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Short Communication

Anxiety and depression from military medical aspects

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Abstract

Anxiety and depression are the most common issues of mental health problems. In military medicine, healthcare professionals are facing even more of it because the military population is taken out to tasks that are more likely to lead to these kinds of symptoms and/or disorders even with attention, training, and preventive measures. The military medical system focuses on that and in special cases like disasters and pandemics the civilian side could also profit from its experiences.

Anxiety-based disorders and depression in mood disorders are said to have a higher ratio among the military population. Taking veterans and the complex military family as a system into consideration, millions of people are affected all over the world by mental health problems that are the responsibility of military medical services [1]. This may stem from the fact that they are taken out to significant stressors like deployment, combat, or relocations. In this sense, we have to pay attention to a quite large population. Nowadays local conflicts like the ones in the Ukraine or Israel make this more obvious and involve more and more people being affected, and emotionally involved in military operations.

Besides these from the 9/11 case, we have learned that one could be emotionally affected even when one is not presented on the scene. Big events could be traumatizing even through media, mainly TV and social media [2] which we call vicarious trauma. In these cases not the individual himself who is taken out personally by the traumatic event but could feel the whole emotional part of it. This "microsimulation" shows that availability and exposure to media coverage of mass traumatic events, particularly as social media becomes more ubiquitous, has the potential to increase community PTSD prevalence and depressive or anxiety-connected symptoms following these events even without being personally involved. That shows us, that military activity has a greater, long-term impact than we could think, it could have an impact on the whole society.

Anxiety and depression as symptoms and major mental health issues are the most common reactions to any kind of change and potentially traumatizing events. When they exist for a longer period after the event that evoked them, the symptoms are more serious and highly influence the individual's daily life. In the case of soldiers, there is the opportunity to prepare for those tasks and situations, we could make a long follow-up and - from the professional side – expect some changes in their mental health so their mental health issues are more observed than those in their civilian environment in the society.

In the case of soldiers we have special programs to help their preparation for their emotionally demanding tasks and the processing of potentially traumatizing events, and experiences in we could say every NATO and partner country, because a prepared, trained soldier is as valuable as a person and as an employee for the company either, we want to preserve his deployability as long as it is possible. We pay attention to

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the critical stages of the process in the well-prepared follow-up programs, which also have a focus on the military family. Contradictory to this help and special attention we could not avoid the development of mental health problems, but we have the opportunity to intervene in time and know where to put our focus or when to be prepared for a larger load of patients. Besides this, the military population has its specialties in symptoms and mental disorders. If we are taking the so-called delayed PTSD that is more common among the European military population [3] than the Americans [4] it is absolutely unique. In civilians, the delayed version usually appears at about 6 months and later than the event, in the military we can find examples of 1 – 1.5 years when the symptoms start to develop. The reason for that is the fact that a well-trained, experienced, older soldier has a longer and more efficiently functioning coping capacity, so can cope more effectively or can delay the harsh reactions in time and space. Usually, another not as obvious significant burden starts the process where the emotions, and memories slip over control and slowly turn into symptoms. Usually with depressive mood changes and anxiety. Of course, in these cases, there is always some kind of new burden that induces the process, but the symptoms and reactions refer to the original traumatic event. In most European NATO countries with similar military-medical, and military-psychological supporting systems psychologists at the troops can observe continuously the soldiers throughout the deployment cycle. This kind of care is also underlined by the NATO Standardization Agreements (STANAGs) [5,6] that are giving also some focus to the critical points. Moreover, we can say, that a well – carried out statistics or research on delayed symptoms could be valuable for the civilian medical community also. For this aspect, it is an unfortunate situation because, in most of the European NATO countries, the regulations do not allow to publish openly those collected data that has any connection to deployability.

In civilians before the COVID-19 pandemic, there was usually a need for cooperation between military medical and civilian medical services when there was an event connected to some kind of disaster, but after the pandemic, this has changed because a lot of phenomena that formerly could be detected only in military medical circumstances appeared in civilian too. Functioned as overwhelming mass casualty events, with hard triage, a lot of loss, helplessness, and grief, with moral injury [7] that could not be expressed or supported right away, just like the moral injury besides PTSD. The two sides, the two services working together could share their experiences and support each other in order to cope with the situation. Also in other situations, in treatment, the two segments of mental healthcare are in strong connection with each other, which can cause communication disturbances too, because of the different mindset of the population that is well-known in the organization. Besides these the information is essential for the medical staff in the organization in order to carry out preventive measures to protect the individual and their co-members, other soldiers. When civilian medical care is taken that is (those data to the military organization) are not always provided, but with a high overload of potential mental health problems, good cooperation is needed [8]. We must also consider that an unreversible mental health problem can lead to the individual's dismission from service, which is totally understandable with the responsibility of carrying a weapon.

Military personnel's mental health always had been in focus of the military organization. That is for the formerly mentioned preserving deployability and carrying out long-term tasks in smaller or larger groups is unimaginable without some kind of accommodation that is based on a stable mental health state [9]. For doing this there is a screening for mental health and general health state at the entering the organization and of course at the critical points of the military career before and after potentially hard burdens involving military tasks. Training supports their resilience and preparation for – from a civilian point of view - extreme situations, tasks, and psychological consultation are always available throughout the whole career when needed, and their reintegration training and follow-up after their long-term military tasks are also provided. Other training and education with a focus on mental health strengthening is available within the organization and has its priority before /instead of leaving the organization. There could be differences in focus or tolerance in the different countries, but these main points are usually critical and could be found.

Conclusion

In summary, we could say that military medical services are facing a special population with a special burden whereas the occurrence of anxiety and depression is evidence that comes with the individual's experiences. The professionals are trying to be as prepared for this workload as possible in treatment, follow -up and preventive medicine either. For a common interest sharing their experiences with the civilian side either. This process has its critical points where the focus is placed both on individual and group levels that could be considered as an advantage of mental health care. A younger, screened, trained population with expected burden and a within short distance available help that also strengthens the individual's responsibility for themselves and their mental health, whose attitude could support society on the general level as well.

References

1. Inoue C, Shawler E, Jordan CH, Moore MJ, Jackson CA. Veteran and Military Mental Health Issues. 2023 Aug 17. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan–. PMID: 34283458.

2. Abdalla SM, Cohen GH, Tamrakar S, Koya SF, Galea S. Media Exposure and the Risk of Post-Traumatic Stress Disorder Following a Mass traumatic Event: An In-silico Experiment. Front Psychiatry. 2021 Nov 25;12:674263. doi: 10.3389/fpsyt.2021.674263. PMID: 34899406; PMCID: PMC8656276.

3. Goodwin L, Jones M, Rona RJ, Sundin J, Wessely S, Fear NT. Prevalence of delayed-onset posttraumatic stress disorder in military personnel: is there evidence for this disorder?: Results of a prospective UK cohort study. J Nerv Ment Dis. 2012 May;200(5):429-37. doi: 10.1097/NMD.0b013e31825322fe. PMID: 22551797.

4. Frueh BC, Grubaugh AL, Yeager DE, Magruder KM. Delayed-onset post-traumatic stress disorder among war veterans in primary care clinics. Br J Psychiatry. 2009 Jun;194(6):515-20. doi: 10.1192/bjp.bp.108.054700. PMID: 19478290; PMCID: PMC2746686.

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DOI: https://dx.doi.org/10.17352/2455-5460.000090

5. AMedP8.10. Index of /files/stanags/03_AMEDP. (n.d.). https://www.coemed.org/files/stanags/03_AMEDP/AMedP-8.10_EDA_V1_E_2565.pdf

6. AMedP8.6. Index of /files/stanags/03_AMEDP. (n.d.). https://www.coemed.org/files/stanags/03_AMEDP/AMedP-8.6_EDB_V1_E_2564.pdf

7. Rosen A, Cahill JM, Dugdale LS. Moral Injury in Health Care: Identification and Repair in the COVID-19 Era. J Gen Intern Med. 2022 Nov;37(14):3739-3743. doi: 10.1007/s11606-022-07761-5. Epub 2022 Aug 15. PMID: 35970958; PMCID: PMC9377663.

8. Copeland LA, Finley EP, Rubin ML, Perkins DF, Vogt DS. Emergence of probable PTSD among U.S. veterans over the military-to-civilian transition. Psychol Trauma. 2023 May;15(4):697-704. doi: 10.1037/tra0001329. Epub 2022 Aug 4. PMID: 35925701.

9. Wang JY, Glover WJ, Rhodes AM, Nightingale D. A conceptual model of the psychological health system for U.S. active duty service members: an approach to inform leadership and policy decision making. Mil Med. 2013 Jun;178(6):596-606. doi: 10.7205/MILMED-D-12-00429. PMID: 23756065.

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