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Ukraine: Meeting the mental health needs of service veterans

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Abstract

The current conflict in Ukraine is a tragedy of epic proportions that without doubt is causing serious psychological damage with inevitable long term consequences affecting combatants, civilians, not to mention displaced refugees. This paper focuses on the mental health needs of service veterans returning home to a country, devastated by the current conflict.

Keywords

military, Ukraine, veterans

The current conflict in Ukraine is a tragedy of epic proportions that without doubt is causing serious psychological damage with inevitable long term consequences affecting combatants, civilians, not to mention displaced refugees. This paper focuses on the mental health needs of service veterans returning home to a country, devastated by the current conflict.

Although there is a substantial literature on the mental health of service veterans the vast majority of this is from the US and UK and based on expeditionary forces returning from operations to relative normality. Much of this is irrelevant to the current Ukrainian war which is becoming an existential conflict, and a fight for national identity. Service Veterans will be returning to devastated, broken country and to a home where many family and loved ones have been equally traumatised by the impact of war.

In the US and UK literature there is considerable debate whether there should be bespoke services for veterans, superior to those available to the general population and whether these are ethically desirable? Once again this is an irrelevant issue in Ukraine where the majority of the male population are service veterans and their sheer numbers make any bespoke provision, impossible, especially given the massive burden of psychopathology within the baseline population overall, resulting from war trauma (*World Economic Forum*, 2022).

Despite the current conflict entering its second year, despite its impact on the rest of the world, and despite the substantial military and financial assistance that is being given to Ukraine by the West, scant attention has been paid, thus far, to the impact of the conflict on the mental health of its combatants and what might be done to mitigate this when the country finally has an opportunity to rebuild. Bricks and mortar are easily replaced, broken minds, less so.

A literature search identified only two papers studying the mental health of current combatants: Haydabrus et al. (2022) conducted a Retrospective analysis of 3,995 medical records at Military Center for the Northern Region, Karkhiv. Against the background of anxiety related disorders that were most prevalent in peacetime, admissions increased dramatically in wartime: 76.1% cases comprised anxiety, dissociative, PTSD, stress-related, somatoform disorders, frequently with co-morbid substance abuse (especially Alcohol), and other non-psychotic disorders. Less than 10% of admissions were for Psychotic disorders, with a further 7% diagnosed as Personality disorders.

In a second paper, Pavlova et al. (2022) conducted a mobile phone survey of 178 combatants in March 2022 comprising 107 Regular Army and 74 Civilian combatants previously known to the Lviv University network. A total of 1,173 soldiers were screened for possible selection, the 178 being those who had been directly involved in war fighting. Using simple measures, they recorded an incidence of anxiety of 44.4% (GAD), depression 43.3% (PHQ) and sleep disturbance 12.4% (ISI). Symptoms were more likely to be reported from combatants in Russian occupied areas, professional soldiers were more likely to be symptomatic than reservists or civilian soldiers. This may reflect regular soldiers being more likely to be put in harm's way and high intensity conflict compared to less experienced reservists and civilian soldiers.

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Both studies came to the same general conclusions: the need for recruit screening (despite US and UK literature emphatically demonstrating that screening for particular personality traits doesn't work) (Rona et al., 2017). A need to reduce or stop alcohol consumption altogether on operations, and preventative interventions aimed at high risk groups (although it is not specified who the high risk groups are or what the interventions might be). Both studies have their limitations (although deserve to be commended considering the circumstances in which they were conducted). Both are small studies, certainly too small on which to base policy. Sampling suffered from multiple biases and a lack of diagnostic precision . Moreover, Ukrainian diagnostic statistics need to be treated with caution, whereas western psychiatric nosology is originally based on the German school, Ukraine's long affiliation with Russia has led to a Soviet understanding of psychiatric diagnosis and not ICD or DSM. Although US and UK research would disagree with the authors enthusiasm for screening, both US and UK would certainly echo their call to limit the availability of drugs and alcohol on any military operation.

What to do with psychiatric casualties on the battlefield poses a perennial dilemma for commanders who traditionally receive little or no training in this area (In my own UK experience, On a UK Commanding Officer's Designate course, mandatory for all prospective military Commanders one of the authors [MD] somewhat bizarrely spent 3 days of the course devoted to different ways of disciplining malfeasant soldiers, but nothing in relation to the psychological welfare of troops or dealing with mental breakdown on the battlefield)! Establishing criteria for becoming a psychiatric casualty on the battlefield is ultimately the Commanding Officer's decision. Medical Officers may advise, but the Commanding Officers temperament, personal prejudices and tactical situation often carries more weight than the views of a medical officer or mental health professional. The Commanding Officers dilemma is that if the threshold is set too low, there is the possibility of a mass exodus from the battlefield (after all, who in their right mind would risk their lives and fight on, if they knew there was an easy, and honourable way out? On the other hand, setting the threshold too high risks psychologically impaired soldiers in combat who are not only militarily ineffective, but also potentially undermining morale creating more problems than their contingent presence justifies. The two World Wars teach an interesting lesson; in the First World War all protagonists set strict criteria to define a psychiatric casualty and many soldiers on all sides (who with hindsight were clearly ill) were executed for cowardice or desertion., The incidence of psychiatric breakdown was roughly the same on all sides, more than 3,000 death sentances were passed and 346 UK servicemen were executed, many of these undoubtedly mentally ill.. By the time of the Second World War attitudes in the UK and US had softened, whitest German and Soviet forces maintained the same harsh criteria used in the First World War. The incident of psychiatric breakdown remained at 9 per 1,000 in German and Soviet forces, whitest unsurprisingly it rose to 39 per 1,000 amongst US and UK forces. What was interesting was that there was a proportionate increase in rates of disease and non-battle injuries (DNBI), potentially self-inflicted by neglect or directly self-inflicted such as Trench Foot, Frostbite, accidental gunshot wounds etc.) in the German and Soviet forces, that offset the reduced number of psychiatric casualties, that is to say, exactly the same numbers of soldiers on all sides were being evacuated, but German and Soviet troops resorting to other means avoiding the potential for harsh punishment by their chain of command and the opprobrium of their peers. It appears that soldiers who were unable to function or cope in combat, and who were denied the possibility of becoming a psychiatric casualty, 'broke down' in other less obvious and more institutionally acceptable ways. The overall numbers of casualties remained the same; only the manner of their presentation varied.

Despite the different context of US and UK research, there are a number of lessons from which our Ukrainian friends might profit: First and foremost, we quickly forget the lessons of history and good practice in previous conflicts has to be re-learnt. Secondly, the delayed onset or presentation of symptoms means that apparently new cases of combat related mental health problems may fail to present for many years (e.g. In the UK there is a 14.1 year delay between discharge from military and presentation to specialist veterans mental health services) (Fletcher, 2007) and it is well established that 10% of PTSD cases are delayed in onset or presentation (Utzon-Frank et al., 2014). PTSD is but one of a number of Post Traumatic Disorders (PTD's). 90% PTSD have at least one other diagnosis (Brady et al., 2000), it is important not to narrowly focus on PTSD as a lot of other psychopathology will be overlooked. Screening at recruitment for potentially vulnerable personality traits or intellect doesn't work, of course, a history of major mental illness should serve as an exclusion criterion but more subtle indicators are unreliable (Rona et al., 2017).

Mental illness and suicide more likely in young (<25), single male servicemen, who also happen to be the individuals least likely to seek help (Crawford et al., 2009). Stigma and reluctance of men to admit mental health problems remains a common barrier to treatment. The displacement of suffering and anger into alcohol, drugs and domestic and sexual violence is commonplace on return from operations, as is, so called 'Risky' behaviour such as reckless driving, gambling, fighting, sexual promiscuity, all of which are of course fuelled by excessive alcohol use (Killgore et al., 2008).

The warning signs of a significant mental health emergency amongst military veterans in Ukraine are already

evident. A 2020 study by the Ukrainian Foundation for Public Health found that 57% of veterans needed psychological support. In 2021 the Minister for Veterans Affairs Inna Drahanchuk estimated that 700 Ukrainian Veterans had committed suicide since 2014, and admitted that tracking former military personnel (Chen & Melwani, 2022) was difficult and that the number of suicides. . . ‘might be a gross underestimate’. The psychological toll of the war extends well beyond the immediate protagonists, many US and UK Veterans, including older veterans have experienced exacerbation of symptoms watching images of the Ukrainian conflict reported in the western media .

What can be done? Managing the mental health of service personnel and military veterans

Serving personnel

Veterans mental wellbeing is immeasurably improved if they receive effective, timely care whilst still in service. It is worthwhile, therefore, to reflect on aspects of care delivery not found in textbooks.

Clearly prompt access to medical officers or psychological officers properly trained to recognise combat stress reactions is key, however, chaplains and other welfare personnel have a role to play and should also receive training in the recognition of mental disorders. Similarly, medical officers should have ready access to mental health professionals to enable timely referral and advice. Given a relative lack of training and reliance on personal proclivity and whim, it behoves medical officers and mental health professionals to establish good working relationships with commanders to foster mutual respect and understanding, pre-empting potential conflict and disagreement over individual cases. Ideally, they should be invited to operational briefings both to increase mutual contact and familiarity but also, especially, to give medical and mental health professionals an appreciation of the bigger picture to enable them to put their work in context and better understand the conflicting pressures facing the Chain of Command. It is worth mentioning that current western initiatives such as TRIM (trauma incident risk management) remain experimental and are almost certainly ineffective in the current Ukrainian context not least because of the sheer weight of numbers being exposed to multiple traumatising events. It is also worth noting that many soldiers suffering from apparently serious psychological symptoms (including psychosis) are also physically exhausted, extremely tired and dehydrated, or in physically poor condition and if operationally possible, simple measures such as allowing these individuals to receive adequate rest, comfort and nutrition, itself can be curative. Efforts to identify psychological problems on return from operations, although laudable, are seldom effective. The authors have first hand experience of groups of homecoming soldiers in one large room, being asked. . . ‘Anybody with psychological issues?’ The responses were predictable!

Transitioning into civilian life

Returning to civilian life can itself be both challenging and traumatic. Acutely, personnel returning from operation are often exhausted, dirty and emotionally still in war fighting mode. Operational decompression, allowing personnel to rest and recuperate for a few days before returning home allows them an opportunity to process a shared experience with comrades and regain composure and physically refresh before returning to loved ones (Jones et al., 2010). As well as the obvious physical needs of returning combatants it is important to bear in mind the loss of rank, status and identity which can itself create, or exacerbate problems. . .as one General once said. . . ‘you go from being a somebody to a nobody, overnight’. Education on demobilisation, particularly in relation to excessive alcohol, drug use and risky behaviour may be useful, but only if delivered by someone with perceived credibility in the eyes of the audience. Information about benefit entitlements, and support and services available post discharge are equally important taking care to deliver this information in an easily understood format, too often servicemen are anxious to get home pay little attention to verbal information at the point of discharge .

The Unit, the Regiment and the Corps are perceived by many servicemen as a family and wherever possible there should be mechanisms for maintaining links for those who wish with both the wider military as well as former comrades: Regimental associations, veterans networks promoting social contact can be more effective than specific therapies for veterans. Finally, the manner in which a serviceman leaves the military can be crucial to mental wellbeing and an appropriate fulsome ‘goodbye, well done and thank you.’ from, once again, a senior military figure with perceived credibility can make all the difference in the adjustment to civilian life and the ability to tolerate and cope with psychological symptoms.

Established veterans

Any specific therapeutic interventions will be few and far between in the Ukraine theatre with such a large Veteran population. Nevertheless, efforts to provide therapy (particularly by NGOs and humanitarian organisations such be coordinated to avoid duplication of effort as well as trying to promote equity of access according to need to very scarce resources. Locally, self-help support groups for veterans and families, the provision of practical support such as food, warmth, shelter and safety are a more effective use of resources than providing individual therapy for the few. Mental health professionals have an important coordinating

and supervisory role to play, advising on policy, training and making themselves available to the most complex cases. On a national level, efforts to reduce stigma and facilitate help seeking should be promoted exploiting the media wherever possible to reach as many of the population as possible. Although health education is an obvious format, the use of drama and fiction to address real world situations, and key opinion leaders to share their own mental health problems, thereby legitimising the suffering of others, are potentially powerful tools to influence the Illness behaviour of large numbers of people.

In conclusion servicemen and women face far more stress and strain than bombs and bullets and understanding these can make any therapy or mental health intervention much more effective. Ukraine has many broken buildings to repair, but repairing the broken minds of much of the veteran population will be a task immeasurably more challenging and civilian, politicians and professionals of all stripes, need to try to understand the issues faced by those who risked their lives to protect and preserve the way of life of their fellow countrymen.

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