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Combat stress within the Polish Armed Forces

Introduction

With a high degree of probability, one can claim that among the many unpleasant experiences of any human being, the most traumatic one is related to active participation in an armed conflict. Having said this, every war, apart from the human ordeal it causes, can still contribute to the development of humanity. Polish General Władysław Sikorski once said that "from the earliest days of human existence, and ever since the history of the humankind came to the fore, war has been regarded as one of the principles of human development."[1]

The earliest references to mental disorders can be found in Homer's *Odyssey*, in the poetic records dating back to the eighth century BC. This piece of literary art describes the experiences of Odysseus, a veteran of the Trojan War, who experiences the reminiscences of war trauma. In 1871, Jacob Mendes Da Costa described the "soldier's heart" syndrome in his notes on the American Civil War.[2]

One of the chronicles by William Shakespeare, which dates back to around 1596, looks at the fate of Henry IV, the then king of England. The monarch, after

[1] W. Sikorski, *Przyszła wojna*, Wydawnictwo MON, Warszawa 1984, p. 29.

[2] A. Holiczer, M. Gałuszko, W.J. Cubała, *Zaburzenie stresowe pourazowe – opis ewolucji koncepcji zaburzenia i podejść terapeutycznych*, "Psychiatria" 2007, vol. 4, no. 1, p. 25.

coming back from the war, experienced nightmares and avoided everything that would remind him of any possible traumatic situation. A few decades after Shakespeare, Robert Burton, a seventeenth-century humanist, in his *Anatomy of Melancholy* (1621), looked at the psychological consequences of traumatic events. A witness to the plague epidemic of 1665 and the Great Fire of London a year later, Samuel Pepys, in his *Diary*, recorded his experiences related to bringing back a variety of traumatic events.[3]

During the American Civil War (1861–1865), the stress of fighting was called "the irritable heart", or "the soldier's heart syndrome", or "Da Costa's syndrome." Its key symptoms were shortness of breath, heart palpitations, headaches, fatigue, sleep disorders, as well as a feeling of homesickness and nostalgia. It was accompanied by severe apathy, a loss of appetite, diarrhoea, and obsessive thoughts related to home. During the Civil War, about 2,500 cases of mental disorders – chiefly mental insanity – and almost 5,000 cases of nostalgia were diagnosed, which ended in hospital treatment. To this number, one should add about 200,000 deserters, and 160,000 cases of severe disorders of the human digestive system, referred to as the "precombat syndrome." [4] Overall, about 3 million soldiers fought in the Civil War, of whom 970,000 were killed or seriously wounded. Those who survived reported serious physical or mental health problems later in life. The youngest soldiers from the sub-units that suffered the greatest losses on the battlefield were those most exposed to this kind of health issues.[5]

In their 1945 book *Men under Stress*, Roy R. Grinker and John P. Spiegel look at the symptoms revealed in American airmen fighting in World War II, the major ones being anxiety, irritability, aggression, sleep disturbances, nightmares, chronic fatigue, and attention deficit disorders.[6]

However, the crux of the actual and diagnosed issue related to symptoms of post-traumatic stress disorder (PTSD) was found in US soldiers who fought in Vietnam, when in 1989 the US government decided to set up the National Center for PTSD within the Department of Veterans Affairs in response to a Congressional mandate to address the needs of Veterans and other trauma survivors with PTSD. The centre was developed with the ultimate purpose to enhance the well-being, status, and understanding of Veterans in American society.[7] Major

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3 M. Makara-Studzińska, I. Partyka, P. Ziemecki, *Zespół stresu pourazowego – rys historyczny, terminologia, metody pomiaru*, "Current Problems of Psychiatry" 2012, vol. 13, no. 2, pp. 109–112.

4 A. Korolczuk, A. Gołębiowski, M. Tomko-Gwoździewicz, *Od nostalgii do PTSD*, "Zeszyty Naukowe WSOWL" 2009, no. 3 (153), p. 116.

5 *Ibidem*, pp. 116–117.

6 A. Holiczer, M. Gałuszko, W.J. Cubała, *op. cit.*, p. 25.

7 *VA History*, United States Department of Veterans Affairs, https://www.va.gov/HISTORY/VA_History/Overview.asp [accessed: 19.08.2022].

emphasis was also placed on those serving in Iraq and Afghanistan. The data on the percentage of symptoms, both on the battlefield and after returning to the homeland, vary. For example, Henryk Skłodowski and Paweł Błaszczyński, in their research paper entitled *Combat stress: history and present. The Polish perspective*, referring to the 2004 publication by Charles W. Hoge *et al*.,[8] argue that the veterans who underwent treatment following the subsequent wars were, for example, "1.2% in Vietnam (but as many as 16% sought treatment after returning home) and 2% in Iraq, while 17% of the US infantry serving in Iraq admitted to having significant stress symptoms 3–6 months after returning home." Thus, it seems legitimate to claim that the majority of victims report their problems not in the war zone, but only after coming back home.[9]

At the same time, the already mentioned Department of Veterans Affairs, on its website, devotes a lot of space to both the problems related to the origins, diagnosis and assistance provided to victims of PTSD. On it, one can also find abundant statistical references that serve to select the appropriate way to tackle the problem. For example, the authors of the article *PTSD in Iraq and Afghanistan Veterans* estimate that during the Enduring Freedom and Iraqi Freedom operations, 15.7% of the veterans who took part directly in the mission area (i.e. deployed veterans) confirmed symptoms of PTSD, compared to 10.9% of the soldiers not involved in the warfare during those operations. At the same time, as a whole, in their research, representatives of the Department estimate that about 13.5% of all the surveyed soldiers were found positive for PTSD.[10]

French physiologist Claude Bernard (1813–1878) is commonly referred to as the forerunner of the theoretical insights into the notion of stress. In the nineteenth century, he argued that there are certain defence mechanisms within the human body the interaction of which allows it to combat a vast array of threats, and thus to stay alive. Decades later, these assumptions became the cornerstones for the work of American physiologist Walter Cannon (1871–1945), known as the creator of the theory of homeostasis, i.e. the ability to remain the same.[11]

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8 Ch.W. Hoge *et al.*, *Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care*, "New England Journal of Medicine" 2004, vol. 351, no. 1, pp. 13–22.

9 H. Skłodowski, P. Błaszczyński, *Stres bojowy: historia i współczesność. Perspektywa polska*, "Psychiatria i Psychologia Kliniczna" 2013, vol. 13, no. 2, p. 127.

10 *PTSD in Iraq and Afghanistan Veterans*, United States Department of Veterans Affairs, https://www.publichealth.va.gov/epidemiology/studies/new-generation/ptsd.asp [accessed: 19.08.2022].

11 A. Potocka, *Stres – natura zjawiska*, [in:] M. Waszkowska, A. Potocka, P. Wojtaszczyk, *Miejsce pracy na miarę oczekiwań: poradnik dla pracowników socjalnych*, Oficyna Wydawnicza Instytutu Medycyny Pracy im. prof. J. Nofera, Łódź 2010, p. 11.

The nature and typology of stress

In the modern age, the notion of stress has become a separate field of research within the larger domain of psychology. Issues related to stress have been subjected to numerous theoretical models that explicate the aetiology, dynamics and mechanisms of burnout, as well as those that facilitate planning and a vast array of other actions geared towards counteracting this negative phenomenon.

Władysław Łosiak notes that the influence of the social environment is not always beneficial, especially in the context of social support. Often, the presence and actions of other people is a source of stress. The circumstances in which this interaction takes place revolve primarily around the workplace. The issue of stress in the workplace is of primary importance, given the role work and professional activity plays in the life of adults. The impact of the social environment at work is associated with such basic stressors as excessive demands, competition, poor management styles, role ambiguity, or mobbing.[12]

Stress is inextricably linked to the life and work of every human being. It affects all spheres of the functioning of the individual mind and body. "Good" stress, also known as eustress, mobilises and motivates people to take action and achieve their set goals. This said, excessive or chronic stress has a variety of negative consequences in the form of health disorders that significantly worsen human functioning and reduce the quality of one's personal and professional life. Nowadays, the importance of stress and its effects are gaining momentum, as evidenced by numerous studies and publications that deal with the notion. The UN has called occupational stress "the global epidemic of the twentieth century."[13]

The Dictionary of Psychology, in its definition of stress, distinguishes two types of stress. The former is physiological stress, which means that the body responds to it with various factors, such as cooling, overheating, or injury. The latter is psychological stress, which is caused by a stressor, i.e. an internal or an external stimulus, or by an increase in emotional tension, which leads to the mobilisation of forces, and this, in turn, leads to psychosomatic diseases and exhaustion.[14]

Stress is defined very broadly. There are many definitions of this concept in various fields of science. One can even call it a disease of the civilisation of the twenty-first century. In the media, primarily on the Internet or in the press, a lot of attention is drawn to long-term stress, which has a destructive effect on human physical and mental health.

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[12] W. Łosiak, *Psychologia stresu*, Wydawnictwa Akademickie i Profesjonalne, Warszawa 2008, p. 170.

[13] K. Jabłkowska, A. Borkowska, *Ocena nasilenia stresu w pracy a cechy zespołu wypalenia zawodowego u menadżerów*, "Medycyna Pracy" 2005, vol. 56, no. 6, p. 439.

[14] *Słownik Psychologiczny*, ed. W. Szewczuk, Wiedza Powszechna, Warszawa 1985, p. 297.

PTSD: the essence of the problem

Traumatic stress is the cause of destructive changes that occur in the body. Psychological injuries differ from physical injuries only in that the former cannot be seen with the naked eye.

Since 1980, the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification of the American Psychiatric Association (APA), currently in the DSM-5 revision, has included PTSD. Maria Lis-Turlejska believes that PTSD, according to the DSM-IV class, is epitomised by the following factors:

a) exposure to life-threatening experiences;
b) re-enactment of trauma;
c) persistent avoidance or decrease in overall reactivity, and
d) persistent symptoms of increased agitation.[15]

Charles R. Figley and William P. Nash distinguish several groups of stressors that can be found on the battlefield. The five basic ones include:

1) physical stressors: heat and cold, dehydration and dampness, dirt and mud, sleep deprivation, noises and explosions, fumes and bad smell, bright light and darkness, poor nutrition, illness and injury;
2) cognitive stressors: lack of information or excess of information, ambiguous or changing task or role, ambiguous or changing rules of engagement, loyalty conflicts, boredom and monotony, experiences that seem meaningless;
3) emotional stressors: loss of friends caused by death or fatal injuries, fear, shame and guilt, helplessness, horror of massacre, killing;
4) social stressors: isolation from social support, lack of privacy and/or personal space, the media and public opinion;
5) spiritual stressors: loss of faith in God, inability to forgive or to experience the emotion of having been forgiven.[16]

The most common symptoms include isolation from the environment, excessive and inadequate responses to various stimuli, e.g. outbursts of anger, flashbacks: extremely vivid and intense memories of the course of a traumatic event that occur independently of one's free will, nightmares associated with a traumatic situation, anhedonia: inability to feel pleasure, avoiding situations that may evoke memories related to the situation that has caused the trauma, suicidal thoughts, sleep disorders, palpitations, headaches, rapid breathing, and lack of appetite.[17]

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[15] M. Lis-Turlejska, *Stres traumatyczny. Występowanie, następstwa, terapia*, Wydawnictwo Akademickie "Żak", Warszawa 2002, p. 9.

[16] Ch.R. Figley, W.P. Nash, *Stres bojowy. Teorie, badania, profilaktyka i terapia*, transl. by J. Radzicki, M. Höffner, M. Dragan-Polak, Wydawnictwo Naukowe PWN, Warszawa 2010, pp. 23–35.

[17] M. Wysokińska, *PTSD (zespół stresu pourazowego) – objawy, leczenie, przyczyny*, Medicover, https://www.medicover.pl/zdrowie/psychiczne/ptsd/ [accessed: 26.06.2022].

Diagnosis is carried out by psychologists, including psychotraumatologists, or psychiatrists. Structured interviews, scales and questionnaires are used in diagnostics, including Solomon's PTSD questionnaire, Goldstein's PTSD interview, Card's questionnaire, and Foy's questionnaire.

The medical criteria of PTSD

The diagnostic criteria of ICD-10 and DSM IV-TR are similar. Both classifications assume the occurrence of common elements, such as a recurrent experience of trauma, avoidance of the stimuli associated with it, and excessive emotional arousal. Also, both classifications posit that the cause of the injury is known and it is (point A in ICD-10) an event or a situation that is extremely threatening or catastrophic which can cause suffering to almost everyone, and (also point A) in DSM IV, which refers to the confrontation with a threat (A1), also as a witness to a particular event, and in point A2 adds specific reactions, including fear, a sense of helplessness or horror. The criterion of recurrence – a recurrent trauma experience in ICD-10 is criterion B. It includes triggering of the stressor in the form of flashbacks, memories, dreams, or deteriorated well-being in a stress-like situation. These symptoms are also included in the DSM IV category. Both classifications in point C contain descriptions of avoiding trauma-related stimuli. The DSM IV classification emphasises the presence of blunting, a reduction in overall reactivity. The criterion of overstimulation, expressed in ICD-10 in point D2, is equivalent to point D in DSM IV and focuses on symptoms such as sleeping disorders, irritability, outbursts of anger, difficulty concentrating, hypervigilance, and increased reactions to surprises. The criterion of the time elapsed from the injury to the beginning of the disorder is important (point E, both classifications). In the case of DSM IV, this is the duration of symptoms that exceed one month. In ICD, this criterion refers to the duration of symptoms beyond 6 months, rarely longer. In the DSM IV, the criterion of patient disruption is still present, while it does not occur in the ICD-10.[18]

Systemic solutions in Polish Armed Forces

In fact, the issue of battlefield stress in the Polish Armed Forces began to be noticed by commanders and on individual levels of command of the armed forces during the first shift of the stabilisation mission in Iraq. One cannot claim that the first cases were underestimated by the top-rank officers, but one could argue that they were neglected given the poor awareness of the seriousness of the problem. Soldiers with clear symptoms of the disorder were removed from direct duty and

[18] M. Makara-Studzińska, I. Partyka, P. Ziemecki, *op. cit.*, pp. 109–112.

rotated to the country with the entire shift, i.e. in the normal rotation mode. However, the number and further consequences forced the superiors to change their approach and strive to seek comprehensive solutions to the problem, starting from proper preparation of commanders and soldiers themselves during the training programmes through further changes implemented along the way and during the mission itself. Solutions were sought both in the formal and legal domains, by e.g. regulating these issues in relevant pieces of legislation and in the various decisions of the Polish Ministry of National Defence, as well as by launching a reporting system – by registering the reporting cases – and commencing the treatment of the injured.

Current systemic solutions in this scope concern several levels, starting with properly empowered full-time and non-permanent structures at individual levels of command and control, the entire area of care of veterans or soldiers diagnosed with symptoms of PTSD, monitoring and reporting those suspected of possible symptoms, and devising a training system for soldiers and commanders, in particular, before they set out on foreign missions.

Before moving on to a more detailed analysis of the provisions of formal and legal documents, which contain an outline of the tasks for the individual structures and those responsible for the above issues at all organisational levels, it is worth specifying the units and the people operating at the individual levels of the structure of the military forces.

Analysing the system at the level of the Ministry of National Defence, one will find the Department of Social Security of Soldiers and Veterans, which was located in the Department of Social Affairs. In general, the Department "is responsible for the functioning of the social security system, the military pension scheme and conversion assistance, and the formation of the employment and wage system of the staff."[19] Within its competences, the Department of Social Security of Soldiers and Veterans is in charge of coordinating the issues that may arise from the Veterans' Service Beyond the State Borders Act of 19 August 2011; thus, the issues related to PTSD have been featured in the Act.

Similarly, also at the level of the Ministry of Defence, one can come across various provisions regarding the responsibility in the care of veterans and soldiers who require psychological assistance in the Department of Military Health Service. The preamble of the scope of the tasks set for this Department contains a provision that reads: "[t]he Department of Military Health Service is responsible for setting the goals and directions of the development and functioning of the health care system and psychological care. The aim of the Department is to create proper conditions for the functioning of the health care system and psychological assistance in the

[19] *Departament Spraw Socjalnych*, https://www.gov.pl/web/obrona-narodowa/departament-spraw-socjalnych [accessed: 1.08.2022].

ministry for those on duty, the staff, veterans and injured veterans."[20] What follows is a more detailed list of the tasks set for this Department:

"1) setting guidelines and goals for the development of the health care system and psychological assistance at the ministry;
2) defining standards of health protection and psychological care, production, storage and marketing of medicinal products and medical devices, as well as sanitary-hygienic and veterinary protection schemes at the ministry;
3) preparing bills at the ministry that regulate the organisation and functioning of health care and psychological assistance, and monitoring legislation in this area;
4) developing health, psychological and preventive schemes; implementing them, and monitoring their implementation;
5) organising health care and psychological assistance within the ministry."[21]

The Director of the Department of Military Health Service reports directly to the Central Military Psychological Laboratory, five Regional Military Psychological Laboratories, and thirty Military Psychological Laboratories.

Below the level of the Ministry of National Defence within the Polish Armed Forces, there are specially designated representatives for veterans' affairs. At the Armed Forces Branches General Command (Pol. Dowództwo Generalne Rodzajów Sił Zbrojnych, DG RSZ) and the Armed Forces Branches Operational Command (Pol. Dowództwo Operacyjne Rodzajów Sił Zbrojnych, DO RSZ), there are the only full-time positions; in other institutions one can find non-full-time positions. They are assisted by consultants of the commander for psychological prevention. In addition, the representative of the DO RSZ also performs his function for the veterans who have been injured in civilian life. At the military unit level, Veterans Assistance Coordinators work on a part-time basis.

Clearly, discussing the issue of post-traumatic stress or battlefield stress, one should primarily look at veterans (participants of foreign missions), but one should also take into account all the soldiers and staff of the Ministry of National Defence serving and working in the country. All the more so in the current era of technological development, or the experience of the last three years of the COVID-19 pandemic, stress can affect anyone who has been exposed to problems that they are unable to cope with on their own.

The salient role in the entire system of recognising the first symptoms of post-traumatic stress disorder is played by the psychoprophylactic tier found in military units, psychologists in psychological clinics, and superiors or colleagues who are usually the first ones to notice any possible symptoms. Of course, we are looking at the same time at military units stationed in the country and those military units that have been sent

[20] *Departament Wojskowej Służby Zdrowia*, https://www.gov.pl/web/obrona-narodowa/departament-wojskowej-sluzby-zdrowia [accessed: 1.08.2022].

[21] *Ibidem*.

to serve in foreign operations. The only difference may be the fact that it is not always the case for psychologists of military units, who know their soldiers by working with them or spending time with them on a daily basis in their unit, to travel with their unit to the area of the foreign operations. In this case, however, they participate in the whole process of preparation – as a rule, from 6 to 12 months, depending on the nature of the mission – trying to get to know all the soldiers, while cooperating with various psychologists of the military units from which the soldiers originate.

Rules for dealing with PTSD

Post-traumatic stress disorder is diagnosed on the basis of current diagnostic standards – DSM-5[22] and ICD-10.[23] PTSD can occur in the aftermath of the situations mentioned above and affect soldiers, police officers, rescuers or people experienced by such an event.

In the case of PTSD symptoms – i.e. recurring and persistent memories, dreams featuring a traumatic event, or a wide array of dissociative reactions – one begins to behave as if they were still experiencing the event: their mood can change dramatically, they try to avoid similar situations or do their best to keep those that may remind about the trauma at bay. People suffering from PTSD can manifest the following symptoms: hypervigilance, poor concentration, self-destructive behaviour, irritability, and sleep disorders.

As regards the above disturbing symptoms in a soldier, which can be observed by people who are not psychotraumatologists or psychiatrists, they first consult a psychologist employed in a given military unit. It is extremely important that the consultation takes place at the request of the person concerned or their immediate superior, who has been informed about the situation by other soldiers, or who has noticed the problem himself. The goal of such a consultation is to carry out a preliminary analysis of the reported problem and make an attempt at determining the next steps.

If a military psychologist confirms the symptoms that may be indicative of PTSD, an interview should take place with the immediate superior and/or commander of the unit in order to possibly remove the soldier from those duties in which the use of firearms is required.

Depending on the attitude – cooperative or resistant – of the soldier, the psychologist may try to undertake therapeutic work as part of a psychological consultation centre in the unit, or refer the soldier to external institutions, such as Mental Health Clinics, Psychotherapeutic Centres, or Psychiatric Hospitals with the simultaneous

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[22] *Diagnostic and statistical manual of mental disorders*, 5th ed., American Psychiatric Association, Arlington, VA 2013.

[23] International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version 2019, https://icd.who.int/browse10/2019/en [accessed: 1.08.2022].

regular delivery of certificates from a specialist that prove the treatment undertaken and continued. At the same time, in the absence of cooperation on the part of the person affected by PTSD, it is possible to refer a medical commission for examination to assess the state of this individual's mental health. At this point, it should be remembered that each case is considered separately, as the overriding goal of the procedure is to improve the mental state of the person affected by the disorder.

While a whole system of support and management after the detection of symptoms has been organised, there are no normative guidelines that regulate actions in the event of PTSD symptoms. The actions taken by the psychologist is based primarily on his experience and expertise.

Legal aspects

An extremely important problem that allows to monitor the scale of the problem and thus to provide an appropriate response at all levels of management, command and support for the victims is the reporting system that serves to keep a record of the cases identified. In accordance with Decision no. 155 of Minister of National Defence of 26 October 2021 regarding the organisation and functioning of psychological care and assistance at the ministry, introducing specific guidelines for the activities of psychologists and providing psychological assistance at the ministry, as well as the psychological assistance scheme for participants of foreign missions, and their families,[24] it deals with transferring this type of data "upwards", i.e. from the lowest levels of command to the Ministry of National Defence upwards through all the intermediary levels. This is carried out both in the cycle of ordinary reports about events, as well as the information contained in the so-called reports on people's moods, and ending with annual reports, carried out both in the country and in missions performed abroad.

Two paths are especially important. The first one rests on the information contained in quarterly reports on moods. It is true that there is no special point dedicated to PTSD, but part 1 point 3 makes explicit reference to "[s]ocial moods against the background of social and living and material-technical conditions of service and work", which covers, among other things, the problems related to PTSD and veterans.

[24] Decyzja nr 155/MON Ministra Obrony Narodowej z dnia 26 października 2021 r. w sprawie organizacji i funkcjonowania opieki psychologicznej w resorcie obrony narodowej, wprowadzenia wytycznych do działalności psychologów i wykonywania opieki psychologicznej w resorcie obrony narodowej oraz programu opieki psychologicznej dla uczestników misji poza granicami państwa i ich rodzin, Dziennik Urzędowy Ministerstwa Obrony Narodowej [Official Journal of the Ministry of National Defence] 2021, item 235.

The second path is dedicated to this issue and has been set out in Decision no. 155 of Minister of National Defence. It concerns the aggregate numerical data for units that are provided by all units to the psychologist coordinator from the General Command as part of annual reports and further upwards to the Department of Military Health Service. Similarly, such a report is drawn up at the end of each shift in the framework of activities outside the country.

An important element of the support system or care for veterans, including the area of PTSD, is the Centre for Veterans of Activities Outside the State,[25] which reports to the Department of Social Affairs of the Ministry of National Defence. It offers help and the opportunity to get assistance, in particular with regard to the legal and psychological nature of the problem in question. In addition, the Centre for Veterans of Activities Outside the State has published a comprehensive booklet entitled *Veteran's guide: the rights of veterans who have served outside the state*.[26] The booklet is a guide to the areas that can significantly help every veteran and injured veteran: starting from obtaining the status of a veteran or injured veteran to the issues related to their honouring, their benefits and/or entitlements, and many more. Of primary importance are parts 5 and 6 of the guide, where those interested can find information on psychological assistance and health care benefits.

The system was complemented by the establishment of the Centre for the Treatment of Veterans Serving Outside the State (Pol.: Centrum Leczenia Weterana). The centre was set up in August 2021 at the Provincial Medical Institute and its key goal is to provide professional and comprehensive care and assistance to veterans, including veterans and soldiers affected by the symptoms referred to in this article. The very idea of launching the centre is not at all new, but it has rather finalised many years of experience in this area, dating back to 2009, regarding comprehensive care for injured veterans. There is no doubt that this place has in itself a huge therapeutic potential that will ensure proper diagnosis and comprehensive treatment, including PTSD.

The key goals of the Centre, based on its mission statements, are:

"1) to provide professional and comprehensive care for injured veterans by improving access to health care for veterans injured in activities outside the state;
2) to run an information and coordination point to help to obtain proper support in the process of coordinating the acquisition, security, implementation of medical services;
3) to conduct activities related to health education related to the reduction of disability among injured veterans;

[25] *Centrum Weterana Działań poza Granicami Państwa*, https://www.wojsko-polskie.pl/weterani/ [accessed: 3.08.2022].

[26] *Poradnik Weterana – uprawnienia weteranów działań poza granicami państwa*, Warszawa 2022, https://www.wojsko-polskie.pl/weterani/u/de/cf/decf6234-cb0b-45b0-815e-2fab33885414/poradnik_weterana_luty_2022_-_interaktywny.pdf [accessed: 3.08.2022].

4) to conduct activities related to health education, including in the area of psychology;
5) to provide psychological support for veterans and their families; as part of the Veteran's Treatment Centre, the implementation and development of an integrated model of psychiatric and psychological interactions shall be continued;
6) to monitor the availability of the types and ranges of services offered."[27]

The system of diagnosis, care and reporting presented above requires localisation in formal and legal documents, as well as the legislative process. The first legal basis in the above matter goes back to 2011, i.e. the Veterans Serving Outside the State Act of 19 August 2011,[28] which originally specified such issues as e.g. health care services and psychological assistance for veterans and their families. A particularly important provision was Section 23 of the Act, which unambiguously interpreted the principles of free psychological assistance:

In Section 23 (1), one can read that "[a] veteran-soldier or an injured veteran-soldier and the closest members of his/her family have the right out of turn to free psychological assistance provided by psychologists in military units and by military psychological laboratories, as well as to that provided in health care institutions established and supervised by the Minister of National Defence, if the soldier's health problems are related to his/her service outside the state."[29] At the same time, Section 23 (4) of the Act states that "[t]he Prime Minister, the Minister of National Defence and the minister responsible for internal affairs, each within the scope of their competences, shall determine, by virtue of a relevant regulation: 1) the manner in which psychological assistance shall be provided, and its scope, and 2) the manner and procedure for monitoring the implementation of the right of injured veterans to get assistance referred to in paragraphs 1–3, and the competence of the authorities in this respect, with a view to ensuring efficient access to psychological assistance and its implementation adequate to the needs of veterans."[30]

While the Act has sanctioned the issue of soldiers with symptoms of post-traumatic stress disorder to a basic extent, after the stabilisation mission in Iraq, and in the extremely difficult period of the mission in Afghanistan, the year 2021 brought the latest well-established formal and legal foundations in the field of assistance and psychological care originating at the Ministry of National Defence. Here, particular focus ought to be placed on Decision no. 155 of Minister of National Defence.[31] The above decision has been discussed in more detail with regard to the area of post-traumatic

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[27] *Centrum Leczenia Weterana*, p. 3, https://wckmed.wp.mil.pl/pl/pagescentrum-leczenia-weteranax/pdf/ [accessed: 3.08.2022].

[28] Ustawa z dnia 19 sierpnia 2011 r. o weteranach działań poza granicami państwa, Dz.U. [Journal of Laws of the Republic of Poland] 2011, no. 205, item 1203.

[29] *Ibidem*, Section 23 (1).

[30] *Ibidem*, Section 23 (4).

[31] Decyzja nr 155/MON Ministra Obrony Narodowej..., *op. cit*.

stress. For the sake of clarity, it is worth mentioning the tasks in the area of psychological care at the Ministry of National Defence are carried out by:

1) in the field of social psychology: psychologists of military units and psychologists-coordinators;
2) in the field of labour psychology: psychologists of military psychological laboratories;
3) in the field of clinical psychology: psychologists of a military medical institute, a military hospital, a military spa and rehabilitation hospital, or a specialist military medical clinic.

The above mentioned Decision of the Minister of National Defence lays down the responsibilities and tasks at all the individual levels of command in the Polish Armed Forces, and the tasks assigned to individual institutions and persons functioning within the overall system. A major guideline for the actions taken by psychologists working at military units is also the Polish Mental Health Act of 1994.[32]

Conclusions

One does not need to wear a military uniform to get an idea of the vast array of stressors that modern war provides. The stressors themselves only partially explain the impact of war on people. It is equally important to understand the contemporary attitudes, beliefs and expectations that dominate military units as part of their common culture and traditions.

The specific stressors of combat and military operations are an area that has been largely neglected in empirical research conducted thus far. Most clinical work, of course, has focused on the experiences of those who have suffered from a negative reaction to combat and military operations, rather than on stressors affecting the entire population of soldiers fighting at the front.[33]

It is important to note that as part of the experience gained, both by serving in other armies and based on one's own experience from the first mission in Iraq, cases of PTSD have been diagnosed more and more often already in the mission area. This has allowed to reduce the number of such cases, but above all to mitigate their possible negative effects and facilitate the treatment itself after coming back home. At the same time, the awareness of how serious the situation is has led to the construction of a system that starts as early as during the preparation for each mission, and lasts throughout the mission until the soldiers and/or veterans return to their country of origin.

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[32] Ustawa z dnia 19 sierpnia 1994 r. o ochronie zdrowia psychicznego, Dz.U. 1994, no. 111, item 535, as amended; consolidated act: Dz.U. 2022, item 2205.

[33] Ch.R. Figley, W.P. Nash, *op. cit.*, pp. 15–16.

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Combat stress within the Polish Armed Forces

Abstract

The military forces usually conjure up the image of soldiers who serve in a given country, or those who carry out their duties in peacekeeping missions. They are frequently in the spotlight during their stay in the area of their operations and the performance of their duties. The memories of them and of any of the possible problems that they may encounter usually fade away once they have gone back to their country, or once they have returned to their parent unit. Interestingly, this rule also applies to other members of the military personnel. Service in the army, which frequently implies exposure to atrocities and ongoing hostilities, undoubtedly leaves its mark on people's physical and mental health, and it can also have a major impact on the lives of professional soldiers and their families. Paradoxically, the level of stress experienced increases as the sense of a real threat goes down. Being a soldier is one of those professions in which exposure to stress is high, and there is a major risk of post-traumatic stress disorder (PTSD), especially in those members of the armed forces who have taken part in foreign missions. This paper looks at the historical background of the phenomenon, its symptoms, its methods of diagnosis, as well as the entire system of monitoring, supporting and treating post-traumatic stress in the Polish Armed Forces. Such a study has been possible thanks to a thorough analysis of the applicable pieces of legislation, backed by an insight into a series guidelines, orders and dispositions given at all levels of command and supervision in the army.

Key words: stress, PTSD, soldier, Polish Armed Forces

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