

Experience of resocialisation policy for veterans with post-traumatic stress disorder as a factor of security and socio-economic stability of Ukraine and the European Union

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ABSTRACT

Aim: To substantiate the strategic role of the resocialisation of veterans with PTSD as a critical factor in the security of Ukraine and the EU; to analyse the clinical specificity of contemporary combat-related disorders; and to demonstrate the necessity of implementing inclusive governance models of rehabilitation at the community level to prevent cross-border social risks.

Materials and Methods: A comprehensive approach was applied, including statistical, comparative, and clinical-diagnostic analyses. The source base consisted of a secondary analysis of data from international organisations (GPI, GLOBSEC, UNODC) and departmental statistics for the period 2008–2025. A systematic selection of publications was carried out in the Web of Science Core Collection, Google Scholar, and the electronic catalogues of the V. I. Vernadskyi National Library of Ukraine using the keywords: resocialisation, veterans, PTSD. Of 68 identified sources (including 34 articles), 22 studies that fully met the criteria of scientific validity were included in the final analysis.

Conclusions: It has been demonstrated that Ukraine's resocialisation policy represents a unique precedent for EU and NATO countries. It shows that the stability of the veteran community serves as an instrument for mitigating cross-border crime and social destabilisation in the region. Public administration bodies and local self-government play a decisive role in creating multi-level interventions. The transition from a punitive to a rehabilitative model proves its economic efficiency. Clinical advances by Ukrainian physicians in PTSD are fundamental for the European healthcare system, particularly in the context of rehabilitating foreign volunteers and preparing medical professionals for the challenges of modern conflicts.

KEY WORDS: policy, resocialisation of veterans, PTSD

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INTRODUCTION

The modern world is characterised by an extremely high level of conflict: according to the Global Peace Index (GPI) 2025 report, 59 active state-based conflicts and more than 180 regional armed confrontations have been recorded. This intensity has tragic consequences: data for 2024 indicate approximately 152 thousand war-related deaths [1]. Given Ukraine's status as an immediate neighbour of EU countries and a strategic partner of NATO, Ukrainian practices of veterans' resocialisation acquire critical importance for the European system of security and healthcare. Notably, foreign nationals from 75 countries serve in units of the Land Forces of the Armed Forces of Ukraine, participating in the defence of Ukraine against Russian aggression [2].

As of 2025, the number of veterans in Ukraine amounts to 1,3 million individuals [3], and according to projections, this figure may increase to 5 million

after the end of hostilities [4]. According to the Department of Healthcare of the Ministry of Defence of Ukraine, 29% of diseases among military personnel are PTSD-spectrum disorders, and this figure continues to rise [5]. Studies published in *Psychiatry Research* indicate a high prevalence of PTSD among medical personnel and paramedics (up to 14.5%), while among veterans this показатель reaches 15–20% or higher, with a risk of symptom chronicity lasting for decades [6]. Data from the analytical center GLOBSEC confirm that in 25% of cases combat stress transforms into PTSD of varying severity [7].

The formation of a million-strong veteran community in the center of Europe requires not only local solutions but also synchronization with the medical standards of the North Atlantic Alliance. The experience of Ukrainian physicians in treating veterans and implementing multidisciplinary models of rehabilitation governance

represents a unique contribution for EU countries facing emerging mental health challenges. Thus, the development of an effective resocialisation policy in Ukraine is a shared interest of the EU security space, as the stability of the veteran community directly affects the social and economic resilience of the entire region.

AIM

To substantiate the role of the resocialisation of veterans with PTSD as a critical factor in the security of Ukraine and the EU; to analyse the clinical specificity of contemporary combat-related disorders; and to demonstrate the economic efficiency of investments in rehabilitation for preventing cross-border social risks.

MATERIALS AND METHODS

The study is based on a comprehensive analysis combining clinical-diagnostic, medico-economic, and statistical methods for the period 2008–2025. The empirical base consisted of a secondary analysis of reports from international organizations (GPI, GLOBSEC, UNODC, World Bank), as well as departmental statistics from the Ministry of Health of Ukraine and the Ministry of Defence of Ukraine. A systematic search for relevant publications was conducted in the Web of Science Core Collection, Google Scholar, and the electronic catalogues of the V. I. Vernadskyi National Library of Ukraine using the key descriptors: resocialisation, veterans, PTSD. Of 68 identified sources (including 34 articles), 22 original peer-reviewed studies, official reports, and departmental statistics were selected for the final analysis based on eligibility criteria. Exclusion criteria included conference abstracts, editorial materials, letters, and book chapters.

ETHICS

This review is based on the analysis of publicly available scientific data from peer-reviewed publications, databases, and clinical guidelines. As the study did not involve conducting new clinical trials or the direct collection of primary patient data, there was no need for personal identification or approval from an ethics committee.

In the course of preparation, the authors adhered to the principles of the Declaration of Helsinki and international publication standards, including the recommendations of the ICMJE. The work was carried out in accordance with the principles of academic integrity. The text contains no indications of plagiarism or data manipulation in addressing the health issues of

veterans with PTSD, and all primary sources related to clinical studies and statistics have been properly cited and included in the reference list.

FRAMEWORK

The study was conducted without financial support from external organisations and forms part of the “Plan of Scientific and Scientific-Technical Activities of the National Academy of Internal Affairs for 2026”, approved by the decision of the Academic Council of the NAIA dated 30.12.2025 (Minutes No. 25). The content of the article directly correlates with item 26 of the said Plan: “Administrative and legal mechanism for the reintegration of veterans and combatants into the system of bodies and units of the Ministry of Internal Affairs”.

REVIEW AND DISCUSSION

The consequences of modern warfare create long-term challenges for mental health, requiring adaptation of public governance systems. There is a high probability that the actual prevalence of PTSD significantly exceeds official statistics due to the latent nature of the disorder, insufficient diagnostic capacity, and a substantial number of unregistered cases. For EU countries bordering Ukraine, studying these dynamics is strategically important, as uncontrolled maladaptation within the veteran community generates shared risks – from increased cross-border crime to additional pressure on European healthcare systems due to migration processes. Therefore, the development of preventive resocialisation models in Ukraine is a necessary condition for ensuring the collective socio-economic resilience of the European region.

Studies by A. Zalihić, H. Skobić, and N. Pejanović-Skobić demonstrate a direct correlation between the mental health of veterans and their socio-economic adaptation. In particular, employment rates among veterans without signs of PTSD are significantly higher than in the group with a confirmed diagnosis. The clinical profile of veterans with PTSD is characterized by higher comorbidity, including frequent sleep disturbances, systematic use of psychoactive and anxiolytic substances, and a tendency towards addictive behaviours (including alcohol misuse). These findings confirm that undiagnosed PTSD is a key barrier to the successful reintegration of combatants into civilian life [8].

The validity of these assumptions is confirmed by reports of the United Nations Office on Drugs and Crime (UNODC), which systematise the relationship between military trauma, substance abuse, and increasing criminal risks. UNODC identifies psychological trauma as a

dominant predictive factor of drug use in post-conflict regions. For EU countries, this conclusion has strategic significance: undiagnosed PTSD, combined with addictive behaviour, creates preconditions for the formation of transnational criminal networks and illicit trafficking of substances [9]. Timely treatment of combat-related trauma, in accordance with UNODC protocols, is considered not only a humanitarian measure but also an instrument for stabilising the criminogenic situation at the international level.

Standardisation of indicators has shown that veterans are more likely to serve sentences for violent crimes – 64% (including 35% for sexual offences); property crimes account for 12%; drug-related offences for 14%; and driving under the influence for 3%. Overall, the offender profile indicates that for a significant proportion of veterans (32%), the offence represents a first episode occurring in adulthood. This directly points to a crisis of resocialisation and the impact of trauma rather than an inherent criminal predisposition.

The analysis shows that 53% of veterans are held in penitentiary institutions awaiting sentencing. This stage is critical for the involvement of probation authorities and psychological services in implementing programmes for the treatment of addictions and PTSD. Such a strategy enables the application of alternative forms of punishment, replacing isolation with specialized therapy. The effectiveness of this approach is supported by the fact that 22% of veterans receive prison sentences of up to one year; this period has a high preventive potential for intensive community reintegration, helping to prevent criminal recidivism and ensuring the rational use of budgetary resources [10].

Studies by Horesh D., Solomon Z., and Ein-Dor T. confirm the critical role of social resources as a buffering mechanism in overcoming PTSD. The authors demonstrate that a stable supportive environment at both the micro level (family) and macro level (community) is a key determinant of successful resocialisation. Clinically significant are the identified markers of early manifestation: a persistent association between initial reactions to combat stress and the risk of delayed-onset PTSD enables early intervention. An effective rehabilitation governance strategy should include multilevel interventions – from peer-to-peer support groups to systematic psychoeducation of society. From an economic perspective, investments in strengthening the social capital of veterans are highly cost-effective, as maximising internal community resources at early stages reduces the need for prolonged and costly clinical treatment in the future [11].

Hoyer J. N., Chavez M., Lind J., Hamm B., Melillo C., and Besterman-Dahan K conclude that the effectiveness of

veterans' resocialisation directly depends on the inclusiveness of research approaches and the active involvement of local self-government bodies and territorial communities in the rehabilitation process. According to the authors, integrating scientific developments into local governance practice is a key factor in overcoming gaps in the provision of medical and social services and improving long-term recovery outcomes for combatants. To address existing service gaps, public governance should promote partnerships between the scientific community and local organizations that directly interact with veterans in their places of residence. Dissemination of research findings on the importance of social support among policymakers and healthcare professionals is critical for shaping an adequate understanding of the needs of the veteran community.

An important element of this process is the integration of veterans into community and religious organizations, where the principle of peer-to-peer support is implemented, contributing to the restoration of an individual's sense of social purpose. Particular attention within public policy should be paid to the diversification of samples: resocialisation programmes must include previously underrepresented groups (women veterans, minority representatives, and individuals not registered within specialised healthcare systems), while also accounting for geographical diversity (from metropolitan areas to rural settings). Analysis of existing practices has revealed a significant limitation – the short-term nature of programmes, which does not allow for the assessment of long-term reintegration dynamics. A multidisciplinary analysis of these gaps confirms the difficulty of unifying the concept of "veteran services", which requires flexible governance decisions and the development of comprehensive indicators for monitoring the process of lifelong social adaptation of veterans [12].

The effectiveness of decentralised governance models for resocialisation is directly dependent on their technological content, which creates a critical need to integrate the most promising innovative therapeutic methods into the public health system that can be tested in Ukrainian clinical practice. For example: 1. Biotechnological and neurophysiological methods: stellate ganglion block (SGB), repetitive transcranial magnetic stimulation (rTMS); 2. High-tech rehabilitation methods: virtual reality exposure therapy (VRET), neurofeedback therapy (biofeedback); 3. Psychopharmacological innovations: psychedelic-assisted therapy (MDMA-assisted therapy), ketamine therapy; 4. Complementary and somatic methods: eye movement desensitisation and reprocessing (EMDR), animal-assisted therapy (canine therapy) [13–16].

The extreme intensity of combat operations and persistent threat contribute to the formation of cumulative traumatic exposure, known as chronic operational stress. Insufficient systematisation of rotations and prolonged exposure of personnel to active combat zones without adequate recovery significantly increases the risk of delayed and chronic forms of PTSD. Although the aetiology of PTSD is directly linked to combat experience, its clinical manifestation and progression are substantially determined by extra-medical factors, including the quality of social support and the family and living environment. This makes PTSD not only a subject of military psychiatry but also a complex socio-governance issue requiring integrated management approaches.

The clinical manifestations of PTSD are traditionally grouped into four main clusters: intrusion (intrusive memories, flashbacks), avoidance (of trauma-related stimuli), negative alterations in cognition and mood, and changes in arousal and reactivity (hyperarousal). These criteria are defined both in the International Classification of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

In addition to the core categories of post-stress pathology, the scientific literature, as noted by O. Chaban, O. Khaustova, and V. Omelianovych, actively employs concepts describing conditions that do not meet full diagnostic thresholds: 1. Partial (subthreshold) PTSD: this term is used for patients who exhibit clinically significant post-traumatic symptoms but whose constellation of symptoms does not reach the threshold for a full PTSD diagnosis; 2. Complex PTSD (CPTSD) (ICD-11 code 6B41): this nosological entity is used to classify conditions resulting from prolonged and repeated trauma exposure (e.g., sustained combat operations). CPTSD is characterised not only by core PTSD symptoms but also by significant disturbances in self-organisation [18].

The etiological factors of PTSD in military personnel are multiple; however, the most significant triggers that act as a direct precipitating cause of the condition are the death of fellow soldiers or the necessity to use lethal force with its corresponding psychological consequences. During a traumatic event, the individual experiences an extreme state of fear combined with a total loss of control over the situation. The clinical manifestation of PTSD develops in a delayed manner, usually approximately one month after the traumatic incident. However, the post-traumatic continuum begins much earlier: within the first 48–72 hours, pronounced symptoms of acute stress reaction are observed; in the following days, signs of acute stress disorder may be diagnosed [19].

The clinical symptomatology of PTSD in military

personnel is characterised by a multidimensional spectrum of disturbances: recurrent memories of the traumatic event (intrusions, flashbacks, nightmares; strong emotional and/or physiological reactions); hyperarousal and sleep disturbances; avoidance of trauma-related reminders; increased anxiety, a need for excessive control, and heightened vigilance; nightmares often related to the traumatic situation; memory impairments; loss of interest in usual activities; emotional instability; and detachment from others, including close relatives and family members [19].

In 2019, a comprehensive medico-social study conducted by O. Lashyn identified significant deficits in the healthcare system for military personnel. It confirmed the absence of an integrated, structurally and functionally interconnected system of measures encompassing detection, assessment, treatment, rehabilitation, and prevention of PTSD. This created an urgent need for scientific substantiation and the development of new methods and comprehensive interventions for managing PTSD.

Particular attention in the study was given to the description of the “Hybrid War Syndrome”. It was found that in its development, the place and timing of the crisis acquire specific characteristics, as conventional and non-conventional actions occur against the backdrop of the predominant role of informational, psychological, and cognitive influences. Unlike the Gulf War Syndrome (which involves multisystem damage affecting the central nervous system, gastrointestinal tract, heart, liver, immune, endocrine systems, bones, and skin), the pathogenesis of “Hybrid War Syndrome” revealed for the first time a pronounced ophthalmological pathology (damage to the visual analyser in more than 90% of patients).

The key aggravating factor sustaining the development of PTSD and sensory system damage is informational and cognitive trauma, reinforced by almost constant continuous overload of sensory systems. Physical and physiological manifestations were recorded in 75% of cases and included headaches, dizziness, physical weakness, somatic pain, nausea, and dysfunction of internal organs.

The clinical picture of the syndrome is also characterised by:

- Psychological and psychosocial disorders: personality and reactive anxiety, reduced emotional stability, sexual dysfunction and interpersonal problems (including family breakdown), addictive disorders (alcoholism, drug addiction, gambling, and a return to extreme activities);
- Socio-psychological manifestations: reduced self-esteem, decreased social adaptability, and reduced frustration tolerance;

- Physiological and somatoform disorders: predominance of sympathetic over parasympathetic nervous system tone, haemodynamic changes, and increased activity of the sympathoadrenal and hypothalamic-pituitary-adrenal systems. Severe somatoform disorders with predominant localisation of bodily sensations are combined with psychovegetative paroxysms in the cardiovascular (54%), gastroenterological (26%), and cerebral (20%) anatomical domains;

- Metabolic changes: increased transport forms of lipids in the blood with a shift in the lipoprotein spectrum towards atherogenic fractions [20].

The socio-economic effectiveness of the implemented differentiated approach was confirmed by the analysis of medical indicators. Among the key achievements, the following were recorded: 1. Reduction in treatment duration: the average length of hospital stay in the psychiatric clinic decreased by almost 25 bed-days, from 45.97 bed-days in 2015 to 21.08 in 2016, and remained at a low level in subsequent years (23.54 in 2017, 21.21 in 2018). This reduction in hospitalisation days and minimisation of treatment volume, particularly pharmacotherapy (due to early intervention at the pre-PTSD stage), resulted in decreased state expenditure on inpatient care; 2. Improvement in rehabilitation outcomes: the proportion of medical leave granted due to health status (ICD-10 code F43.0) decreased from 10.4% in 2015 to 5.8% in 2018. At the same time, the proportion of service members returning to military units for further service increased significantly, from 36.3% in 2015 to 64.5% in 2018; 3. Reduction in disability rates: the proportion of military personnel discharged from the Armed Forces due to mental health conditions decreased almost twofold, from 46.6% in 2015 to 21.2% in 2018 [20].

A particular scientific interest is the study by O. Venger, aimed at assessing the prevalence of depressive symptoms. The study differentiated participants into two groups based on the duration of combat experience: Group 1 (up to three months of participation) and Group 2 (more than three months). Depressive symptoms were identified in 31% and 53% of individuals, respectively.

Overall, participants in Groups 1 and 2 exhibited the following symptoms: depressed mood (55.3% and 66.7%); anhedonia (77.3% and 83.3%); fatigue (51.5% and 65.8%); pessimism (21.2% and 31.7%); feelings of guilt, worthlessness, anxiety, or fear (78.0% and 87.5%); low self-esteem (21.2% and 31.7%); impaired concentration and decision-making ability (25.8% and 43.3%); thoughts of death or suicide (25% and 35.8%); fluctuating appetite and weight changes (17.4% and

24.2%); and sleep disturbances (47% and 61.7%) [21].

The assessment of psychopathological symptomatology using the SCL-90-R (Symptom Checklist 90-Revised) conducted by O. Venger revealed a clear positive correlation between the length of military service and the intensity of psychopathological manifestations in service members. In particular, the group with longer service experience demonstrated statistically higher scores across several key syndromal scales. The dominant manifestations included increased somatisation, obsessive-compulsive symptoms, heightened interpersonal sensitivity, pronounced depressive states (often combined with phobic reactions), as well as elevated levels of hostility, anxiety, and paranoid ideation [21].

The study conducted by I. Klymenko, O. Shelestova, and N. Naumenko provided an objective analysis of the distribution of psychological trauma among former prisoners of war. The authors' conclusion that the findings are critically important for the development of individualised rehabilitation and psychological support strategies for this specific category of victims is well substantiated and should be supported.

A study of a group of 50 former military prisoners revealed an extremely high level of psychotraumatic exposure: acute stress reactions were recorded in 94% of respondents. The leading traumatic factors included physical violence (100%), social degradation/disrespect (82%), and emotional aggression (80%). The rate of sexual violence was 24%, although this figure may be underestimated due to socio-cultural barriers and gender-specific perceptions of trauma.

It was established that dissociative experiences are determined directly by the experience of captivity (physical torture and neglect), rather than by individuals' pre-traumatic history [22]. Dissociative symptomatology was diagnosed in 25% of former prisoners of war, with the leading manifestation (38%) being intense reminiscences. High levels of amnesia and cognitive immersion correlated with the use of dissociation as an adaptive defence mechanism to reduce psychological distress.

Within the diagnostic structure, depersonalisation-derealisation syndrome (10%) and dissociative disorders with neurological symptoms (8%) were predominant. Less prevalent were dissociative amnesia (6%), trance states, and identity disorders (2–4%). The similarity of these symptoms to PTSD intrusion criteria confirms the complexity of differential diagnosis and the need for a multidisciplinary approach to the rehabilitation of this group.

A longitudinal analysis conducted three months after liberation showed positive dynamics: the overall prevalence of dissociative disorders decreased by

50%. The most pronounced regression was observed in depersonalization-derealisation syndrome (a 60% reduction) and dissociative neurological disorders (a 50% reduction). The statistical significance of the improvement in mental health status was confirmed using McNemar's test ($p < 0.05$) [22].

These findings indicate a complex architecture of the dissociative spectrum in former prisoners of war and highlight the need to develop adaptive, individualised rehabilitation protocols.

CONCLUSIONS

Ukraine's veteran resocialisation policy represents a unique precedent of significant importance for stabilising the European security space. Timely treatment of combat-related trauma serves as an instrument for preventing cross-border risks, ranging from increased crime and drug abuse to migration-related pressure on healthcare systems in partner countries. To minimise transnational risks and ensure regional resilience, the implementation of a decentralised multidisciplinary rehabilitation model is advisable. This model is based

on the synergy of clinical PTSD treatment protocols and flexible governance decisions by local self-government bodies. It envisages the creation of an inclusive environment within territorial communities, ensuring continuity of care and early detection of maladaptation.

The economic efficiency of this approach is driven by a shift from costly, isolated inpatient treatment to preventive community-based interventions. Maximizing veterans' social capital and implementing alternative sentencing programmes instead of penitentiary isolation significantly reduces public expenditure on prison maintenance and the treatment of chronic conditions. Thus, the model transforms the rehabilitation process from a budgetary cost item into an instrument of socio-economic stabilisation and strengthening of the security framework.

The experience of Ukrainian medical professionals in treating complex forms of PTSD using innovative methods is shaping new standards in military psychiatry. Given the participation of foreign volunteers in combat operations, these developments are becoming a foundation for updating rehabilitation protocols within the medical systems of NATO and the European Union.

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CONFLICT OF INTEREST

The Authors declare no conflict of interest

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