CARE UNDER FIRE:

Rethinking Mental Health in Conditions of Chronic Threat

Extended QR presentation | clinical observations from interdisciplinary practice in wartime Ukraine

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Psychiatry | Clinical psychology | Rehabilitation medicine | TeleHelp Ukraine | Autism Unity | Ukraine

> ***Behavior must be interpreted in context, not in isolation.***

What this deck adds

practice patterns, ethical examples, research anchors and future video slots

How to read it

a working framework, not a diagnostic manual or causal claim

What comes next

short team reflections with Ukrainian and English subtitles

When standard care assumptions do not hold

The approved abstract asked what changes when threat is ongoing, not past.

Safety

Common assumption

often assumed before intervention

Under chronic threat

incomplete, local and temporary

Continuity

Common assumption

often treated as the frame of care

Under chronic threat

interrupted by alarms, displacement or service demands

Stable access

Common assumption

often expected for treatment plans

Under chronic threat

disrupted by logistics, medication supply and communication

> ***The goal is not always restoring a safe baseline. Sometimes care helps preserve regulation, agency and functioning while safety remains incomplete.***

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Practice-informed working framework, not a validated causal model

The deck is built from four practice voices plus research anchors

We kept the team's clinical material central and used research/guidance as support, not as a substitute for practice.

Oleh Fitkalo, MD

psychiatry and field practice

compensation threshold, environmental fit, context-dependent strengths

Roman Haiovyi, MD

psychiatry and military clinical work

differential assessment, executive dysfunction, treatment access and alliance

Maryia Zabaronak, MD

rehabilitation perspective

participation under load, sensory environment, structured instructions

Fialkora Myndru, MS

integrative psychology lens

access before intervention, regulation before interpretation, incomplete safety

Igor Gontaruk, MD

TeleHelp / continuity

flexible communication, care delivery under instability

Danna Summers, PhD

cognitive/neurodiversity lens

interpretation, cognition, communication and support needs

Synthesis principle The presentation does not assign one slide to each author. It integrates the repeated patterns that emerged across psychiatry, psychology, rehabilitation and telehealth practice.

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Practice-informed working framework, not a validated causal model

Care happens while the threat is still active

The clinical task changes when the stressor is not in the past.

Common trauma-care sequence

Danger → Safety → Processing

Assumes a transition into enough stability for trauma work.

Care under continuing threat

Air-raid alerts

sleep disruption

Displacement

lost routines

Service demands

constant switching

Interrupted treatment

medication access

Shared threat

provider strain

The intervention may need to be shorter, clearer, more modular and more accessible before deeper processing is possible.

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Practice-informed working framework, not a validated causal model

Central practice-informed framework

War does not create neurodevelopmental differences. It can expose what was previously compensated.

1. Pre-war / pre-trauma profile

- routines
- preferred environments
- masking and adaptation
- structured roles that fit cognitive style

→

2. Chronic war-related load

- ongoing danger
- disrupted sleep
- uncertainty
- sensory overload
- pain / TBI
- interrupted recovery

→

3. Compensation threshold exceeded

- coping strategies may no longer be sufficient
- under extreme demands

→

4. Mixed clinical presentation

- executive dysfunction
- shutdown
- rigidity
- withdrawal
- sensory overload
- reduced participation

These presentations may reflect overlapping mechanisms: **PTSD + neurodevelopmental differences + exhaustion + environment mismatch**

> ***The clinical question is not only "What diagnosis fits?" but "What mechanisms shape functioning?"***

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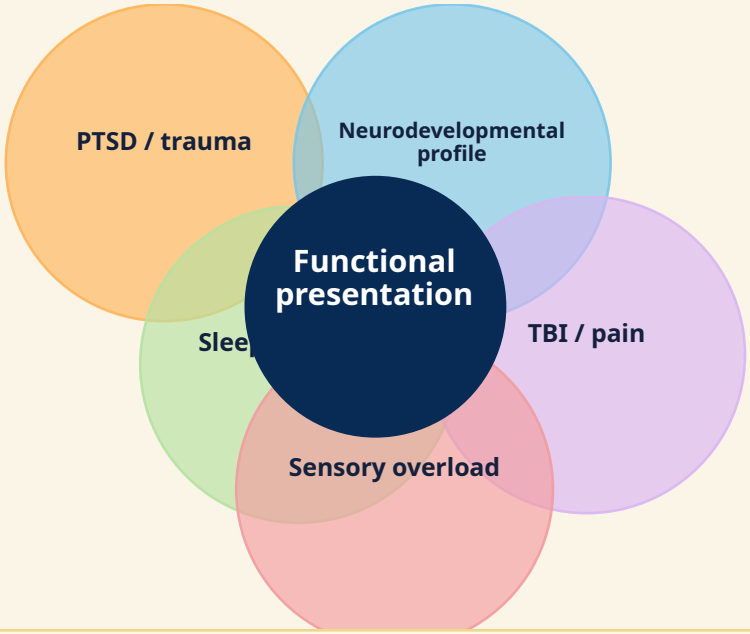
Mixed presentation does not mean one diagnosis has to explain everything

Roman and Oleh both emphasized trajectory, context and mechanism over a single label.



Assessment shifts from labels to trajectories

- What existed before trauma or service?
- What emerged after specific exposures?
- What worsens with sleep loss, noise, pain or switching?
- What changes when the environment becomes clearer or less loaded?
- What support needs become visible only under extreme demand?

Neurodiversity-informed point: differences may be masked until the environment exceeds available compensation. This does not erase trauma, and trauma does not erase developmental history.

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Avoid moralizing behavior before checking function and context

Repeatedly, the team's practice material pointed to the same risk: clinical problems can be mistaken for attitude.

What it may look like	What may also be happening
"Lack of motivation"	exhaustion, shutdown, initiation difficulty, executive dysfunction
"Noncompliance"	unclear instructions, processing difficulty, sensory overload, limited trust
Withdrawal	shutdown, emotional protection, energy conservation, depressive symptoms
Rigidity	need for predictability under excessive load, difficulty switching
Inconsistent functioning	environment-dependent capacity, role fit or mismatch
Severe avoidance	trauma cues plus sensory hyperreactivity or overload

> ***Do not turn a clinical problem into a moral judgment.***

Environment can reveal both vulnerability and strength

This is the key neurodiversity-informed correction to a deficit-only reading.

May function well when there is:

- clear concrete tasks
- predictable sequence
- rapid feedback
- good fit between role and cognitive style
- reduced ambiguity
- meaningful urgency or technical precision

May struggle when there is:

- constant switching
- unclear communication
- unpredictable demands
- sensory overload
- social ambiguity
- limited recovery time

Clinical implication: functioning depends not only on the person, but on the fit between person and environment.

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Practice-informed working framework, not a validated causal model

De-identified practice pattern: when “bad discipline” may be executive dysfunction

Based on Roman Haiovyi’s clinical material, stripped of identifying details.

Before service

Remote work, self-organized schedule, partly compensated ADHD-related difficulties

→

After mobilization

Strict routine, disrupted sleep, external orders, switching and sensory load

→

Presentation

conflicts with command, difficulty waking, missed steps, alcohol use for relief, secondary distress

→

Care response

psychiatric assessment, developmental history, alliance, ADHD-specific treatment and structure

Why it matters The case pattern supports assessment of developmental history and mechanism before interpreting difficulty as unwillingness, laziness or moral failure.

Ethical note: This is a pattern summary, not an identifiable patient story.

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What looks like “does not participate” may be inaccessible participation

Maryia’s rehabilitation material emphasizes environment, body, instructions and load.

High load session

- noise and many people
- multiple simultaneous instructions
- unexpected changes
- touch, movement, pain or fatigue
- limited time to process

May appear as: withdrawal, short answers, “not trying”, reduced cooperation

Adapted rehabilitation environment

- one instruction at a time
- predictable sequence
- reduced sensory load
- time for switching and response
- shorter, repeatable steps

May support: better participation, trust, pacing and functional engagement

> ***Participation is not the same as motivation.***

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Practice-informed working framework, not a validated causal model

Before choosing a technique, check whether the person can access care

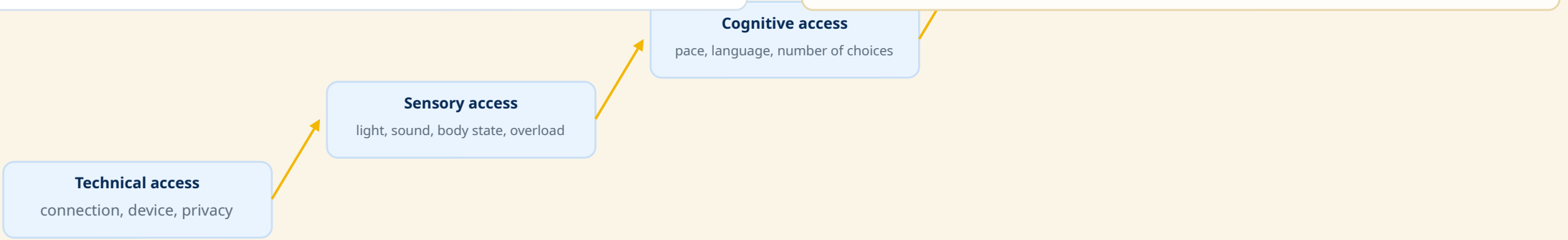
This integrates telehealth, trauma work, neurodiversity-informed care and volunteering under unstable conditions.

Regulation before interpretation

- reduce overload before demanding complex reflection
- allow silence or text when speech is too costly
- use one choice instead of five
- shorten contact when the nervous system is saturated

Incomplete safety

- do not tell the nervous system that danger is absent when danger remains
- look for more predictable, less overwhelming moments
- support enough agency and functioning for the present context



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Practice-informed working framework, not a validated causal model

The clinical question is not only “What diagnosis fits?”

A more useful question: What mechanisms shape functioning right now?

Developmental history

What was present before trauma?

Previous functioning

Where and under what conditions did the person function well?

Current environment

What conditions worsen or improve functioning?

Multiple interacting factors

Trauma, ND profile, sleep, TBI, pain, stress, substances

Response to adaptation

Does function change when structure, pace or sensory load changes?

Interpretation rule Improvement after environmental adaptation does not establish a diagnosis, but it may clarify the mechanism of difficulty.

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Practical adaptations from real-world care

The aim is not to abandon evidence-based care, but to make it accessible and feasible under instability.

Access before intervention

Can the person access care in its current format?

Regulation before processing

Reduce overload before complex reflection.

Clear communication

Short instructions, explicit expectations, time to respond.

Environmental adaptation

Reduce unnecessary sensory load and ambiguity.

Interdisciplinary continuity

Psychiatry, psychology, rehabilitation and social support working together.

Continuity as return

Interruption does not have to mean failed care.

> *Care under fire means adapting the form of care without losing its clinical seriousness.*

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Practice-informed working framework, not a validated causal model

One person, multiple mechanisms, shared care

This is why the poster and deck do not use separate “expert columns”.

Psychiatry

- differential diagnosis
- pharmacotherapy
- comorbidity
- medical risk

Psychology

- regulation
- relational safety
- meaning-making
- access to processing

Rehabilitation

- body, pain, fatigue
- participation
- functioning
- load-sensitive pacing

TeleHelp / community

- continuity
- communication access
- care during instability
- family and social support

Clinical integration The same behavior can carry psychiatric, psychological, sensory, bodily and environmental meanings at once.

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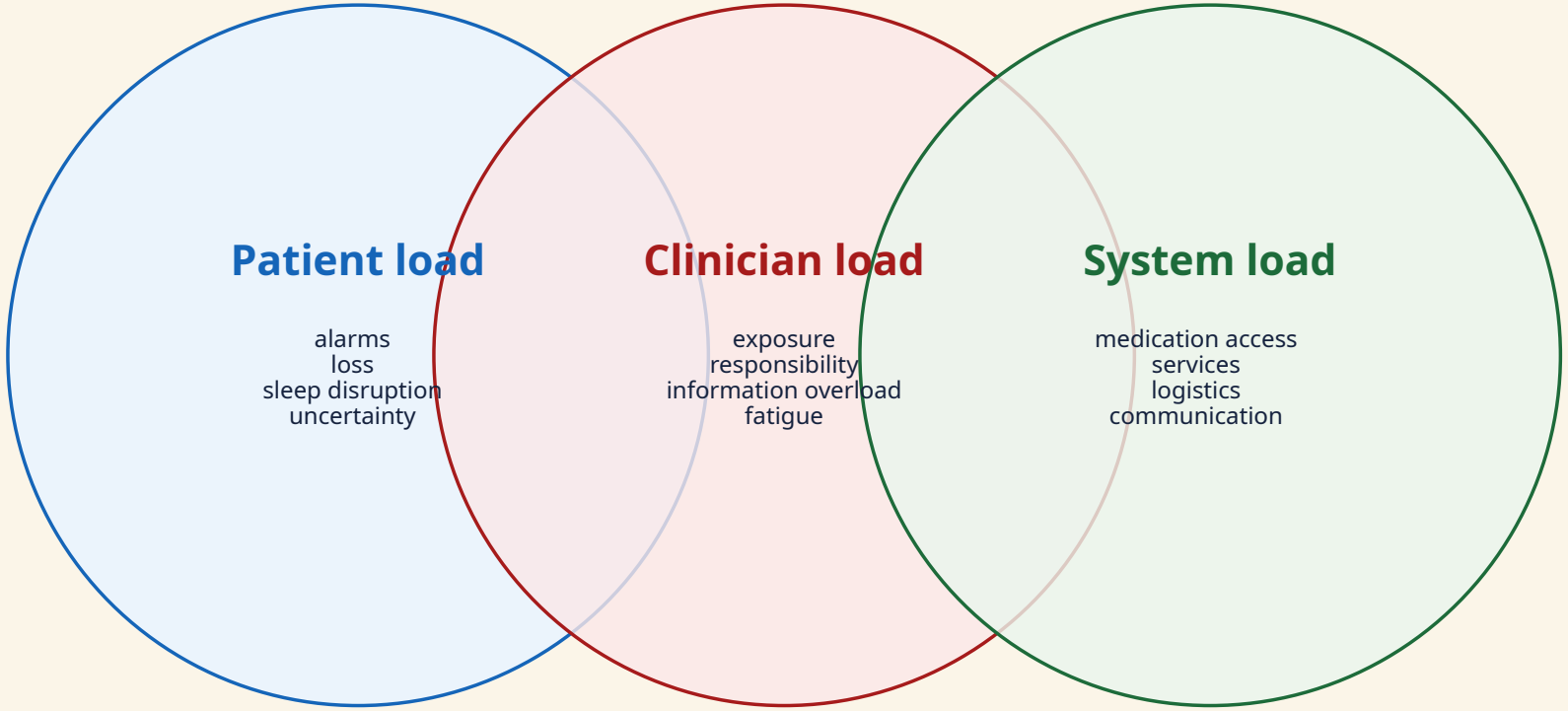
Practice-informed working framework, not a validated causal model

Provider sustainability is part of continuity of care

Under chronic threat, the care system is also under load.



> ***The clinician is not outside the war. Sustainability is not a luxury, it is part of patient safety and continuity.***

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Practice-informed working framework, not a validated causal model

Research anchors support, but do not replace, practice-based observations

We use evidence to situate the framework, not to overclaim causality.

ADHD and postdeployment PTSD risk

Prospective U.S. Army study: predeployment ADHD associated with later PTSD, MDE and GAD.

Howlett et al., 2018, J Trauma Stress

Environmental modifications in ADHD care

NICE defines environmental modifications and recommends considering them before adult ADHD medication decisions.

NICE NG87

Adult autism assessment and support

NICE emphasizes developmental history, structure, predictability, sensory environment and access to care.

NICE CG142

PTSD, TBI, sleep and pain

Veterans with TBI+PTSD showed greater sleep disturbance and pain, illustrating interacting mechanisms.

Balba et al., 2018, J Clin Sleep Med

MHPSS in emergencies

WHO/IASC guidance supports coordinated, layered, multi-sector support during emergencies.

WHO/IASC

See final reference slide for full citations and stable links.

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Planned video layer: short, ethical, subtitled reflections

The videos should add what a poster cannot: clinical voice, nuance and lived professional context.

Fialkora

Why the team was brought together

opening synthesis

Oleh

Environmental fit and compensation threshold

psychiatry / field lens

Roman

What may be misread as discipline or motivation

military clinical lens

Maryia

When participation is limited by load

rehabilitation lens

Igor

Continuity and communication under instability

telehealth / psychiatry

Danna

Cognition, interpretation and support needs

neurodiversity lens

Suggested format 45-90 seconds each, no identifiable patient details, Ukrainian audio acceptable with English subtitles and Ukrainian transcript.

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Selected research and guidance anchors

Practice material comes from the Care Under Fire team. These sources situate the framework.

1 Howlett JR, Campbell-Sills L, Jain S, et al. Attention Deficit Hyperactivity Disorder and Risk of Posttraumatic Stress and Related Disorders: A Prospective Longitudinal Evaluation in U.S. Army Soldiers. Journal of Traumatic Stress. 2018;31(6):909-918. doi:10.1002/jts.22347. PMID:30461069.

2 Balba NM, Elliott JE, Weymann KB, et al. Increased Sleep Disturbances and Pain in Veterans With Comorbid Traumatic Brain Injury and Posttraumatic Stress Disorder. Journal of Clinical Sleep Medicine. 2018;14(11):1865-1878. doi:10.5664/jcsm.7482. PMID:30373686.

3 NICE. Attention deficit hyperactivity disorder: diagnosis and management. NICE Guideline NG87. Recommendations, updated guidance. Includes environmental modifications and shared treatment planning.

4 NICE. Autism spectrum disorder in adults: diagnosis and management. Clinical Guideline CG142. Recommendations emphasize developmental history, structure, predictability, communication and sensory environment.

5 Inter-Agency Standing Committee. IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings. 2007. WHO-hosted publication.

6 World Health Organization. Mental health in emergencies and WHO MHPSS emergency response resources. Updated web guidance on emergency mental health and coordinated care.

Working status: This deck presents a practice-informed interdisciplinary framework and ethical pattern examples. It should not be read as a validated causal model or diagnostic guideline.