human resources and some of them might even migrate to European countries to get re-united with their families that had to flee Ukraine in early days of the full-scale war. It deems reasonable to consider possibilities of using more financial instruments of the EU and NATO to work in the area. For example, **The European Peace Facility** instruments of assistance measures,⁸⁵ as well as **NATO Science for Peace and Security/ Human and Social Aspects of Security** should be explored in this regard.

⁸⁵ managing actions to strengthen the capacities of third states, regional and international organisations relating to military and defence matters and support to military aspects of peace support operations led by a regional or international organisation or by third states.

IX. LEGISLATIVE SETTING

Analysis of scientific research on mental health in Ukraine shows that before February 2014 the system of institutional psychological services was not ready to meet the challenges of martial law. The problem of PTSD in Ukraine began to be studied more intensively in 2016 and resulted in adoption of a number of legislative and regulatory acts to respond to existing legislative loopholes that the anti-terrorist operation (ATO/JFO) exposed.

1. The Decree of the Cabinet of Ministers of Ukraine No. 1018-p from 27 December 2017 **“On approving the Concept of Mental Health Care Development in Ukraine for the period up to 2030”**. In accordance with the Decree, the Action Plan for 2021-2023 to implement the Concept for the Development of Mental Health Care in Ukraine until 2030 was approved. However, fact-checking on actual implementation of the Plan revealed that a significant number of the measures have neither been implemented or have been partially implemented, or even have lost their relevance as a result of the full-scale military invasion of Ukraine by the Russian Federation in February 2022.
2. The Decree of the Ministry of Social Policy of Ukraine No. 810 from 01.06.2018 **“On Approval of the Standard of Psychological Diagnostics and Forms of Documents on the Organization of Psychological Rehabilitation of Participants of the Anti-Terrorist Operation and Affected Participants of the Revolution of Dignity”**.⁸⁶
3. The Resolution of the Cabinet of Ministers of Ukraine No. 1057 from 27 December 2017 **The Procedure for Psychological Rehabilitation of Participants of the Anti-Terrorist Operation and Injured Participants of the Revolution of Dignity**. The Resolution set a framework for psychological rehabilitation of veterans. Meanwhile, an old procedure for the use of methods of psychological and psychotherapeutic influence, approved by respective Decree of the Ministry of Health of Ukraine No. 199 from 15.04.2008, which established unified requirements for the

use of methods of psychological and psychotherapeutic influence, including the places of application of such methods, remained in force.

4. The Decree of the Ministry of Health of Ukraine No. 121 from 23 February 2016 **On Approval and Implementation of Medical and Technological Documents for Standardization of Medical Care for Post-Traumatic Stress Disorder** approved the Unified Clinical Protocol for Primary, Secondary (Specialized) and Tertiary (Highly Specialized) Medical Care **Response to Severe Stress and Adaptation Disorders. Post-Traumatic Stress Disorder** (the Unified Clinical Protocol).⁸⁷
5. The Law of Ukraine **On Social Services** with amendments and additions in the new version of 27.04.2022 — new version N°2671-VIII.⁸⁸
6. The Law of Ukraine **On Refugees and Persons in Need of Additional or Temporary Protection, Who Belong to Vulnerable Groups of the Population and/or Are in Dire Life Situations**,⁸⁹ where concepts of “vulnerable groups”, “low-income person”, “basic social services”, “service providers”, “associations of social service providers” and the concept of a register of service providers were defined.
7. These days a number of draft legislative acts have been introduced to regulate the provision of medical and psychological care and support for patients with signs of acute psychological trauma of direct impact or their mixed nature, associated with the experience of negative consequences, more complex consequences of war, irreversible losses, injuries, etc.
 1. Draft Law of Ukraine No. 9433 of 28.06.2023 **On Amendments to Certain Legislative Acts on the Mental Health Care System and Mental Health Services**,⁹⁰ the draft is currently being considered by the Parliamentary Committee on Nation’s Health, Medical Care and Medical Insurance

⁸⁶ This Decree approved: (1) standards of psychological diagnostics; (2) a standard form of an individual plan for psychological rehabilitation of a service recipient; (3) conclusion-prognosis of psychological rehabilitation; (4) protocol of diagnostic examination.

⁸⁷ Unified Clinical Protocol for Primary, Secondary (Specialised) and Tertiary (Highly Specialised) Medical Care (Order of Ministry of Health of Ukraine of 23.02.2016 No. 121), https://www.dec.gov.ua/wp-content/uploads/2019/11/2016_121_ykpm�_ptsr.pdf

⁸⁸ <https://zakon.rada.gov.ua/laws/show/966-15#Text>

⁸⁹ <https://zakon.rada.gov.ua/laws/show/2671-19#n482>

⁹⁰ proposed amendments to Article 3, to include “provision of mental health services” in the definition of a healthcare facility

2. Draft Law No. 9434 of 25.06.2023 **On Amendments to Certain Legislative Acts on the Introduction of Administrative and Criminal Liability for Providing Psychological Assistance to Persons Who Do Not Have Such a Right and Dissemination of Inaccurate Information about the Availability of a Person's Medical Education or Medical Specialty, the Right to Provide Psychological Assistance.**⁹¹ The draft is to be included into plenary session for first voting.

3. Draft Law of Ukraine “**On Professional Psychological Activity**”⁹²

These legislative incentives aim to resolve existing legislative loopholes when it comes to professional mental health care and institutional networks, foremost, in ensuring proper accreditation and licensing of practicing psychologists. The initiatives are considered to be a right move in a direction to streamline and organize a chaotic process of psychological services in Ukraine. An open issue remains which state agency will become an authority that will certify and accredit specialists.

⁹¹ this law provides for personal liability for illegal activities or violation of protocols related to the provision of specialized medical or psychological care related to borderline conditions and requiring the use of a clinical protocol and psychotherapeutic intervention.

⁹² the law defines the principles, foundations, tasks and organizational basis for self-government of psychologists as a public institution of psychological assistance to the population, which acts in the interests of clients by ensuring professional autonomy and compliance of psychologists in conducting psychological practice.

X. PTSD THROUGH SOCIETAL LENSES

Raising awareness of the PTSD problem in Ukraine: eliminating ignorance

Surge in interest to PTSD topic in Ukrainian society has led to heated discussions about level of affected population and potentials aftereffects for the health of the nation. At the same time the lack of public professional discussions and research on the topic creates anchoring of negative stereotypes in the society and hardens unhealthy stigma. It would be justifiable to say that there is still much of ignorance about PTSD among the population of Ukraine, and even among professional medical staff.

Contributing factors:

1. **Lack of advocacy:** Despite being a common mental disorder, PTSD and its symptoms, causes, and treatment methods are not duly communicated to most people, including healthcare professionals. Such information shortage leads to incorrect assessment of PTSD phenomenon as such, and of challenges relating to its proper diagnostics and treatment.
2. **Social prejudice:** Some societies and cultures may have stigmatizing views of mental health disorders, including PTSD. This can lead to people being reluctant to seek medical help for fear of being judged or isolated.
3. **Limited access to medical care:** In some regions of Ukraine, access to quality medical care is limited. This leads to that even if a person is symptomatic of PTSD, he or she may not be considering to seek professional help.
4. **Insufficient training of medical professionals:** Teaching and training on mental health and PTSD diagnostics barely meets the actual needs of the society. Many healthcare professionals are unable to receive quality education on the subject (due to limited availability/unavailability of qualified trainers/specialists), thus, making them not qualified enough to properly assess their patients' mental condition and diagnose PTSD.
5. **Cultural differences:** Understanding of and approaches to mental health differ across various cultures. Cultural profile and beliefs predefine perceptions and attitudes towards PTSD. Bad legacy of punishment therapy of the Soviet era has hardened a negative frame in Ukraine for psychiatric clinics as places of

forceful detention with enforced treatment against one's will. However, over the years of socio-economic uncertainty, the public sentiment towards psychological and psychiatric care, professionals at large, and the prestige of the profession has begun to demonstrate positive changes.

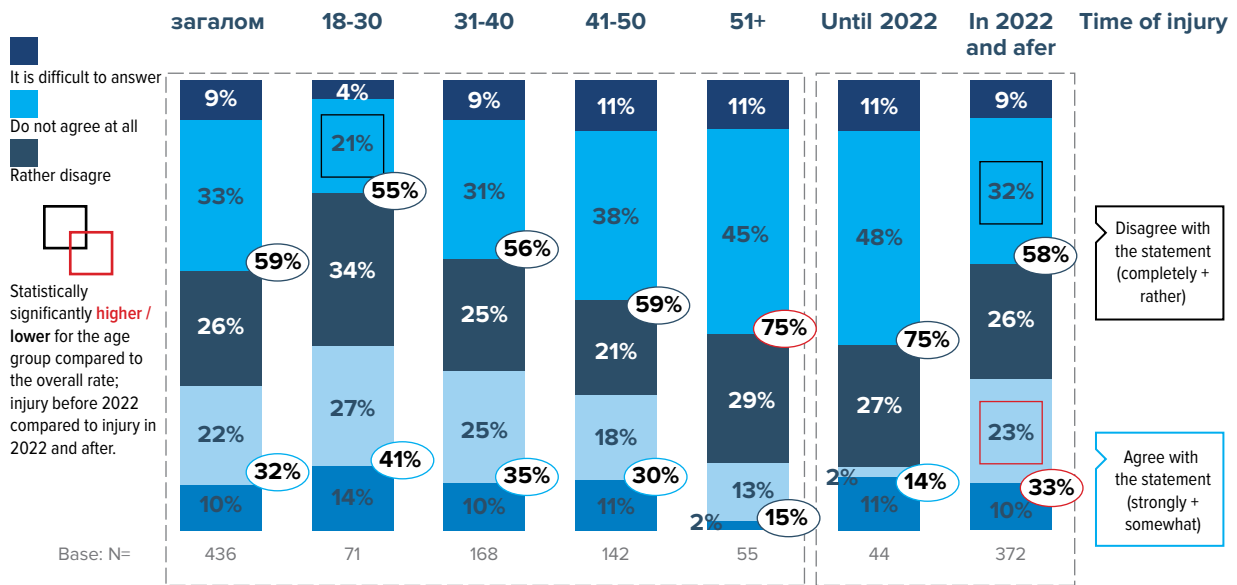
In the view of the above there is a strong need for nationwide advocacy campaigns to set a positively frame for PTSD as temporary mental disbalance that can be effectively treated, especially with timely diagnosis. Society should be informed about its nature and consequences and become mature and responsible enough to face this phenomenon as one of wounds of the war that needs to be healed.

► Social environment for reintegration of veterans

While triggers for PTSD are mostly a result of the internal dynamics of the brain's work, experience of other countries shows that social environments can play a major role in triggering emotional conditions of mentally vulnerable veterans. Among the most common challenges that a veteran could face after switching from a combat regime into a peaceful life is a shaken identity, a changed system of values (indifference to material things, understanding fragility of life etc), lost sense of purpose and self-realization. This is where a society can be of great assistance and reduce the bitterness accrued from these feelings.

Many countries, who faced similar challenges of accommodating ex-combatants into peaceful life, acknowledge that providing a veteran with mere pension allowances (however high) could be destructive and lead to increased negative side-effects like alcohol and drugs abuse, domestic violence and criminal activities and so on. For example, this was one of the shortcomings of governmental policies in Western Balkans. Also, social and economic uncertainty, with vague perspectives for employment after the war is over could aggravate concerns about the future and deepen feelings of depression and anxiety, which is likely to be the case in Ukraine if there are no clear cut pathways for a peaceful life. Extracts from **Gradus Survey "Path of a Wounded: Needs, Problems and Vision of Future"** below, conducted among wounded combatants in July 2023, prove our assumption. It is important, however, to underline, that general level of anxiety about the future remain rather low

Feelings of fear about life after the war



Source: Gradus Research report “The path of the wounded: needs, problems and vision of the future” <https://gradus.app/en/>

(33% against 58% of positive confidence in the future), this mood might change with the time, especially if there is no definite government strategy to address the issue in place.

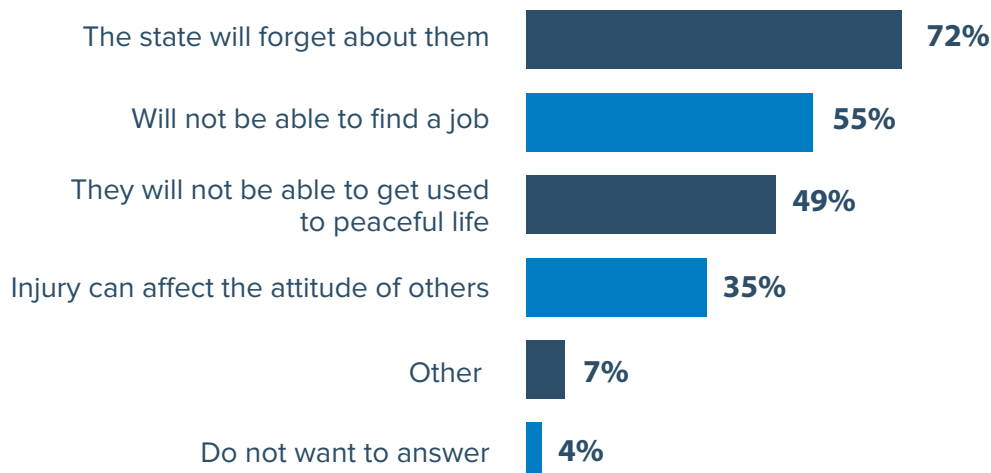
A goal and determination in life, meeting challenges combined with achieved results could be very fruitful, especially for adrenaline-dependent ex-combatants, and could help restore a sense of oneself as a useful member of society. Different researches and the personal experience of veterans provide enough evidence that professions like paramedics, rescuers, deminers, emergency services and other adrenaline-high professions, as well as military psychologists and psychotherapists would be very suitable for former combatants. They

also can demonstrate themselves very good as private entrepreneurs and para-sportsmen.

The Ukrainian government and society are well aware of this positive societal effect. Therefore, both are quite active in developing opportunities for veterans to realize themselves in new professions and find a new sense of purpose. In 2015-2021 30 872 veterans received training and were qualified in new professions. In 2023 demand for professional training among veterans has risen up to 31% more than the number envisaged. A novel decision was taken to include compulsory psychological assistance throughout the training process. The MVAU responded to these needs with respective normative changes to expand opportunities to meet this

Reasons for fear of life after the war

They are afraid that:



Source: Gradus Research report “The path of the wounded: needs, problems and vision of the future” <https://gradus.app/en/>

demand. Then MVAU has elaborated a **Strategy of Transition from Military Service to a Peaceful Life by 2032** and organized its public consultations in July 2023. In this Strategy, one of the main focuses is placed on opportunities for professional training and re-training of veterans in new professions, academic work, veteran entrepreneurship etc. In summer 2023 the Ministry also launched a pilot project of the **Centers for Veteran Development** (with a focus on professional training and further employment) altogether with the veteran assistants' network in 5 regions of Ukraine (Dnipro, Vinnytsia, L'viv, Mykolayiv and Kyiv), with a view to expand the practice onto all 21 regions of the country in 2024. The main role of a veterans' assistant is to help him get accommodated to a peaceful life by a smooth transition process through all necessary stages, which contains a lot of frustrating bureaucracy, and to cope with unexpected stumbling blocks. If successful, this network will be enlarged from original 400 to almost 15 000 assistants in every territorial community of the country.

Housing for veterans remains one of the most acute problems. Existent funding does not cover all the needs of veteran families, which has been aggravated by the scale of destruction of private houses and even residential blocks as a result of heavy shelling. As of April 1, 2023 there has been a queue of over 32 000 veteran families waiting for housing under government benefit scheme (5,5 bln UAH from state budget capable to cover needs of 2 843 families). The Ukrainian government is also currently working on a new program for compensations of mortgage rates (7%) for housing "e-Oselya"/"There is a house".

CASE BOX: CROATIA

The social problem of PTSD in Croatia remains extensive. It has existed since the beginning of the Homeland War, although its importance and extent may not have been immediately recognized. Before the Patriotic War, dealing with PTSD within the framework of psychiatry was preferred.

Since the end of 1993, public and health care for veterans with PTSD and their various psychological and other health, familial and social issues has become one of the priorities of psychiatry and general social engagement. However, veterans with PTSD were dissatisfied of the level of taking care of their bodily, somatic and social consequences of their condition. Regardless of certain privileges (as an example, we cite priorities in

enrolling their children in college), veterans with PTSD were dissatisfied because the consequences of PTSD in many were permanent and could only be alleviated and not completely removed by any interventions and benefits.

On the other hand, during this time, there was also a growing dissatisfaction among other categories of the population. For example, other severely sick patients, for other reasons besides PTSD, were dissatisfied with the imagined or real difference of their care compared to care provided to veterans.

► Family and community environment

The impact of war on those that serve, their families and wider communities is well documented.⁹³ Families of the military and veterans are exposed to an increased risk of developing symptoms of psychological disorders.⁹⁴ Unlike more individualist Western cultures, in Ukraine, family and religion play important role in the system of values and could be effectively used as efficient accommodating factors when it comes to healing psychological wounds of war in a soldier or a veteran. Like in Israel and Western Balkans Ukrainian families are also more likely to show sympathy and understanding of war traumas, as they partially experience the same because of the Russian attacks on civilians. Within this group of closer relatives, a particularly vulnerable one is that of relatives of missing and captured servicemen, who are living through everyday anxiety about destiny of their loved ones. They are more likely to develop PTSD symptoms than those who still communicate with their relatives fighting on the front line. On the other hand, the mentioned category is also more active in public campaigns that contribute to disseminating information and rising awareness to the costs of war internationally.

A survey on the initiative of the "Ukrainian Veterans Fund" of the Ministry of Veterans Affairs of Ukraine conducted by the Sociological Group "Rating" in January 2023 found that 63% of the respondents have among their close friends and relatives those who fought or are fighting at the front, starting from February 24, 2022 (compared to 47% of those who had their relatives and friends who had participated in hostilities on the territory of Ukraine between 2014 and 2021). Compared to the similar survey in August 2022, the number of those whose loved ones are fighting at the front today has increased.

⁹³ Betancourt, T. S., Keegan, K., Farrar, J., & Brennan, R. T. (2020). The intergenerational impact of war on mental health and psychological wellbeing: Lessons from the longitudinal study of war-affected youth in Sierra Leone. *Conflict and Health*, 14(62). <https://DOI.org/10.1186/s13031-020-00308-7>

⁹⁴ Invisible Injuries of War: Impact on Military Families and Children

The implication is that by the end of war a significant part of the Ukrainian society will have direct experience of war through their family ties. They need to be prepared how to deal with a relative, who is returning home after the war, and how to accommodate him better to a peaceful environment. The rich experience of other countries teaches us that family members being estranged from this experience in most cases fail to understand inner conflict in a soldier and cannot cope with new reality. As a result, we see higher levels of domestic and sexual abuse, divorces and separations, which makes all suffer.

In anticipation of the end of war and eventual demobilization of a high number of Ukrainian servicemen a lot of efforts must be undertaken now for training family members of combatants to be able to cope with the new reality and changed nature of persons coming from the front and to prepare them to handle situations maturely. 2020 survey⁹⁵ found that friends and family members of veterans would be willing to have individual consultations and training to learn how to deal with a family member who returned home from the war. Such measures would be important to help veterans' family members understand the mindset of a person who was engaged in combat operations and build comfortable relations with him/her.

This is especially urgent as many of GLOBSEC respondents from combatants' family members confessed that there is still minor attention given to families when it comes to making them prepared for return of their loved ones. "It looks like we are the least priority for the government" — confessed one of the lady-chairs of a veteran association on a condition of anonymity, "vigorous efforts should be made to correct the situation as soon as possible". For the sake of objectivity, it should be said, however, that there are a number of government initiatives to work with combatants' family members, but their scale is not enough because of limited resources and qualified professionals to provide this kind of training. Situation is particularly acute in rural areas, which, however, provided with the highest number of people during mobilization.

CASE BOX: INCLUSIVITY AND CHANGE OF OVERALL ENVIRONMENT: THE BOSNIAN EXPERIENCE

B&H went through a mental health reform with the aim not only to „treat illnesses“, but to transform the way we look at health. According to

their philosophy, all aspects of social life can be used as tools of early diagnosis of trauma or as a helping tool in treatment, support, or recovery. Everywhere in art, music, sports, culture, there is a potential to find ways to help each other and support each other. B&H created "user associations", connecting people receiving help with their trauma related issues. These people work on anti-stigma program, talk on media, work in schools, talk everywhere about trauma and motivate others to find help.

Case-management is one of the products of this reform. Each client is assigned to an interdisciplinary team of practitioners - psychiatrist, psychologist, social worker, occupational therapist, 4 nurses. When the client comes for the first time, this team analyses his needs and specific situation using a set of questionnaires and other tools to understand the unique situation. After that, the client and the team of specialists develop an individual recovery oriented plan that includes working with the client and also with his family. Everybody in the team is involved in designing this plan and, if needed, provides services to make the plan work. When treatment is completed, the client can join a "user association" to keep in touch, get support later or provide support or motivation to others. Multidisciplinary team of professionals communicating with each other works much better than when a client communicates with each of said professionals independently.

Spirituality in PTSD Treatment

Great deal in PTSD treatment is also devoted to spirituality as part of post-traumatic growth. For this concept US VA offers two definitions of spirituality: (1) "an inner belief system providing an individual with meaning and purpose in life, a sense of the sacredness of life, and a vision for the betterment of the world"; and (2) "a connection to that which transcends the self."⁹⁶

Traumatic incidents can lead to positive and negative spiritual outcomes for survivors. Negative spiritual outcomes include loss of faith, feelings of abandonment or punishment from God, and loss of meaning and purpose in life. However, spirituality can be an asset for healing trauma. Healthy spirituality is associated with lower levels of symptoms and clinical problems in some populations.⁹⁷

⁹⁵ Life After Conflict: Survey on the Sociodemographic and Socioeconomic Characteristics of Veterans of the Conflict in Eastern Ukraine and Their Families, January 2020, commissioned by the International Organization for Migration (IOM), Mission in Ukraine, in cooperation with the Ministry of Veterans Affairs, Temporarily Occupied Territories and Internally Displaced Persons, funded by the European Union (EU)

⁹⁶ https://www.ptsd.va.gov/professional/treat/care/spirituality_trauma.asp

⁹⁷ <https://onlinelibrary.wiley.com/doi/10.1002/jclp.20049>

Spirituality can mitigate instances of alcohol and substance abuse^{98,99} promote coping skills,¹⁰⁰ lessen loneliness and isolation,¹⁰¹ improve relaxation,¹⁰² and aid post-traumatic growth.¹⁰³ Spirituality is also a way to expand the circle of healing by integrating additional community resources as therapeutic assets. Participation in a spiritual community puts people with PTSD among caring individuals who can provide emotional support and encouragement, as well as material needs.¹⁰⁴

In the Ukrainian context higher spirituality will definitely be a positive result of PTG after the war due to general cultural loyalty to religion and faith in God. This will especially be the case for those families, who lost their loved ones in the war, and would be seeking for ways of coping with grief of loss. Here we see a potential of Ukrainian religious confessions to restore its role in the society and to help those vulnerable accommodate themselves with new reality.

► Veteran groups and associations. Volunteer organizations

The veteran community in Ukraine is very vibrant and sometimes could be seen being strikingly united. On August 21, 2023 37 veteran associations and unions came up with appeal to withdraw a Bill on Veteran Status (#9637), which had been submitted to the parliament a day before and was swiftly recommended by the Committee on Social Policy and Veteran Rights' Protection for voting in a plenary session. The veteran community stood against the Bill as the one that had not been consulted properly with the veteran community and contained a number of provisions that could seriously undermine veterans' rights. The bill had been withdrawn the next day and redirected for further revision and amendments.

The veteran movement started to form in years of the first modern war with Russia of 2014–2015 with 400 registered in 2016 and 750 in 2017.¹⁰⁵ Since the beginning of current war their number has grown exponentially. Among the most active are NGO “Legal Hundred”, Veteran Hub ++, Human Rights Center for military personnel “Prynzyp”, NGO “Ukrainian Women Veteran Movement”, NGO “Dobrovoltsi”, NGO “Space of Opportunities”,

NGO “Women of Steel”, NGO “Association of ATO Disabled Veterans”, Public Council of the Ministry of Veterans Affairs of Ukraine, Charitable Foundation “Volunteer Association “VESTA”, Volunteer service of the Lviv Military Hospital, NGO “Association of ATO combatants of Odesa region”, NGO “Polygon 56 Berdiansk”, NGO “Families of captured defenders of the Chernobyl nuclear power plant”, Veteran’s Space ‘Sercevir’, NGO “About Those Who Are Silenced”, NGO “Veterans for Medical Cannabis”, Charitable Foundation “Fenix”, All-Ukrainian public movement of mothers and relatives of ATO combatants “Berehynya”, Vinnytsia Analytical and Educational Center “Veteran Space”, NGO “Support of the Titans”, Veterans’ Fund “Pislya Sluzhby” (“After Service”), NGO “Civil Safety”, Human Rights Group “SICH”, Mykolaiv City Center for Support of War Veterans, NGO “Veteranske Braterstvo” (“Veterans’ Brotherhood”), NGO “Association of Disabled People and Veterans of Khmelnytskyi Region”, NGO Boyarka Municipal Organisation of Combatants, ATO veterans, and volunteers, YARMIZ Center for Rehabilitation and Readaptation, NGO “All-Ukrainian Association of Relatives of Missing and Fallen Defenders of Ukraine”, Public Organization “Protection — Association of Volunteers”, NGO “Association of war veterans, ATO/JFO veterans, their families, volunteers and persons with disabilities, Mobile volunteer group, NGO “Dim Veterana” (“Veteran’s House”), NGO “Zaporizhzhia city organisation of ATO veterans”, associations of different Azov groups (especially, women organizations) etc. They also form different coalitions among themselves and nowadays are considered of being extremely powerful in terms of public pressure.

Some veteran/combatant groups like the Azov Patronage Service have developed into a coherent eco-system of taking care of their comrades’ needs from first aid on the front line to psycho-rehabilitation, employment and families’ support. Their network is often said to be recommended as a role model for the government’s plans to develop a veteran care eco-system at national level. Others like the NGO “Space of Opportunities” actively engage with local authorities and municipalities to build a network of veteran entrepreneurs educated in modern project management to set up their own business.

⁹⁸ <https://hrcak.srce.hr/clanak/84619>

⁹⁹ <https://link.springer.com/article/10.1007/s11126-012-9223-5>

¹⁰⁰ <https://onlinelibrary.wiley.com/doi/10.1002/jclp.20049>

¹⁰¹ <https://doi.org/10.1080/10926771.2021.1912875>

¹⁰² <https://link.springer.com/article/10.1007/s12529-011-9186-1>

¹⁰³ <https://www.tandfonline.com/doi/abs/10.1080/15426430802113814>

¹⁰⁴ https://www.ptsd.va.gov/professional/treat/care/spirituality_trauma.asp

¹⁰⁵ https://lb.ua/society/2017/03/10/360875_kolichestvo_veteranskih_organizatsiy.html

The phenomenon is easily explained by the general culture of active civil society and volunteer movement to help those, fighting on the frontline, injured and wounded soldiers on treatment and those already decommissioned from service, which received stronger impetus with the current invasion. Broadly, these associations could be divided into three broad categories:

1. Active groups, participating in veteran policy formation (strategic initiatives present-future) — about 20-30% of all groups and associations;
2. Those, seeking solutions to existing needs of veterans and oriented onto problem-solving in present time — the biggest group at around 50-60%;
3. Those seeking potential capitalization of their veteran activities (including potential and/or prospective political activity) — up to 20% (less visible now, but potentially active in the future).

Compared to other countries, veteran charities in Ukraine do not specialize so much in the provision of mental health support. In the UK there are NGOs a special focus on PTSD. About 2/3 of all **76** armed forces charities are engaged in this type of activity. None of the Ukrainian veteran charities provide clinical services so far. In assessing the activity of associations and charities time factor and personality issue play an important role. The US, UK, Western Balkans demonstrated a surge in numbers of veteran charities and associations during or immediately after combat periods. In the UK, for instance their number was into thousands in early 2000ies and dropped to 76 in 2019. A strong case can be made that the veteran community in UK is fragmented these days; most of the charities that were established during the Iraq and Afghanistan campaigns have folded by now. The main reasons for this are reduced interest to the topic of veterans in society, poor management or even misuse of funds and the weakened inflow of donations. Many veteran groups are community led however, again being very limited and ineffective.

The same situation is observed in the Western Balkans countries. After 12 years from the war a veteran movement in BiH was very strong and centralized,¹⁰⁶ but this was attributed to the strong personality of Mr Pantelija Ćurguz, the head the Veterans' Organization of Republika Srpska,¹⁰⁷ who managed to develop productive relations with the Ministry of Veterans for the benefit of veteran needs. Now this fashion for veterans has almost gone and different fragmented veteran associations and unions are getting engaged in political activity in order to gain some reputational capital and visibility.

CASE BOX: SOCIETAL ASPECTS — ISRAEL

There is no Hebrew word for veteran — there is no such social category or segment population.

The main shift that occurred in last 20-30 years in Israel is the awareness of the fact that some citizens that took part in their active duty, reserve or civilian capacity might develop PTSD, normalization and de-stigmatization of this fact and willingness to reach-out to mental health professional.

The discussion of PTSD in Israeli society has become open. The government and society itself are actively discussing the issue of PTSD, and no one hides its presence. This has led to a change in the perception of veterans with PTSD, who might have been feared at first, but now the image is perceived mostly positively. This result was achieved through mainly by NGOs, volunteers and veterans coping with PTSD. Significant role in this shift was also played by movies, theatre and literature scenes by exposing the general population with what many veterans are coping years after returning to civilian life.

This approach helped with the socialization of veterans, as their socialization is an important aspect of veterans' rehabilitation. Changing the perception of the image of veterans with PTSD

¹⁰⁶ During the war conflicts in Bosnia and Herzegovina, three armies fought: the Army of the Republic of Bosnia and Herzegovina, the Croatian Defense Council and the Army of the Republic of Srpska, from which three "main" organizations of veterans emerged after the war. About 1,600 associations stemming from the last war were registered in Bosnia and Herzegovina in 2018, and many of them are on the payroll of municipalities, cities, cantons and entities.

¹⁰⁷ The Veterans' Organization of Republika Srpska is the largest non-governmental organization in the Republika Srpska and one of the largest in Bosnia and Herzegovina. In recognition of its influence and efficiency in defending veterans' rights, the Government of Republika Srpska determined in October 2007 its status as an organization of special interest to the entity. The activities they have undertaken since 2007 and the following few years to improve the mental health of their members (research on the state of mental health with an emphasis on PTSD and associated disorders 12 years after the war, good cooperation with the ministries in the Government of the Republic of Srpska, providing support through the opening of veterans' clubs, the hiring of psychologists and social workers for support in the veteran clubs, the establishment of international cooperation and the exchange of experiences with veterans from other countries (especially Denmark) and other international organizations, and numerous other activities, which was attributed to the vision and abilities of the organization's leadership at the time.

helped veterans find jobs, changed the attitude of ordinary people towards them, and helped them to resume their lives in society.

With psychologists and psychiatrists, the situation was similar: quite a few people and the military treated them with caution and open distrust, although this has changed thanks to the state system of rehabilitation of the military. Now

the military treat them with trust and turn to them whenever they need to.

A separate social aspect is veteran communities. In Israel, veteran communities are very active and large. Through these communities, veterans help each other with work, and inform each other about various news and needs that may arise. For example, they run marathons, sing, create dog shelters, etc.

XI. MOST COMMON WEAK SPOTS FROM INTERNATIONAL EXPERIENCE

► Individual biases: not to overdramatize, but to manage; not a weakness, but normal reaction in abnormal circumstances

“Physical wounds make you a strong man; mental wounds make you miserably weak”.

Deliberate avoidance of seeking treatment for clear mental health issues is a cross cultural factor. Despite the difference in the cultural mindset of role of a psychologist in someone’s life, which is more organic for Western cultures and less fashionable in Ukraine, veterans and active servicemen across continents equally tend to decline this perspective for almost the same reasons as:

- they do not want to be the “weak” one who self identifies as having mental health issues;
- they do not want their career to be permanently impacted because they sought help;
- fear that a certain diagnosis can make them non-deployable, forced to change military occupations, or even see them removed/retired from service.

In Ukraine this also explained by:

- mythological mindset (only the mentally ill/weak would seek help, someone may find out, stereotypes, distortions, defense mechanisms, etc);
- low level of education, knowledge and understanding of potential consequences;
- low self-care culture in terms of general attitude to health;
- neglect of blast-injury consequences;
- prejudice against psychiatrists/psychotherapists/psychologists;
- negative previous experience (one’s own/others’);
- fear.

*Life After Conflict: Survey On The Sociodemographic And Socioeconomic Characteristics Of Veterans Of The Conflict In Eastern Ukraine And Their Families survey*¹⁰⁸ on veterans found that:

- 46% do not want to receive any type of psychosocial support for themselves
- over 50% confident that the veterans generally need psychological support;
- 56% stating that the veterans might neglect psychological support for simply being unaware that he or she needs help (53%); unwillingness to show their problems (54%); reluctance to recall the experience related to the armed conflict.

Whilst accepting a necessity for a psychological assistance most would rather go for individual consultations with a psychologist (39%), preferably one who has experience of military service, for example as a military chaplain (16%).

In Focus Groups’ Discussions (FGDs) veterans also pointed out (1) the complexity of returning to civilian life; (2) changes in their attitudes towards life and the people around them; (3) feelings of a lack of future prospects; (4) developed strong sense of justice. 26% admitted alcohol abuse as the main way to manage stress instead of psychosocial aid.

As it is seen from the information above all of these concerns could be addressed by proper public campaigns that reframe negative stereotypes of mental assistance as ‘illness’ into more positive ‘mental hygiene’. People need to get used to considering constant psychological checking after receiving complex war traumas as something routine, but necessary for wellbeing.

► Public biases/Combatting public biases

In Ukraine, Western Balkans and Israel it is much easier to deal with public stereotypes of war veterans, which are in most cases considered as glorious defenders of their motherlands. The situation is more difficult for countries like the US and UK, where

¹⁰⁸ which interviewed 1,780 veterans who had been directly involved in the execution of military operations in the east of Ukraine (Donetsk/Luhansk oblasts) since April 2014 and 750 family members of veterans (wives,

glorification of veterans has been built around more abstract understanding of duty to defend their countries in distant territories. For example, Lord Ashcroft report **Perceptions Of Service Leavers And Veterans** (2017) on the public's perception of veterans in UK found that:

- 82% believed that mental health problems were one of the three most common problems faced by people leaving the Armed Forces; and
- 78% believed that mental health problems were either somewhat or much more likely to happen to someone who has been in the Armed Forces compared to people in general.

These public biases strikingly contrast with only around 10% of ex-servicemen, who might develop PTSD symptoms after the service. But the report just confirmed the popular view of veterans as 'bad, mad and sad' and dangerous members of society.

Unlike this view, **survey** conducted by the Sociological Group "Rating" on the initiative of the "Ukrainian Veteran Fund" of the Ministry of Veterans Affairs of Ukraine in January 2023 delivers a much brighter image of Ukrainian ex-servicemen in the eyes of ordinary Ukrainians:

- level of trust in the military peaks at its high with: 95% trust the military of the Armed Forces of Ukraine, 93% — veterans of the current war, and 95% — veterans of the anti-terrorist operation (ATO) in 2014–2021;
- 91% believes that society respects veterans;
- 97% those who run their own business, or would like to have one, are ready to hire a veteran of the Russian-Ukrainian war;
- 93% are ready to work in the same team with such a veteran;
- 93% support the idea of granting benefits to businesses founded by veterans of the Russian-Ukrainian war;
- 75% are confident that veterans of the Russian-Ukrainian war will not abuse benefits;
- Over 50% confident that conflicts in the family, lack of job, and abuse of alcohol or drugs will likely to be key problems that veterans of the Russian-Ukrainian war are likely to face after returning home;¹⁰⁹

- 2/3 are convinced that suicide and breaking the law will not be signature markers in veterans' behaviour after the war;
- 40% identified psychological disorders to be among the main problems that veterans face most often 23% to 29% consider the main problems to be difficulties with registration of benefits, job search, receiving healthcare, misunderstanding of society;
- At the same time 2/3 indicated that they were completely or somewhat uninformed about the problems of veterans;
- 47% stay rather positive towards the fact that various political forces can invite veterans to run in the elections.

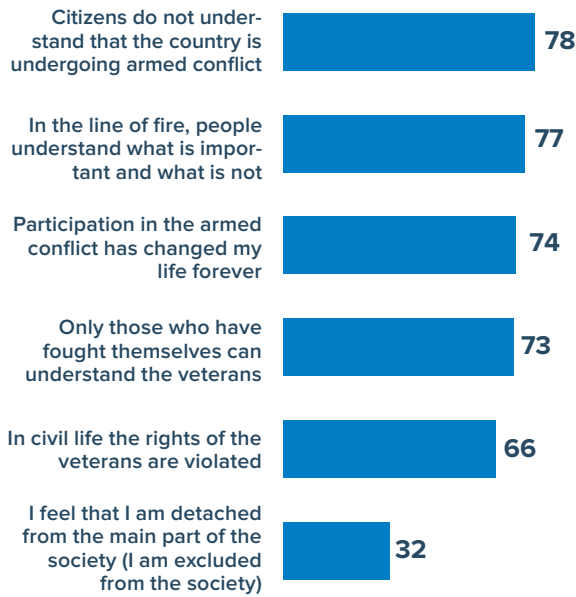
These optimistic figures have to be assessed, however, alongside with **Life After Conflict: Survey On The Sociodemographic And Socioeconomic Characteristics Of Veterans Of The Conflict In Eastern Ukraine And Their Families**, which studied veterans' experience in a society in 2019-2020:

- 49% experience any bias or unfair treatment (discrimination) directed at veterans in the last six months in different spheres (mostly, in public transport, medical services, while applying for benefits or social care);
- 78% agreed that citizens do not understand that the country is going through an armed conflict
- 77% agreed that "in the line of fire, people understand what is important and what is not";
- 74% confirmed that participation in the armed conflict has changed the life forever;
- 73% confident that only those who have fought themselves can understand the veterans;
- 66% said that the rights of the veterans are violated in civil life;
- 32% admitted they feel being detached from the main part of the society (excluded from society).

The survey showed that veterans still tended to divide their surroundings into "us" and "them", as well as to divide their life into "before" and "after" military service; they felt uneasy and out of place and emphasized the feeling that people around them tried to disconnect from them, avoided noticing veterans or even disrespected them as the latter remind of the reality of the armed conflict in the country.

¹⁰⁹ Relatives of ATO veterans who fought and are fighting now feel the presence of conflict in the family, or abuse of alcohol or drugs, more acutely.

Assessment on military experience impact and reintegration, % of the veterans who agreed with the statements



Source: Life After Conflict: Survey on the Sociodemographic and Socioeconomic Characteristics of Veterans of the Conflict in Eastern Ukraine and Their Families, January 2020, commissioned by the International Organization for Migration (IOM), Mission in Ukraine, in cooperation with the Ministry of Veterans Affairs, Temporarily Occupied Territories and Internally Displaced Persons, funded by the European Union (EU)

The said means that with a length of time the society might be showing more visible signs of indifference to veterans’ deeds and needs, thus, creating more risks of social tension and polarization. Even now quite a few veterans say that they notice a changing mood in the Ukrainian society towards people in uniform from what it used to be in the early months of the war. This risk is aggravated by the fact that unlike Israel in twenty-one months of the war Ukraine still has not developed a sense of

total defence, where each citizen considers himself as a defender of the country on its own front. Owing to the size of the country’s territory, war is not so much in the air in Western regions (except for air raids periods): people enjoy their normal life apart from those, whose loved ones are on the frontline. Because the nation still has not developed a state of active war in every Ukrainian soul, developing proper attitudes to and appreciation for servicemen and the veterans’ cohort becomes a visible challenge.

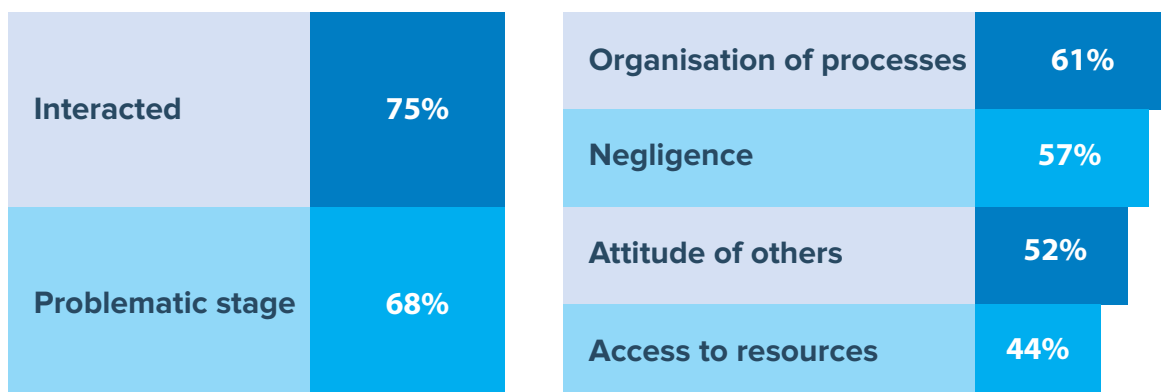
► Indifferent bureaucracy (de-commissioning humiliation, long queues vspecialists in local areas, unqualified psychotherapy counselling)

At least one of these factors was named as being relevant to experience of sample countries in the research with Israel being the least troublesome (de-commissioning humiliation) and UK gaining top score for with long queues (sometimes waiting list is up to 18 weeks), slow bureaucracy and lost papers, shortage of qualified staff, answer-machines on hot-lines etc.

The Ukrainian government is currently trying to streamline the process by creating an electronic database of veterans, personal web-cabinets, and digitalization of most services for veterans to reduce bureaucracy. Yet, some of the problems still exist, with the most acute being the transition of a military personnel to civil clinics (there is no coherent integrated system of sharing documents with a clinical history of a patient among medical institutions involved in the process of treatment).

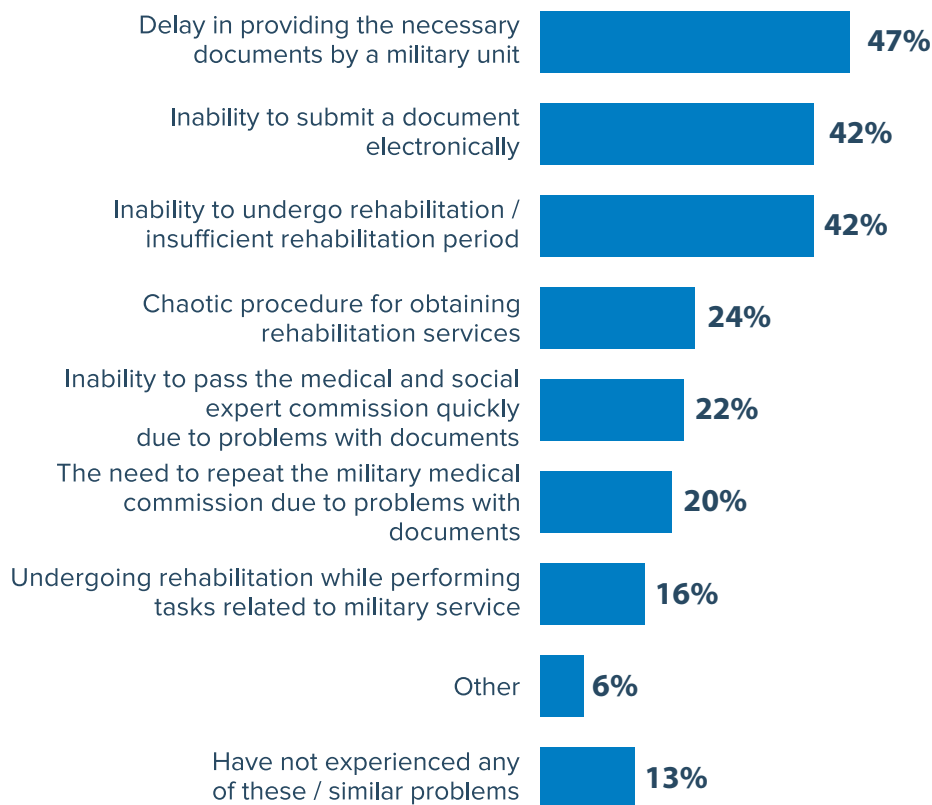
Extracts from **Gradus Survey “Path of a Wounded: Needs, Problems and Vision of Future”** below, conducted among wounded combatants in July 2023, are quite illustrative in this regard:

Passing the military medical commission

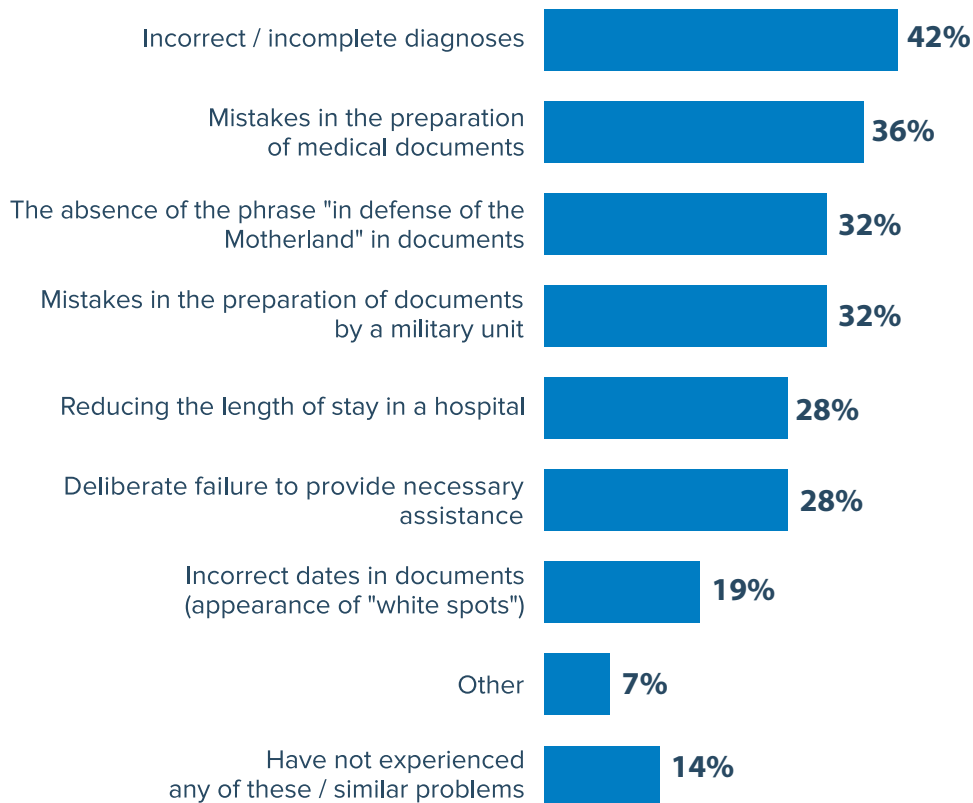


Source: Gradus Research report “The path of the wounded: needs, problems and vision of the future” <https://gradus.app/en/>

Organisational problems



Problems due to negligence



► Social costs — suicides, homelessness, criminal records

Despite positive expectations of Ukrainian society that suicides and law abuse won't be a signature problem for Ukrainian veterans, statistics of other countries and previous experience from the war in Ukraine of 2014–2015 shows that Ukrainian government still needs to consider the risks seriously and to elaborate a number of prevention initiatives to mitigate the risk. On the positive side is the fact that culturally Ukraine is not a country with excessive rates of depression. On the other hand, figures of suicides committed by veterans and servicemen are very difficult to count, especially these days when all the information about the losses is classified.

During the Iraq and Afghanistan conflicts a high number of veterans in UK entered the criminal justice system. Even with smaller number of cases of Ukrainian ex-servicemen getting to jail for criminal offenses, the practice of other countries, especially the US and UK show that kind of crimes committed by ex-servicemen are often the most serious kind: murders, rape and various other abuses.¹¹⁰ This phenomenon could be very well explained by psychologists and psychiatrists, but it is important to know this peculiarity and to consider a number of preventive measures for mitigating the risks of increased criminality with the gravest consequences for human security. That said however, it is important to be conscious of the need to avoid stigmatization of veterans in this respect.

According to then Chairwoman of Parliamentary Committee for Healthcare Ms Olha Bohomoletz, from 2014 to 2017 over 100 ATO veterans committed suicide with most of them being under 30. Most popular method was the use of firearms in a state of alcoholic intoxication. Against the background of US statistics, which reports about 16 to 22 cases daily pending on year, these figures in Ukraine look rather optimistic, especially with the view that on general number of suicides per population Ukraine **exceeds** US. So does the UK with **82** in 2020. By contrast in Israel, the number of suicides among (ex)servicemen is very low, which can be explained by the fact that: (1) military is very closely integrated into society; (2) rehabilitation is conducted in the community and not in “veterans resort”; (3) expectation to return to normal functioning is realistic and time defined; (4) early diagnostics as soldiers meet many care-providers

both on various stages of service (in the military) and on return to civilian life, who are trained to identify suicide markers and tendencies at very early stages.

CASE BOX US VETERAN SUICIDE STATISTICS

In September 2022, the VA published their annual National Veteran Suicide Prevention Report summarizing veteran suicide data from 2001 through 2020.[xviii] This report, along with the National Strategy for Preventing Veteran Suicide 2018-2028, serve as the key publications in tracking trends in veteran suicidality.[xix] This represents the U.S “whole government” approach that leverages agency resources, public-private partnerships, and local communities to implement a full public-health approach unified in collective engagement for Veteran suicide prevention.[xx]

The VA reports that there were 6,001 veteran suicides in the U.S. recorded in 2001.[xxi] Over the next 19 years, the number of veteran suicides averaged approximately 6,205 deaths per year (roughly 17 veterans per day) with a peak of 6,796 in 2018.[xxii] The final two recorded years in the Annual Report, 2019 and 2020, showed a steady decline of 9.7% from the 2018 peak with 6,479 and 6,146 suicides respectively.[xxiii]

Despite this decline the 2020, the statistics show that suicide is still a disproportionately deadly trend in the U.S. veteran population compared to non-veterans. For example, the VA reports that the suicide rate for non-veteran U.S. adults was 16.1 per 100,000 in 2020.[xxiv] Comparatively, the rate among the veteran population (not adjusted for age or sex) in that same year was 31.7 per 100,000.[xxv] Though this number has fluctuated considerably over the 20 recorded years, the current trend shows veterans are essentially committing suicide at double the rate of the average U.S. adult.[xxvi]

These statistics can be further broken down by age, race, and sex to identify further trends in veteran subgroups. When looking at age, the highest proportion of suicides in 2020 were committed by veterans between the ages 18 to 34 with an unadjusted rate of 46.1 per 100,000.[xxvii] The remaining age groups break down as follows: the next highest group were veterans aged 75 or older at 32 per 100,000;

¹¹⁰ A review of veterans in the criminal justice system in the UK Phillips (2014) found high rates of veterans incarcerated during and following the Iraq and Afghanistan conflict, with veterans being reported the highest sub-cohort professional group in UK prisons making up between 13 — 17% of the prison population: classed as high-risk offenders Category A and B recorded (Phillips 2014).

then the 35-54 group at 31.8 per 100,000; and the 55-74 group at 27.4 per 100,000.[xxviii] Each of these age groups clearly exceed the non-veteran average, but while all other age categories decreased from 2019 to 2020 the 18-34 group continues increase.[xxix] A similar disproportionality exists when adjusting for sex. The 2020 suicide rate for male veterans was 33.7 per 100,000 whereas the same rate for female veterans was 13.8 per 100,000 not adjusted for age.[xxx] This data clearly demonstrates that younger and generally male veterans are most at risk.

There is less of a contrast when adjusting for race. The VA reports that in 2020, the suicide rate for White Veterans was 34.2 per 100,000; 30.2 per 100,000 among Asian, Native Hawaiian or Pacific Islander Veterans; 29.8 per 100,000 among American Indians or Alaska Native Veterans; and 14.2 per 100,000 among Black or African American Veterans.[xxxi] Though there is a considerable gap between the white and black veteran populations, the data generally shows a closer rate distribution across race when compared to age and sex.

Suicide is currently the 13th leading cause of death for the total U.S. veteran population and is far behind heart disease and cancer which lead the age adjusted mortality rate.[xxxii] Although this data clearly points to other significant problems in veteran care it does not represent what is happening with the youngest generation of veterans. For the 18-34 veteran age group of both sexes, suicide is the second leading cause of death.[xxxiii] For males specifically this also true for the 35-44 age group behind only accidents as the leading killer of U.S. male veterans.[xxxiv]

The weight of the data in totality shows that across age, race, and sex suicide is an enormous issue in the veteran population. What is perhaps most notable about the information is the disproportionate impact of suicide on the younger, male veterans who represent the most recent GWOT veteran cohort. The relatively young age of this cohort coupled with the higher reported rates of PTSD suggest that this will continue to be a long-standing issue in the U.S. veteran community.

XII. CREATING AN INTEGRAL ECO-SYSTEM IN UKRAINE FOR VETERANS' CARE AND PTSD TREATMENT: POLICY RECOMMENDATIONS FOR THE UKRAINIAN GOVERNMENT

Advanced research and evidence-based practice of treatment and rehabilitation

1. To develop international partnerships with the research institutions and teams worldwide, who are developing advanced methods of PTSD diagnosis to include neurophysiological assessment based on lab testing for neuroendocrine and inflammatory biomarkers (foremost, the USA and some UK researchers).
2. To enter into cross-collaboration with international partners to develop an international data repository to better understand the epidemiological link between PTSD and autoimmune diseases.
3. To re-educate clinicians to recognize poor physical health outcomes as part of a diagnosis of PTSD and pollinate across multidisciplinary specialists to create new polytrauma pathways of care linked to the work of international scientists and clinicians in the field, who are at the forefront of research and treatment.
4. To develop a culture of applying a wider eclectic treatment regime to slow down PTSD disease progression and provide optimum recovery.
5. To go beyond mainstream traditional research on PTSD and with like-minded partners internationally to co-construct a new paradigm aligned with evolving science.
6. To develop a comprehensive strategy addressing both physical, mental and social well-being to respond to the needs of those traumatised by war.
7. To apply a polytrauma approach to CPTSD for more accurate assessment, diagnosis and treatment with a cross-reference on a triage of related injuries, including ongoing monitoring constellation of health-related immune diseases linked to the disorder.
8. To develop partnership networks (similar to the one established between VA DOD (USA) and IDF (Israel) in 2021) on experience exchange with the respective research entities within the framework of military and veteran affairs institutions in Ukraine, the US, the UK, Israel and WB to share best practices in polytrauma assessment, treatment and recovery for veterans who are diagnosed with PTSD/CPTSD and traumatic brain injury, and to share expertise in areas such as post-deployment rehabilitation and reintegration, career transition and vocational rehabilitation, veteran and family readjustment counselling, and the use of telehealth technology.
9. To conduct comparative evidence-based studies on different forms of non-medical treatment as indicated in Chapter VI of this report.
10. To study more extensive use of psycho-correction mechanisms and tools in PTSD treatment to enrich evidence-based practice.

Diagnoses and Treatment

11. To align with ICD-11 standards at the national level and to adjust all the necessary regulatory documents (standards, clinical guidance) of the Ministry of Health of Ukraine.
12. To develop special support and rehabilitation programs for CPTSD-affected veterans with an integrative approach to physical, mental and social well-being.
13. To consider the usage of telemedicine and other digital forms of distance counselling in to least accessible regions of Ukraine.
14. To include psychologists' counselling at all stages of rehabilitation and habilitation.
15. To consider an introduction of a 'balancing house' model as a tool for (C)PTSD-affected veterans' treatment developed by Sheba Tel Hashomer Medical Clinic (Israel).

Infrastructure and institutions

16. To consider an option of moving all veteran-related affairs (research and medical treatment of WTMD included) under the responsibility of the MVAU, which should be working more closely with the Ministry of Defence (like in the US model).
17. To elaborate the number of initiatives with the active involvement of veterans' associations and support institutions to achieve more visible leadership of the MVAU both in driving veteran policies, and establishing communication among the ministries. Given the nature of competence, it would be advisable to see more authority of the MVAU-MOU link in running veteran affairs.
18. To set clear cut subordination structure of multiple coordination inter-agency networks for WTMD and mental health issues, which have come into existence over the last year: Interagency Coordination Council on Mental Health Care and Psychological Support for Individuals Affected by Russian Aggression against Ukraine, Coordination Center for Mental Health, Support Centers for Civilians Network within the Regional State (Military) Administrations.
19. To elaborate an integral strategy of inclusion of private rehabilitation centers, volunteer organizations and veteran charities into the integral system of WTMD treatment in Ukraine. To consider possible forms of private-public partnerships (also international ones) at the national and regional level to compensate scarcity of resources available from the state budget.
20. To consider the possibility of establishing a national (C)PTSD Center under the MVAU (like in the US) and a national decompression center under MOD (like the Deployment Transition Center at Ramstein Air Base).
21. To examine the possibility of establishing five role-model WTMD treatment and rehabilitation centers, that could each be specified in rehabilitation methods and practices used in the US, UK, Israel, Croatia, and Ukraine (experimental methodic) with a view of potential further scaling up the model, which will demonstrate to be most efficient for rehabilitation of Ukrainian veterans.
22. To introduce compulsory psychiatric pro-paedeutics for all psychologist courses in non-medical high schools, military and educational psychologists.
23. To ensure compulsory certification and licensing of all professionals, operating in psychiatry, psychology and psychotherapy fields. To this end to ensure swift adoption of all necessary legislation as discussed in the Chapter IX of this report.
24. To elaborate a number of initiatives to stimulate the education of a higher number of psychiatrists, psychologists and psychotherapists in Ukraine with training programs internationally. To this end to foresee respective budget allocation for professional education in the next 5-10 years alongside with investments into respective educational infrastructure and facilities (also, might be in the form of international public-private partnerships).
25. To consider special educational professional training and benefits programs for veterans, who are willing to become psychiatrists, psychologists and psychotherapists.
26. To consider a gradual increase in budget spending on WTMD treatment, psychological and general mental care of veterans (as a mid-term strategy after the war is over).
27. To consider extending accessibility for services in WTMD and general mental care on a regional level, which has to be supported with necessary finance, human and infrastructure resources (for this purpose to use different international donor programs).
28. To consider possibilities of using more financial instruments of the EU and NATO, as well as on a bilateral basis to work in the area of WTMD treatment and mental health assistance to veterans and other trauma-affected society groups (as enlisted in Chapter I of the report). For example, The European Peace Facility instruments of assistance measures, as well as NATO Science for Peace and Security/ Human and Social Aspects of Security should be explored in this regard.

Family, community and wider social environment

29. To develop and introduce at national and regional level training programs for family members of combatants to be able to cope with the new reality and changed nature of persons coming from the front and to prepare them to handle situations maturely. Such measures would be important to help veterans' family members understand the mindset of a person who was engaged in combat operations and build comfortable relations with him/her.

30. To create a widespread network of non-stigmatized psychosocial support on the ground, at the community level.
31. To introduce psycho-education and training not only for mental health professionals, but also for teachers and employment clerks, nurses and volunteers, policemen and parents, social workers and postmen — everyone whose job involves interaction with persons and families (based on Israel's model).
32. To develop clear policies and strategies that will take into account the organization of community services for WTMD treatment and rehabilitation, anti-stigma programs, promotion of mental health, and education of mental health professionals.
33. To develop policies of engagement of other than mental health sectors into protection and promotion of mental hygiene. Experts in schools (psychologists, which every school should have), and experts in social work (at municipalities' level) can significantly contribute to the detection of problems; they can also act preventively and sometimes therapeutically by organizing activities that contribute to mental hygiene, such as sports competitions, socializing, cultural events.
34. To develop training and re-qualification programs for veterans with a special focus on professions like paramedics, rescuers, deminers, emergency services and other adrenaline-high professions, as well as military psychologists, psychotherapists and para-sportsmen.
35. To encourage further development of veteran entrepreneurship.
38. To ensure that a coherent eco-system of veteran treatment is a distinctive one, but is firmly incorporated into wider programs of psychological wellbeing of the nation.
39. To introduce full-cycle psychological support to servicemen and their families at pre-, during and post-deployment stages.
40. To develop decompression programs for servicemen and servicewomen in a systemic way across all types of armed forces and other combatting structures.
41. To conduct a detailed study on resource capacity to maintain the system of WTMD treatment and rehabilitation with mandatory mapping of the situation on the ground to provide a clear picture of all the available resources and potential for the establishment of a quality and accessible mental health system of integrative nature.
42. To conduct a study on specific support needs of female veterans.

Resilience-building and trauma-coping measures

43. To develop a network of resilience centers, at least, in every regional center of Ukraine and more centers in every region that is close to a frontline and has been under temporary occupation of russian forces (based on the model and concept suggested by the Israel Trauma Coalition (ITC)). To this end to scale up the existing pilot centers that have been opened in Ukraine by ITC in Kyiv, Kharkiv, Khmelnytskyi, Ternopil, and Odesa.

Long-term strategic planning

36. To envisage on a governmental policy level a comprehensive nationwide communication strategy to get a positive framing of (C)PTSD and to encourage the society as a whole to take care of veterans as an intrinsic part of national culture.
37. To elaborate nationwide advocacy and literacy campaigns to set a positive frame for (C)PTSD as a temporary mental disbalance that can be effectively treated, especially with timely diagnosis. Society should be informed about its nature and consequences and become mature and responsible enough to face this phenomenon as one of the wounds of the war that needs to be healed.

ANNEX I

HISTORY OF PTSD

Although Post Traumatic Stress Disorder (PTSD) was first codified by the American Psychological Association in its 1980 Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III), accounts of adverse reactions to warfighting can be found throughout history. In Ancient Greece, Homer (8th century BC) offers accounts of psychological distress and trauma in the epic poems Iliad and the Odyssey. Greek historian, Heroditus (484-425 BC) recounts the story of Epizelos, an Athenian soldier fighting in the Battle of Marathon (490 BC), who lost his eyesight without receiving “a blow in any part of his body nor having been hit with a missile.” Following these early authors, the Western literary canon includes numerous works detailing traumatic experiences and their effects, including William Shakespeare’s Henry IV and Charles Dickens’ A Tale of Two Cities.

Attempts to codify and treat military trauma first emerged in the 18th century with the modernization of medical theory and practice. Early diagnoses tended to be medical responses to specific events and conflicts rather than being omnibus diagnoses like PTSD that account for multiple causes and effects of trauma. As a result, prior to PTSD, advances in researching and treating psychological trauma ebbed at the end of conflicts, preventing medicine from creating a coherent body of research until the 20th century.

The United State’s National Center for PTSD, traces the history of the contemporary PTSD diagnosis back to the 1761, when Austrian physician Josef Leopold Auenbrugger described a emotional condition called “nostalgia” that affected young men conscripted into military service who lose hope of returning home from war.[ixi] Symptoms of Nostalgia were sadness, loss of the will to live, sleep disturbances, and anxiety. Nostalgia remained an influential model of psychological injury into the 19th century.[ixii]

During the US Civil War (1861-1865), American physician Jacob Mendez Da Costa posited that Nostalgia was rooted in an underlying cardiac condition called neurocirculatory asthenia. [ixiii] He contended that overstimulation of a soldier’s heart and circulatory system from carrying heavy loads and warfighting precipitated psychosomatic

symptoms similar to our contemporary diagnosis “panic disorder”, such as rapid pulse, anxiety, and trouble breathing.[ixiv] Neurocirculatory asthenia was known by several names, including “Da Costa’s syndrome”, “effort syndrome”, “soldier’s heart”, and “irritable heart”. Symptoms of neurocirculatory asthenia were often treated with medicines and soldiers returned to the battlefield.

Da Costa’s theory that physical injury could lead to PTSD-like symptoms was supported by the civilian diagnosis of “railway spine” or “concussion of the spine” as described by British surgeon John Eric Erichsen in 1866. With the advent of passenger train travel in England in the 1830s, rail transportation accidents produced greater numbers of victims. Frequently, survivors of railway accidents were often unscathed but would develop psychological symptoms similar to PTSD in the following days. Erichsen offered the first and most well-known theory of railway spine, positing that the psychological disturbances were the result of physical damage to the spinal cord and nervous system during the accident. [ixv] Railway spine was broadly considered to be a medico-legal diagnosis that helped injured train passengers win compensation lawsuits from railway companies in British courts.[ixvi] Despite claims that accident survivors simulated symptoms of railway spine for financial gain (detractors called the condition “compensation neurosis”), Erichsen’s and Da Costa’s theories that psychopathology could result from physical injury would prove to be influential to psychiatrists during World War I.

Shell shock is the most well-known combat trauma diagnosis, and although the British War Office prohibited the use of the term in 1922, it remains in colloquial usage today.[ixvii] The term shell shock was coined by British soldiers to describe the syndrome some soldiers manifested after being bombarded by artillery shells during trench warfare. However, not all shell shock patients directly experienced artillery barrages. Symptoms of shell shock included tremors, tics, fatigue, and memory loss, as well as symptoms similar to PTSD such as sleep disturbances, and nightmares.[ixviii] Dueling medical theories of shell-shock emerged among British psychiatrists, with some claiming physical concussion and poison gas caused shell shock and others contending that it was a purely psychological condition. There was also a delayed-onset variant of shell

shock called “old-sergeant syndrome” which manifested after prolonged combat.[^{ix}] The magnitude of WWI and numerous memoirs, novels, and poems written by British soldiers fostered public sympathy for traumatized soldiers.[^x]

During the WWI-era, the US government agencies partnered with the American Medico-Psychological Association (now the American Psychological Association) to standardize medical nomenclature and codify psychiatric conditions. The *Statistical Manual for the Use of Institutions for the Insane* debuted in 1918. The effort to manualize psychiatric disturbances occurring among US soldiers in WWII was led by William Menninger, head of psychiatry at the Office of the Surgeon General. Technical Medical Bulletin number 203 of the US Army (Medical 203) offered a distinctly psychoanalytic approach to mental illness. Medical 203 categorized psychiatric illnesses as reactions and operated under the premise that mental disturbances could arise in any soldier who is exposed to combat for a significant duration. The Army’s nosology provided the basis for the first edition of the American Psychological Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1952.[^{xi}]

During World War II, the medical understanding of psychological effects on soldiers evolved. The term “shell shock” was replaced by “Combat Stress Reaction” (CSR), also known as “battle fatigue.” The prolonged and intense combat engagements of World War II left many soldiers feeling battle-worn and drained. Interestingly, some American military leaders, like Lieutenant Gen. George S. Patton, doubted the legitimacy of “battle fatigue”.[^{xii}]

Remarkably, up to half of all military discharges during World War II were attributed to combat exhaustion. The treatment of CSR revolved around the “PIE” (Proximity, Immediacy, Expectancy) approach. This method emphasized the prompt care of casualties and instilling in sufferers the anticipation of complete recovery, enabling their eventual return to combat after a period of rest. Military psychiatrists also promoted strong military unit bonds as support systems for both preventing stress and aiding in recovery.[^{xiii}]

The contemporary PTSD diagnosis is the result of two important events. The first is that the APA removed “gross stress reaction”, its main post-trauma diagnosis from the second edition of the DSM in 1968. It was replaced with “adjustment reaction to adult life”, which did not encompass the traumatic experiences of US soldiers fighting in the Vietnam War. Secondly, in 1970, a group of anti-Vietnam War psychiatrists collaborated with the activist group Vietnam Veterans Against the War to codify

an informal post-traumatic diagnosis for military veterans called “Post-Vietnam Syndrome”. The group argued that veterans suffered from grief associated with perpetrating atrocities in combat and being abandoned by their country when they returned from war. After lobbying the US Congress and campaigning for the diagnosis at the grassroots level, Robert Jay Lifton, one of the anti-war psychiatrists, was appointed to an APA committee to develop a new edition of the DSM. He joined other psychiatrists who studied survivors of the Holocaust and sexual violence, among other groups. Together, they formulated an omnibus diagnosis called “Post Traumatic Stress Disorder” that described the symptoms people experienced after surviving events outside the scope of everyday life.[^{xiv}]

ANNEX II

MOBILE APPLICATIONS FOR SELF-ASSESSMENT OF PSYCHO-EMOTIONAL STATE AND SELF-HELP, DEVELOPED IN UKRAINE SINCE FEBRUARY 2022

“PTSD Coach”. For prevention and resolution of symptoms of post-traumatic stress disorder (PTSD) as of an extreme manifestation of psychological trauma. The use of this application helps to reduce distress and suppress PTSD symptoms, understand the nature of these symptoms, and helps the user get his/her relationships with loved ones back on track.

“Beat PTSD”, “Bust PTSD”, “Breathe2Relax”, “Tactical Breather” applications are aimed at improving resilience skills through meditation and concentration on breathing.

“PFA Mobile Ukraine” application contains detailed recommendations on how victims can provide first psychological aid both to themselves, after being exposed to psychic trauma, and to those around them — peers, professionals, and loved ones. After installing the app, the following options are visible: Info on psychological first aid (PFA); Typical reactions to stress; Self-preservation; Key stages of PFA; Referral of victims; Resources.

“Baza” mobile application is designed to help veterans, relatives or friends of the military and civilians to stabilize their psychological state. You can also get information on the main types of psychological self-help and ask questions to specialists.

“Calm”. This app helps reduce anxiety and improve sleep. It will help regulate meditation, sleep, breathing, and teach your brain to relax. The duration of meditation can be preset depending on the user’s busyness — from 3 to 25 minutes. The Calm app can be used to work on anxiety, stress management, focus and concentration, gratitude, self-esteem, etc. It also has an option of result tracking.

“Svitlo” is a mobile application designed to help the user develop psychological self-care habits.

“Spokiy” is an app that helps to calm down. The ability to regain self-control is a very useful habit. Today we have many reasons for growing anxious. We need to learn how to handle our feelings of anxiety and panic. This is what this Ukrainian app will help you with.

“BetterMe: Mental Health” application for sustainable emotional well-being and coping with stress will help the user attend to his/her mental health in a comprehensive manner.

“Mobile Psychological Aid” service is available at <http://psyservice.org/>. Essentially, this version is not a mobile application, yet it can be easily opened in a browser of any mobile device. The program allows the user to assess their own condition in such categories as sleep quality, depression and PTSD, and contains text content and memos on PTSD symptoms sorted out in a menu; assistance to family members having combat-related mental trauma; anger and anxiety management; depression control; alcohol and drug addiction; stress; relationships with loved ones; psychological resilience.

Communication campaign within the All-Ukrainian Mental Health Program **“How are you?”** launched by First Lady Olena Zelenska. As part of the campaign, a special page has been created on howareu.com, which contains self-help techniques for dealing with stress, contacts of psychological support hotlines, and useful tips for taking care of mental health.

ENDNOTES

- [i] https://www.va.gov/vetdata/veteran_population.asp; https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/VetPop2020_A_Brief_Description.pdf
- [ii] PTSD added to the DSM-III in 1980, https://www.ptsd.va.gov/understand/what/history_ptsd.asp#:~:text=Battle%20Fatigue%20or%20Combat%20Stress,became%20battle%20weary%20and%20exhausted.
- [iii] Id. at https://www.va.gov/vetdata/veteran_population.asp
- [iv] https://www.ptsd.va.gov/understand/common/common_veterans.asp
- [v] Id.
- [vi] Id.
- [vii] Id.
- [viii] https://www.va.gov/vetdata/veteran_population.asp; National Center for Veterans Analysis and Statistics. Value cited is the 2022 projection from the Period Served excel sheet.
- [ix] Supra note 4.
- [x] Supra note 8; National Center for Veterans Analysis and Statistics. Value cited is the 2022 projection from the Period Served excel sheet.
- [xi] Supra note 4.
- [xii] Id.
- [xiii] Supra note 8; National Center for Veterans Analysis and Statistics. Value cited is the 2022 projection from the Period Served excel sheet Pre-9/11 only table.
- [xiv] Supra note 4.
- [xv] Id.; Supra note 8.
- [xvi] Supra note 8.
- [xvii] <https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf>
- [xviii] [xviii] <https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf>
- [xix] [xix] https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf
- [xx] [xx] Supra note 17 at 4.
- [xxi] [xxi] Id. at 8.
- [xxii] [xxii] Id.
- [xxiii] [xxiii] Id. at 7.
- [xxiv] Id. at 10.
- [xxv] Id.
- [xxvi] Id. (The peak difference came in 2017 where veteran suicide rates were 66.2% greater than non-veterans).
- [xxvii] Id. at 10.
- [xxviii] Id.
- [xxix] Id. at 12.
- [xxx] Id.
- [xxxi] Id. at 13.
- [xxxii] Id. at 20.
- [xxxiii] Id. at 21.

- [xxxiv] Id.
- [xxxv] Full Guideline (2023) p.1, <https://www.healthquality.va.gov/guidelines/MH/ptsd/index.asp>
- [xxxvi] Id.
- [xxxvii] Id.
- [xxxviii] <https://www.ptsd.va.gov/index.asp>
- [xxxix] Supra note 35 at 9-10.
- [xl] Id.
- [xli] Id.
- [xlii] Id.
- [xliii] Id.
- [xliv] Id. at 10-11, These are the first symptoms listed in each Criterion category (Table 2), note that each category has multiple other symptoms that represent a potentially similar but separate manifestation.
- [xlv] Id.
- [xlvi] Id.
- [xlvii] Id. at 24-25.
- [xlviii] Id.
- [xlix] Id.
- [l] https://www.ptsd.va.gov/understand_tx/tx_basics.asp.
- [li] Id.
- [lii] https://www.ptsd.va.gov/understand_tx/cognitive_processing.asp
- [liii] Id.
- [liv] https://www.ptsd.va.gov/understand_tx/prolonged_exposure.asp
- [lv] Id.
- [lvi] https://www.ptsd.va.gov/understand_tx/emdr.asp
- [lvii] Id.
- [lviii] https://www.ptsd.va.gov/understand_tx/meds_for_ptsd.asp
- [lix] Id.
- [lx] https://www.ptsd.va.gov/understand_tx/medications.asp
- [lxi] Matthew Friedman, History of PTSD in Veterans: Civil War to DSM-5, n.d. https://www.ptsd.va.gov/understand/what/history_ptsd.asp.
- [lxii] George Rosen, Percussion and Nostalgia, *Journal of the History of Medicine and Allied Sciences*, Volume XXVII, Issue 4, October 1972, Pages 448–450, <https://doi.org/10.1093/jhmas/XXVII.4.448>
- [lxiii] O. Paul, Da Costa's syndrome or neurocirculatory asthenia. *Br Heart J*. 1987 Oct;58(4):306-15. <https://doi.org/10.1136/hrt.58.4.306>
- [lxiv] See Panic Disorder DSM-5 300.01 (F41. 0) <https://doi.org/10.1176/appi.books.9780890425787>
- [lxv] John Eric Erichsen, *On Railway Spine and Other Injuries of the Nervous System*. (Philadelphia, PA: Henry C. Lea, 1867)
- [lxvi] Leonard Grant, (2017). *Traumatic Formations and Psychiatric Codifications: A Rhetorical History of Post-traumatic Stress Disorder*. [Doctoral Dissertation, Virginia Tech]. https://vtechworks.lib.vt.edu/bitstream/handle/10919/86174/Grant_LF_D_2017.pdf?isAllowed=y&sequence=1
- [lxvii] Report of the War Office Committee of Enquiry into "Shell-Shock" [1922]. (London: Imperial War Museum, 2004)
- [lxviii] Ben Shephard, War, medicine and modernity. *Medical History*. 2000;44(2):287–287.
- [lxix] *ibid.*
- [lxx] Paul Fussel, *The Great War and Modern Memory*. (New York: Oxford University Press, 1975)

- [lxxi] Michael D. Trimble, (1985). Post-traumatic Stress Disorder: History of a concept. In C.R. Figley (Ed.), *Trauma and its wake: The study and treatment of Post-Traumatic Stress Disorder*. New York: Brunner/Mazel. Revised from *Encyclopedia of Psychology*, R. Corsini, Ed. (New York: Wiley, 1984, 1994)
- [lxxii] TR Mareth and AE Brooker, Combat stress reaction: a concept in evolution. *Mil Med*. 1985 Apr;150(4):186-90
- [lxxiii] Edward Jones and Simon Wessely, "Forward Psychiatry" in the Military: Its Origins and Effectiveness. *J Trauma Stress* 16, 411–419 (2003). <https://doi.org/10.1023/A:1024426321072>
- [lxxiv] Leonard Grant, "Post-Vietnam syndrome: psychiatry, anti-war politics, and the reconstitution of the Vietnam veteran." *Rhetoric of Health & Medicine* 3, no. 2 (2020): 189-219. <https://muse.jhu.edu/article/757050>
- [lxxv] How Common Is PTSD? <https://www.ptsd.va.gov/understand/common/index.asp>
- [lxxvi] SC Park and YK, Kim, (2020). Anxiety Disorders in the DSM-5: Changes, Controversies, and Future Directions. In: Kim, YK. (eds) *Anxiety Disorders. Advances in Experimental Medicine and Biology*, vol 1191. Springer, Singapore. https://doi.org/10.1007/978-981-32-9705-0_12
- [lxxvii] *Diagnostic And Statistical Manual Of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* <https://doi.org/10.1176/appi.books.9780890425787>
- [lxxviii] Military Sexual Trauma. US Department of Veterans Affairs. <https://www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/>
- [lxxix] Sonya B. Norman and Shira Maguen, Moral Injury, National Center for PTSD. https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp

SOURCES OF INFORMATION

1. <https://reliefweb.int/report/ukraine/mental-health-ukraine-april-2023>
2. <https://publications.parliament.uk/pa/cm201719/cmselect/cmdfence/1635/1635.pdf>
3. <https://publications.parliament.uk/pa/cm201719/cmselect/cmdfence/813/813.pdf>
4. <http://journal.eu-jr.eu/health/article/view/797/774>
5. <https://www.rsisinternational.org/journals/ijrias/DigitalLibrary/Vol.4&Issue1/07-11.pdf>
6. <https://www.mil.gov.ua/ministry/zmi-pro-nas/2014/10/20/psihologi-dlya-uchasnikiv-ato/>
7. <http://army.unian.ua/998082-psihologi-dlya-uchasnikiv-ato.html>
8. https://api.umj.com.ua/wp/wp-content/uploads/2014/11/104_124-127.pdf
9. <https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf>
10. <https://dx.doi.org/10.1037/e530682014-001>
11. https://www.wilsoncenter.org/sites/default/files/media/documents/publication/kennan_cable_13_what_ukraine_can_learn_from_other_countries_about_ptsd.pdf
12. <https://s31949.pcdn.co/wp-content/uploads/UKVFS-Report-2-v6c.pdf>
13. <https://s31949.pcdn.co/wp-content/uploads/Single-Page-Full-Report.pdf>
14. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1145999/UK_armed_forces_suicides_1984_to_2022.pdf
15. https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf
16. <https://www.ptsd.va.gov/professional/index.asp>
17. <https://www.healthquality.va.gov/guidelines/MH/ptsd/VA-DoD-CPG-PTSD-Full-CPG.pdf>
18. https://www.ptsd.va.gov/understand/common/common_veterans.asp
19. https://www.researchgate.net/publication/314875777_UK_Psychological_Trauma_Society_UKPTS_Guideline_for_the_treatment_and_planning_of_services_for_Complex_Post-Traumatic_Stress_Disorder_in_adults
20. <https://acpuk.org.uk/wp-content/uploads/2022/03/Standards-for-Psychological-Rehabilitation-in-Major-Trauma-CHPN-ACP-Mar-2022.pdf>
21. <https://www.rand.org/news/press/2008/04/17.html#:~:text=Nearly%2020%20percent%20of%20military,a%20new%20RAND%20Corporation%20study>
22. <https://www.wilsoncenter.org/publication/kennan-cable-no13-what-ukraine-can-learn-other-countries-experiences-ptsd>
23. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800086?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=010523
24. https://www.ptsd.va.gov/understand/common/common_veterans.asp#:~:text=At%20some%20point%20in%20their,of%20100%2C%20or%206%25
25. <https://pubmed.ncbi.nlm.nih.gov/31248740/>
26. <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/abs/association-between-posttraumatic-stress-disorder-severity-and-death-by-suicide-in-us-military-veterans-retrospective-cohort-study/2B7ACEA938B808BC53D5AE606E05D484>
27. <https://www.nbcnews.com/us-news>
28. https://bjs.ojp.gov/content/pub/pdf/vpj1112_sum.pdf
29. <https://www.ons.gov.uk/peoplepopulationandcommunity/armedforcescommunity/bulletins/ukarmedforcesveteransenglandandwales/census2021>
30. <https://www.kcl.ac.uk/news/increase-in-probable-ptsd-among-british-military>

31. <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/mental-health-outcomes-at-the-end-of-the-british-involvement-in-the-iraq-and-afghanistan-conflicts-a-cohort-study/E77CCC4B6D0B2A3B6A481C0980D29E93>
32. <https://combatstress.org.uk/new-research-reveals-higher-rate-ptsd-among-veterans>
33. https://books.google.com.ua/books?id=Dc3xDwAAQBAJ&pg=PA269&lpg=PA269&dq=Amon+g+people+who+have+had+a+diagnosis+of+PTSD+at+some+point+in+their+lifetime,+approximately+27%25+have+also+attempted+suicide.&source=bl&ots=4ODX2YgL9g&sig=ACfU3U2BxYoTc9MG-kNbr-eNGUdp1ai&redir_esc=y#v=onepage&q=Among%20people%20who%20have%20had%20a%20diagnosis%20of%20PTSD%20at%20some%20point%20in%20their%20lifetime%2C%20approximately%2027%25%20have%20also%20attempted%20suicide.&f=false
34. <https://www.dailyrecord.co.uk/news/scottish-news/uk-armed-forces-suicide-rate-23891035>
35. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874821/6.6409_CO_Armed-Forces_Veterans-Factsheet_v9_web.pdf
36. <https://www.gov.uk/government/collections/offender-management-statistics-quarterly>
37. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750708/ex-service-personnel-prison-population-2018.pdf
38. <https://www.gov.uk/government/publications/former-members-of-the-armed-forces-and-the-criminal-justice-system>
39. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717033/20180621_Mental_Health_Annual_Report_17-18_O.pdf
40. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694148/20180327-UK_AF_Suicide_National_Statistic_2018_O.pdf
41. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1145999/UK_armed_forces_suicides_1984_to_2022.pdf
42. <https://balkaninsight.com/2018/09/20/inadequate-assistance-of-croatian-veterans-treated-by-ptsd-veteran-association-warned-09-20-2018/>
43. https://www.pilar.hr/wp-content/images/stories/dokumenti/zbornici/21/z_21_103.pdf
44. https://www.psychiatria-danubina.com/UserDocsImages/pdf/In_Press/In_Press_61.pdf
45. <https://www.zagreb.hr/UserDocsImages/arhiva/branitelj/PUBLIKACIJA%20Samoubojstva%20hrvat-skih%20branitelja%20u%20Zagrebu%20i%20Hrvatskoj.pdf>
46. <https://www.vanityfair.com/news/2015/05/ptsd-war-home-sebastian-junger>
47. <https://www.wilsoncenter.org/publication/kennan-cable-no13-what-ukraine-can-learn-other-countries-experiences-ptsd>
48. <https://www.middleeastmonitor.com/20230501-soaring-suicide-cases-among-israel-forces-warns-army-chief/>
49. <https://www.ibtimes.com/suicide-rates-more-doubled-among-soldiers-serving-israel-defense-forces-1772338>
50. <https://www.timesofisrael.com/with-1-in-15-soldiers-jailed-last-year-idf-rethinks-its-rules-of-incarceration/>
51. <https://hromadske.ua/posts/kilkist-veteraniv-ta-chleniv-simej-zagiblih-mozhe-zrosti-do-5-mln-pislya-vijni-minveteraniv>
52. https://elartu.tntu.edu.ua/bitstream/lib/30987/2/MNTKv3_2019v3_Sochenko_T_Y-PTSD_among_military_160-161.pdf
53. <http://eprints.zu.edu.ua/31037/1/%D0%9E%D1%81%D0%BE%D0%B1%D0%B8%D1%81%D1%82%D1%96%D1%81%D0%BD%D0%B5%20%D0%B7%D1%80%D0%BE%D1%81%D1%82%D0%B0%D0%BD%D0%BD%D1%8F%20%D0%B7%D0%B1%D1%96%D1%80%D0%BD%D0%B8%D0%BA%20%D1%82%D0%B5%D0%B7.pdf#page=194>
54. <https://minjust.gov.ua/news/ministry/minyust-ta-minveteraniv-domovilis-pro-stvorennya-robochoi-grupi-z-vzaemodii-schodo-zasadjenih-yaki-e-veteranami-viyini>
55. https://ipz.org.ua/wp-content/uploads/2018/01/MH-report-for_INTERNET_All_ua.pdf

56. Adams, R. S., Larson, M. J., Meerwijk, E. L., Williams, T. V., & Harris, A. H. S. (2019). Post deployment polytrauma diagnoses among soldiers and veterans using the veterans' health affairs polytrauma system of care and receipt of opioids, nonpharmacologic, and mental health treatments. *Journal of Head Trauma Rehabilitation*, 34(3), 167-175.
57. Albright, D. L., Lana-Walsh, K., Thayer, B. A., Godfrey, K. K., & Waller, R. J. (2020). Combat veterans with polytrauma and traumatic brain injury: Exploring variables affecting access to social work outpatient services. *Traumatology*, 26(4), 344-350.
58. American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.)
59. American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.)
60. Baker, D. G., Heppner, P., Afari, N., Nunnink, S., Kilmer, M., Simmons, A., et al. (2009). Trauma exposure, branch of service, and physical injury in relation to mental health among US veterans returning from Iraq and Afghanistan. *Mil Med*, 174, 733-78.
61. Bam, M., Yang, X., Zumbun, E. E., Zhong, Y., Zhou, J., Ginsberg, J. P., Leyden, Q., Zhang, J., Nagarkatti, S. P., Nagarkatti, M. (2016). Dysregulated immune system networks in war veterans with PTSD is an outcome of altered miRNA expression and DNA methylation. *Scientific Reports*. 6. 31209
62. Betancourt, T. S., Keegan, K., Farrar, J., & Brennan, R. T. (2020). The intergenerational impact of war on mental health and psychological wellbeing: Lessons from the longitudinal study of war-affected youth in Sierra Leone. *Conflict and Health*, 14(62). <https://doi.org/10.1186/s13031-020-00308-7>
63. Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. F., Domino, J. L. (2015). The Post Traumatic Check List for DSM-5 (PLC-5): Development and Initial Psychometric Evaluation. *Journal of Traumatic Stress*. 28 (6). 489-498.
64. Boggs-Bookwalter, D., Roenfeldt, K. A., LeardMann, C. A., Yeon-Kong, S., Riddle, M. S., & Rull, R. P. (2020). Posttraumatic stress disorder and risk of selected autoimmune disease among US military personnel. *BMC Psychiatry*, 20(23), 1-8.
65. Bouvard Guzman, M. (2012), *Invisible Injuries of War: Coming Home from Iraq and Afghanistan*. Prometheus
66. Bryant, R. A., Nickerson, A., Creamer, M., O'Donnell, M., Forbes, D., & Galatzer-Levy, I. (2015). Trajectory of post-traumatic stress following traumatic injury: 6-year follow-up. *Be J Psychiatry*, 206(5), 417-423.
67. Burrell, L. M., Adams, G. A., Durand, D. B., Castro, C. A. (2006). The impact of military lifestyle demands on well-being, army and family outcomes. 33(24). 352-355.
68. Courtois, C. (2008). *Complex Trauma, Complex Reactions: Assessment and Treatment*. Psychotherapy: Theory, Research, Practice, Training, S(1), 86-100.
69. Dyball, D., Evans, S. C., M., Boos, C. J., Stevelink, S., & Fear, N. T. (2019). The association between PTSD and cardiovascular disease and its risk factors in male veterans of the Iraq/Afghanistan conflicts: A systematic review. *International Review of Psychiatry*, 31(1), 34-48.
70. Ehrlich, P., and M. Morgenroth. (1900). The Concept of 'horror autotoxicus' first expressed: on hemolysis: third communication. In *The Collected Papers of Paul Ehrlich*. New York: Pergamon. 205-212
71. Friedman, M. J. (2003). *Post-traumatic stress disorder: The latest assessment and treatment strategies*. Compact Clinicals.
72. Fulton, J. J. Calhoun, P. S., Wagner, H. R., Schry, A. R., Hair, L. P., Feeling, N., & Beckham, J. C. (2015). The prevalence of posttraumatic stress disorder in Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) Veterans: A meta-analysis. *Journal of Anxiety Disorders*, 31,98-107.
73. Godbout, N., Hodges, M., Briere, J., Runtz, M. (2016) Structural Analysis of the Trauma Symptom Inventory-2. *Journal of Aggression Maltreatment and Trauma*. 25(3). 333-346.
74. Groer, M. W., Kane, B., Williams, S. N., & Duffy, A. (2015). Relationship of PTSD symptoms with combat exposure, stress, and inflammation in Americans Soldiers. *Biological Research for Nursing*, 17(3), 303-310.
75. Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N. Engl. J. Med*, 351, 13-22.

76. Hotopf, M., Hull, L., Fear, N. T., Fear, Browne, T., Horn, O., Iversen, A., Jones, M., Murphy, Dominic, Bland, D., Earnshaw, M., Greenburg, N., Hacker-Hughes, J., Tate, R. T., Dandeker, C., Rona, R., Wessely, S. (2006). The health of UK military personnel who deployed to the 2006 Iraq war: a cohort study. *Lancet*. 367: 1731-41
77. House of Commons Defence Committee, Mental Health and the Armed Forces, Part One : The Scale of the Mental Health Issues. Eleventh Report of Session 2017 – 2019. Published 2018.
78. Howell, A. (2014). Resilience, war, and austerity: The ethics of military human enhancement and the politics of data. *Security Dialogue*, 46(1), 15-31.
79. International classification of diseases eleventh revision (ICD-11). (2022). Geneva: World Health Organization. Licence: CC BY-ND 3.0 IGO.
80. Jones, N., Jones, E., Robbins, I., Wessely, S., Greenburg, N. (2017). Combat Experiences and their Relationship to Post-Traumatic Stress Disorder Symptom Clusters in UK Military Personnel Deployed to Afghanistan. *Behavioral Medicine*. 44(2). 131 – 140.
81. Jones, N., Whelan, C., MacFarlane, A., Harden L., Burdett, H., Greenburg, N. (2018). Resilience-based intervention for UK military recruits: A randomized controlled trial. *Occupational and Environmental Medicine* 76(2).
82. Karabatsiakakis, A., Hamuni, G., Wilker, S., Kolassa, S., Renu, D., Kadereit, S., et al. (2015). Metabolite profiling in post-traumatic stress disorder. *J Mol Psychiatry*, 3(1), 2.
83. Katrinli, S., Oliveria, N. C. S., Felger, J. C., Michopoulos, V., & Smith, A. K. (2022). The role of the immune system in posttraumatic stress disorder. *Translational Psychiatry*, 12(313), 1-14.
84. Kiyimba, N., Buxton, C., Suttleworth, J., & Pathe, E. (2022). Discourses of psychological trauma. Cham, Switzerland: Palgrave MacMillan.
85. Kulka, R. A., Schlenger, W. E., Fairbanks, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., and Weiss, D. S. (1988). Contractual report findings from the National Vietnam Veterans Readjustment Study: Volume I: Executive summary, Description of finding, and technical appendices. National Vietnam Veterans Readjustment Study
86. Leardmann, C. A., Smith, T. C., Smith, B., Wells, T. S., & Ryan, M. A. (2009). Baseline self-reported functional health and vulnerability to post-traumatic stress disorder after combat deployment: Prospective US military cohort study. *BMJ*, 338, 1273.
87. Lerner, A. Jeremais, P., Matthais, T. (2015). The world incidence and prevalence of autoimmune disease is increasing. *Int. J. Celiac Dis*, 3, 151-155.
88. Lindqvist, D., Mellon, S. H., Dhabhar, F. S., Yehuda, R., Grenon, S. M., Florys, J. D., Bierer, L. M., Abu-Amara, D., Coy, M., Makotkine, I., Reus, V. I., Bersanito, F. S., Marmar, C. R., & Wolkowitz, O. M. (2017). Increased pro-inflammatory milieu in combat related PTSD - A new cohort replication study *Brain Behav Immun*, 59, 260-264.
89. MacManus, S., Bebbington, P., Jenkins, R., Brugha, T. (2016). Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey. Leeds: NHS Digital.
90. McFarlane, A. C. (2015). The impact of war on mental health: Lest we forget. *World Psychiatry*, 14(3), 351-353.
91. McFarlane, A.C., Lawrence-Wood, E., Van-Hooff, M., Malhi, G.S., Yehuda, R. (2017), The Need to Take a Staging Approach to the Biological Mechanisms of PTSD and its Treatment. *Psychiatry Rep* (2017). 19. 10.
92. Mellon, S. H., Gautam, A., Hammamieh, R., Jett, M., & Wolkowitz, O.M. (2018). Metabolism, metabolomics, and inflammation in post-traumatic stress disorder. *Biol Psychiatry*, 83, 866-75.
93. Mellon, S. H., Bersani, F. S., Lindqvist, D., Hammamieh, R., Donohue, D., Dean, K., Jett, M., Yehuda, R., Flory, J., Reus, V. I., Bierer, Makotkine, I., Abu-Amara, D., Henn-Hasse, C., Coy, M., Doyle, F. J., Marmar, C., & Wolkowitz, O. M. (2019). Metabolomic analysis of male combat veterans with post-traumatic stress disorder. *PLoS ONE*, 14(3), 1-25.
94. Miller, K., Discroll, D., Smith, L. M., & Ramaswamy, S. (2017). The role of inflammation in later-life post-traumatic stress disorder. *Military Medicine*, 182, 11-12.
95. Myers, C. (1915). A contribution to the study of shell shock: Being an account of three cases of loss of memory, vision, smell, and taste, admitted into the Duchess of Westminster's War Hospital, Le Toutquet. *The Lancet*, 185(4772), 316-320.

96. Mellon, S. H., Gautam, A., Hammamieh, R., Jett, M., & Wolkowitz, O.M. (2018). Metabolism, metabolomics, and inflammation in post-traumatic stress disorder. *Biol Psychiatry*, 83, 866-75.
97. Newman, E., Briere, J., Kirlic, N., (2012). Clinical assesment as a form of listening and intervention. In R. A, McMackin, E. Newmand, J. M. Fogler, T.M. Keane (Eds), *Trauma therapy in context: The science and craft of evidence-based practice* (pp. 51-71). American Psychological Association. <https://doi.org/10.1037/13746-003>
98. National Institute for Health and Care Excellence. (2018). Post-Traumatic Stress Disorder NICE Guidelines. Accessed from: <https://www.nice.org.uk/guidance/ng116/resources/post-traumatic-stress-disorder-pdf-666141601777861>
99. O'Donovan, A., Cohen, B. E., Seal, K., Bertenthal, D., Margareteen, M., Nishimi, K., & Neylan, T. C. (2016). Elevated risk for autoimmune disorders in Iraq and Afghanistan veterans with posttraumatic stress disorder. *Biol Psychiatry*, 77(4), 365-374.
100. Porges, S. W. (2011). *The Polyvagal Theory: Neurophysiology foundation of emotions, attachment, communications, and self-regulation*. New York, NY: Norton.
101. Schultebrucks, K., Qian, M., Abu-Amara, D., Dean, K., Laska, E., Siegel, C., Gautam, A., Guffanti, G., Hammamieh, R., Misganaw, B., Mellon, S. H., Wolkowitz, O. M., Blessing, E. M., Etkin, A., Ressler, K. J., Doyle, F. J., Jett, M., & Marmar, C. R. (2021). Pre-deployment risk factors for PTSD in active-duty personnel deployed to Afghanistan: A machine-learning approach for analyzing multivariate predictors. *Molecular Psychiatry*, 26, 5011-5022.
102. Shaley, I., Entringer, S., Wadhwa, P.D., Wolkowitz, O. M., Puterman, E., Lin, J., & Epel, E.S (2013). Stress and Telomere biology: A lifespan perspective. *Psycho- neuroendocrinology*, 38(9), 1835-1842. DOI: 10.1016/j.psyneuen.2013.03.010. Epub 2013 Apr 29. PMID: 23639252: PMCID: PMC3735679
103. Sherman, N. (2015). *Afterwar: Healing the moral wounds of our soldiers*. Oxford: Oxford University Press.
104. Sibai, A. M., Fletcher, A., & Armenian, H. K. (2001). Variations in the impact of long-term wartime stressors on mortality among the middle-aged and older populations in Beirut, Lebanon, 1983-1993. *Amercan Journl od Epidemiology*, 154(2)128-137.
105. Smurr, L. M., Robinson, M., & Smith-Forbes, E. (2008). Treating the war casualty: Case reports of polytrauma. *Journal of Hand Therapy*, 21(2), 177-188.
106. Sumner, J. A., Nishimi, K. M., Koenen, K. C., Roberts, A. L., & Kubzansky, L. D. (2020). Posttraumatic stress disorder and inflammation: Untangling issues of bidirectionality. *Society of Biological Psychiatry*, 87, 885-897.
107. Snell, F. I., Hatler, J. M. (2010). A signature wound of war: mild traumatic brain injury. *Nurse Mental Health*. 48(2). 22-28.
108. U.S Department of Veterans Affairs. (2022). VA disability compensation for PTSD. <https://www.va.gov/disability/eligibility/ptsd/> [Accessed on 14/03/22].
109. Vogt, D., Borowski, S. C., Godier-McBard, L. R., Fossey, M. J., Copeland, L. A., Perkins, D. F., & Finley, E. P. (2022). Changes in the health and broader well-being of U.S. veterans in the first three years after leaving the military service: Overall trends and group differences. *Soc Sci Med*, 294, 1-10)
110. World Health Organisation (2022). International Classification of Diseases Eleventh Revision (ICD-11). <https://icd.who.int/en>
111. World Health Organization Ukraine. (2022). Accessing health care in Ukraine after 8 months of war: The health system remains resilient, but key health services and medicine are increasingly unaffordable. <https://www.who.int/europe/news/item/24-10-2022-accessing-health-care-in-ukraine-after-8-months-of-war--the-health-system-remains-resilient--but-key-health-services-and-medicine--are-increasingly-unaffordable>
112. Yehuda, R., Vermetten, E., McFarlane, A.C., & Lehrer, A. (2014). PTSD in the military: Special considerations for understanding prevalence, pathophysiology and treatment following deployment. *Eur J Psycho-traumatology*, 5, 1-7.
113. Кравченко К.О., Тімченко О.В., Широбоков Ю.М. Соціально-психологічні детермінанти виникнення бойового стресу у військовослужбовців – учасників антитерористичної операції : монографія. Харків. Вид-во НУЦЗУ. 2017. 256 с.

114. Невидимі наслідки війни. Як розпізнати? Як спілкуватись? Як допомогти подолати? Довідник для широкого кола фахівців. Київ, 2020. 192 с.
115. U.S. Department of Veterans Affairs | 810 Vermont Avenue, NW Washington DC 20420
116. www.ptsd.va.gov/professional/treat/essenbals/complex_ptsd.asp
117. Мері Бет Вільямс. ПТСР: Робочий зошит. Ефективні методи подолання симптомів травматичного стресу Київ. Видавництво Ростислава Бурлаки. 2023. – 528 с.
118. Ройтер Кірбі, діалектична поведінкова терапія ПТСР. Тренінг навичок. Практичні вправи. СПб.: Діалектика. 2021. – 256 с.
119. Протокол з діагностики та терапії ПТСР. URL: https://ipz.org.ua/wp-content/uploads/2017/12/nice_2.pdf
120. World Health Organization, 2006 - World Health Organization (2006) Health effects of the Chernobyl accident and special health care programmes. Report of the UN Chernobyl Forum Expert Group «Health» (EGH). Editors: B. Bennet, M. Repacholli, Zh. Carr. WHO, Geneva, 160 p.
121. Loganovsky K. et al., 2008 Loganovsky K., Havenaar J.M., Tittle N.L. et al. (2008) The mental health of clean-up workers 18 years after the Chernobyl accident. Psychol. Med., 38(4): 481–488.
122. Тарабрина Н.В. (ред.), 2007 Тарабрина Н.В. (ред.) (2007) Практическое руководство по психологии посттравматического стресса. Ч. 1. Когито-Центр, Москва, 48 с
123. Speckhard A., 2005 Speckhard A. (2005) Psycho-social and physical outcomes of technological disaster: information as a traumatic stressor. N. Berkowitz (Ed.) A Chernobyl reader, University of Wisconsin Press (<http://www.annespeckhard.com/articles.html>).
124. Румянцева Г. М., Степанов А.Л., 200; Румянцева Г.М., Степанов А.Л. (2006). Клинико-психопатологические особенности посттравматического стрессового расстройства при разных типах стрессового воздействия и некоторые терапевтические подходы. Психиатр. и психофармакотер., 8 (6): 10–16.
125. Пострелко В.М., 2001; 2003; б; в Пострелко В.М. (2001) Психічні розлади у ліквідаторів Чорнобильської катастрофи, що страждають на синдром залежності від алкоголю (клініко-психологічні особливості). Архів психіатрії, 1–2: 2–25.
126. Пострелко В.М. (2003а) Особливості анамнезу коморбідних станів, спричинених сукупним впливом іонізуючих випромінювань та синдромом залежності від алкоголю. Вісн. наук. досліджень.
127. Пострелко В.М. (2003б) Особливості перебігу стану відміни у осіб, що є залежними від алкоголю і страждають нервово-психічними розладами радіаційного походження. Укр. мед. альманах, 6(6): 127–129.
128. Пострелко В.М. (2003в) Специфіка патогенезу синдрому залежності від алкоголю у хворих з непсихотичними психічними розладами радіаційного походження. Укр. мед. альманах, 6: 113–115.
129. Bennet B. et al., 2006; Bromet EJ, 2007 Bennet B., Repacholli M., Carr Zh. (Eds.) (2006) World Health Organization. Health effects of the Chernobyl accident and special health care programmes. Report of the UN Chernobyl Forum Expert Group «Health» (EGH), WHO, Geneva, 160 p.
130. Напреєнко О.К., Логановський К.М. (2002) Сучасні психіатричні класифікації: спроба об'єднання. Укр. мед. часопис, 2 (28): 5–12 (<http://www.umj.com.ua/article/1564>).
131. Qureshi SU et al., 2011 Qureshi S.U., Long M.E., Bradshaw M.R. et al. (2011) Does PTSD impair cognition beyond the effect of trauma? J. Neuropsychiatry Clin. Neurosci., 23(1): 16–28.

BIOGRAPHIES OF EXPERTS

Iuliia Osmolovska

Iuliia Osmolovska is a Director of the Kyiv Office of GLOBSEC. She is a sitting member of the Civil Council of the Ministry of Foreign Affairs of Ukraine. Iuliia is a career diplomat with 15 years of diplomatic and civil service at the Ministry of Foreign Affairs of Ukraine, the Office of the President of Ukraine and the Cabinet of Ministers of Ukraine with the focus on institutional reforms in the government sector. She holds a Master of Philosophy in European Studies from the University of Cambridge, a Master in Foreign Policy from the Diplomatic Academy of Ukraine, Master of International Management from Kyiv State Economic University.

Mandy Bostwick, MSc, MA, ISSTD, Specialist Trauma Psychotherapist

Mandy Bostwick is a clinician, consultant, and speaker. Her work in the UK has involved supporting military regiments and veterans and their families, advising mental health services, prison sector establishments, and court and police liaison officers. In 2016, Mandy was appointed as Specialist Trauma Psychotherapist to the Colonel Fund of the Grenadier Guards, a charitable arm of the Grenadier Guards Charity established in 2007. Recognized as one of the leaders in her field, Mandy was appointed to help support the most seriously wounded and traumatized, many suffering Complex PTSD and comorbid disorders as a result of the Afghanistan conflict. Since then, she has championed their causes and worked tirelessly to ensure their injuries are better diagnosed and understood to reduce detrimental impact of PTSD on their health and long-term well-being. Highly respected amongst her peers and patients Mandy has previously provided evidence to the Ministry of Defense and the Defense Select Committee raising the profile of Traumatic Brain Injury for those who had returned from Iraq and Afghanistan without accurate assessment, diagnosis, and treatment. Mandy's pioneering work challenges the current ideology of PTSD and is based on the most up-to-date research and involves collaboration with international experts around the world. Mandy is currently completing her doctorate at Chester University in England and is supporting Ukraine to adopt more advanced approaches to assessment, diagnosis, and treatment of Post-Traumatic Stress Disorder.

Lenny Grant, PhD

Assistant Professor of Writing and Rhetoric at Syracuse University (New York, USA). He researches historical relationships between language and medical codifications of psychological trauma, focusing on how those codifications influence treatment options and patient identity with an eye on addressing present concerns. He is also co-leader of the Onondaga Community Trauma Task Force (NY), which assesses and addresses gaps in mental health infrastructure and psychoeducation. In 2021, Dr. Grant founded the Resilience Writing Project to teach mental health workers and allied professionals to use expressive writing to process primary and secondary trauma and develop pro-social emotions.

RJ Naperkowski

is a 2023 graduate of the Syracuse University College of Law and currently works as the Senior Research Fellow for the Institute for Security Policy and Law (SPL). In this role, RJ supports SPL's esteemed national security professionals such as Judge James E. Baker and Vice Admiral Robert Murrett (Ret.) with qualitative research on topics ranging from Artificial Intelligence to the War in Ukraine. Before working at SPL, RJ served as a U.S. Army Captain in Explosive Ordnance Disposal from 2014 through 2020. As an EOD Officer, RJ worked closely with multiple U.S. Agencies to mitigate Chemical, Biological, Radiological, Nuclear, and Explosives threats as well as train NATO Allies and Partner Nation Forces across the globe.

Yana Sofovich

International Relations Lecturer and Project Executive, with MSc in Political Sociology, MA in Diplomacy and BA in Political Science. Experience in variety of fields such as demining mine fields in Angola, organization of political conferences, interpreter, strategic planning at London Olympic 2012, presenter and served at Israeli Defense Forces as medical nurse. Volunteered at Human Rights Watch London, United Hatzalah and Frida. Medical Volunteer Mission in Ukraine.

Oleksandr Gershanov, M.Ed S.W. CBT psychotherapist

Graduate of Kharkiv and Jerusalem Universities. International psycho-trauma expert. Consultant on psycho-educational programs for the United Nations and Council of Europe. Director of Education Programs,

Israel Trauma Coalition. In the field of mental health since 1997, Oleksandr worked for 10 years as a coordinator at the Israel Crisis Management Center, working with the population in areas under attack during four wars and security escalations. Oleksandr has more than 10 years of experience in social and psychological support of families who have lost their loved ones. Co-author of the Resource-Behavioral Therapy method and the therapeutic cards set “OMNIS”. The author of the book for people who have experienced the loss of loved ones “The One Who Walks With You on the Path” and co-author of the methodical guide “The Path to Healing: The Basics of Working with the Consequences of Traumatic Events” (Ukraine, 2023). Since 2014, has been conducting educational programs for working with trauma for specialists in Ukraine as part of Israel Trauma Coalition programs, and since February 2022 developed and led all ITC projects for specialists and care providers in Ukraine.

Max Goldenberg

Max is a senior emergency management professional, with wide-ranging experience and knowledge in public resilience, contingency planning, continuity of operations, civil-military and interagency cooperation. Since 2016 Max has led all of the international training programs for the Israel Trauma Coalition. He has extensive experience in developing effective programs for all aspects of population crisis awareness and preparedness, as well as readiness and response plans for municipalities and critical infrastructure. Max provides consulting services to Israel National Emergency Management Authority (national-level exercises’ planning, update, and validation of emergency protocols for nationwide emergency scenarios), Ashdod Port (emergency preparedness, development of response protocols), Israel Water Authority (water crisis preparedness and response) and to Home Front Command, IDF (operational planning and development of training programs). He has his Master’s Degree in Emergency Management from Haifa University, Israel. Currently in the rank of LTC (res.) in IDF. During his military career served as on-site coordinator of international support during Carmel Forest Fire (Israel, 2010) and took part in the deployment of State of Israel humanitarian assistance and rescue missions—Japan (2011), Bulgaria (2012), Colombia (2012), Philippines (2013), Ghana (2013) and Nepal (2015). Max has initiated and participated in the INSARAG (UN) classification process for the National Rescue Unit of the HFC as an Operational Focal Point for INSARAG activities in Israel.

Goran Čerkez

Goran Čerkez, a medical doctor, and specialist in social medicine, organization and economics of health care, has more than 25 years of experience in public health, with a special focus on policy, strategy community care development, and crisis situations. Head of the WB project for the rehabilitation of war victims for more than four years. Consultant for human resource development as well as for community services. As a health expert, he worked with the WB, WHO, IOM, UNFPA, and CoE. As an expert participated in the elaboration of the European Action Plan for Mental Health of the World Health Organisation. Since 2000 he has been working in the Federal Ministry of Health, first as an Adviser to the Minister, and after that as Assistant to the Minister where he closely worked with WHO, UNICEF, IOM, and NGOs. Goran Čerkez is an invited lecturer on issues related to the development of health services at the Faculty of Medicine in Sarajevo, the summer healthcare schools in Miločere in the United Nations Center for Peace, the Summer School for Social Workers in Dubrovnik, and the Faculty of Criminology, Criminology and Security Studies on peer violence. As a mental health expert, worked with the World Bank, WHO, IOM and the Council of Europe, ITF, UNICEF, UNFP, Harvard Refugee Trauma, the Southeast Europe Health Network, as well as many NGOs.

Dr Biljana Lakić, MD, MS, psychiatrist, psychotherapist (CBT of anxiety disorders and social phobias, Group analysis, SEE FAR CBT/ Culturally sensitive post-trauma treatment, EMDR).

Since 1998 she has been working at the University Clinical Center of Republika Srpska, Psychiatric Hospital, Banja Luka. From 2010 to 2023 she worked in the Mental Health Project in BH, IPD, as an Entity and Component Leader. In 2006, she was appointed as the Republic Coordinator for Mental Health and WHO focal point for mental health at the Ministry of Health and Social Welfare (MoHSW) in the Government of Republika Srpska, BH. Since then, she has participated in numerous activities of the MoHSW and other partners related to mental health reform processes in BH and developing a network of community mental health centers Co-author of the research project “The impact of war and post-war stress and trauma on the mental health of veterans in the Republic of Srpska”, organized in 2007 by the Veterans’ Organization of the Republic of Srpska, with the support of the MoH and the Ministry of Labor and Veterans’ Disability Protection in the Government of the Republic of Srpska. In 2010 appointed National Mental Health Coordinator for BH in the Stability Pact/SEEHN. On several occasions, she worked as a consultant for the WHO, Regional Office for Europe, in 2015 in Kyiv, Ukraine, related to the WHO Mission on mental health status in Ukraine. Since 2022, she has been a member of the pan-European Mental Health Coalition of WHO. Author and co-author of several papers, brochures, publications, clinical guides, manuals, and books.

Asan Cadyrov

Practicing psychiatrist and narcologist. Since 2014 the founder and head of Cadyrov Clinic (Kyiv, Ukraine), which specializes in PTSD, mental disorders and addiction cases. Is renowned for his signature tailor-made treatment programs, where he applies multidisciplinary approach to PTSD treatment. Prior to 2014 founded and for 10 years headed Cadyrov Clinic in Crimea, but had to abruptly his work and to leave Crimea due to Russian invasion. Previous years of clinical experience include top position in the leading narcological clinic in Tashkent (Uzbekistan).

Prof Valentyn Postrelko

Ph.D. in Medicine (1990); holds the academic titles of Senior Researcher in Psychiatry (1995), Doctor of Medicine (2010), Professor (2021). He has experience in the treatment of PTSD since 1986, as a liaison officer for the accident at the Chernobyl nuclear power plant. Since 2014, he has been actively involved in the development of methods for treating PTSD in ATO and JFO participants. Since February 2022, he has provided assistance to military and civilians with PTSD. In June 2022, he began implementing a new method of rehabilitation for patients using virtual reality glasses. Head of the Department of Mental Health at the International European University. Author of many articles, patents, and monographs.

Myronets Serhii, crisis psychologist

Graduated from the Marshal S. Biryuzov Strategic Missile Forces Military and Political School in Riga (1988) and the Ivan Chernyakhovsky Humanitarian Institute of the National Defence Academy of Ukraine (2001, social and military psychology). Holds Ph.D. in Psychology (2007), the academic title of Associate Professor at the Department of Public Administration and International Projects (2010), doctoral degree in psychology in the specialty of the psychology of activity in special conditions (2020). A member of the Subject (Sectoral) Expert Commission on Health, Safety, and Wellbeing of the Ministry of Education and Science of Ukraine; Chairman of the Institute of Modern Psychological Counselling; member of the Scientific Council of the European Association of Security Sciences (Krakow); member of the Ukrainian Association of Organisational and Labour Psychologists; member of the Ukrainian Association of Family Psychologists; co-editor of the scientific journal "Civil Security: Public Administration & Crisis Management". Author of about 300 scientific publications in professional scientific journals on extreme and crisis psychology, on overcoming the negative effects of acute traumatic stress in extremal professional activities. Member of working groups on the development of several legislative and by-laws, one of the initiators of the Psychological Service in the system of the Ministry of Emergency Situations / SES of Ukraine.

Olena Konovalova

Ph.D. in philosophy, specialty "Psychology", consultant in Positive Psychotherapy (WAPP certificate, Germany). Psychosomatologist. Practical psychologist and lecturer at the Kyiv Trade and Economic College of the State University of Trade and Economics (Kyiv). She has over 10 years of experience in counseling and psychotherapy at the request of clients of different age groups and over 20 years of experience in all areas of practical psychological activity in education. Permanent member of the Ukrainian Association of Organizational and Occupational Psychologists and the International Association of Psychosomatics and Body Therapy. She is the author of curricula and methodological recommendations in the disciplines of Psychology, Psychology of Trade, Conflictology, Sociology, and Economic Sociology. Since 2014, she has been supporting military families and IDPs, and it was during this period that she began working with PTSD. Today, she works with combatants and their families, refugees (since the end of 2022, she has received many requests from refugees abroad - integration, witness trauma, loss of meaning), IDPs, students, and colleagues; she conducts educational activities with all participants in the educational process on the skills of Primary Psychological Care and First Aid.

Denys Bogush

Military doctor, mobilized on 02.03.2022. Neurologist, neurophysiologist, specialist in longevity medicine and psychotechnology. Political and military expert, political strategist, and strategic communications specialist. Graduated from the Kyiv Medical Institute of the Ukrainian Academy of Medical Sciences (general practitioner) and the Shchupyk Medical Academy of Postgraduate Education (neurologist), Kyiv Higher School of Public Relations at the Institute of Sociology of the National Academy of Sciences of Ukraine. Researcher at the Bogomolets Institute of Physiology of the National Academy of Sciences of Ukraine (2000-2013); conducted research in the field of stress, pain physiology, the effects of electromagnetic waves on the human body, extreme exposure, biologically active acupuncture, and acupuncture. Has competence in Acupuncture and Oriental Medicine Japanese, Chinese, Korean, Indian, Vietnamese, Su-Jok Acupuncture, Massage and Manual

Therapy, Survival Courses in Extreme Conditions, Hypnotic Techniques, Psychotherapy, Neuro-Linguistic Programming, Psychotechnology, Psychodiagnostics and Paranormal Influences, Traditional Cossack medicine and characteristic practices. President of Bohush Communications Agency (Kyiv, 2000). Head of the international project "Kozak-Kharacternik" www.kh.org.ua. Author of over 30 books and 100 scientific articles, including "Practical and Experimental Methods of Emergency Care and Self-Regulation in Extreme Conditions in the System "Alpha-Control" (1997), "Anti-Stress Strategy and Practical Methods of the System "Alpha-control", 2001, "How to live 120 years or modern technologies of longevity", "Japanese resuscitation technique in martial arts practice" and many more.

Martin Poliačik

Is a founding member of two liberal political parties in Slovakia, wrote or co-wrote 4 political programs for parliamentary elections and co-worked on the Government Manifesto in 2010. For 10 years he was a Member of Parliament in Slovakia and for 4 years a member of Parliamentary Assembly of Council of Europe. He is a co-founder, senior lecturer and a consultant at Academy of Critical Thinking, with over 25 years of experience in teaching argumentation, patterns of thinking and communication.

Mykyta Havrylei

Received a degree in law. Developed basic knowledge of psychology and is currently completing his degree in this field at the State National University n.a.Taras Shevchenko (Ukraine).



This report has been officially presented at the Third Summit of First Ladies and Gentlemen in Kyiv on September 6th 2023.

It was received by the President of Ukraine Volodymyr Zelenskyy and The First Lady of Ukraine Olena Zelenska.



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