Ministry of Health of Ukraine
Ukrainian Medical Stomatological Academy

APPROVED
at a meeting of the department
disaster medicine
and military medicine
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Methodical instructions
for independent work of students
during preparation for a practical (seminar) lesson
and in class

Academic discipline	**Training of reserve officers**
Module № 1	Pre medical care in extreme situations
Topic of the lesson	Behavior of people in emergencies and combat conditions. Combat stress: symptoms, prevention, home care.
Course	2
Faculty	foreign students training specialty "Medicine", "Stomatology".

Poltava-2020

1. TOPIC 14. BEHAVIOR OF PEOPLE IN EMERGENCIES AND COMBAT CONDITIONS. COMBAT STRESS: SIGNS, PREVENTION, HOME CARE.

Actuality of theme:

Every extreme situation that a person finds himself in during natural, man-made, socio-political and military emergencies causes him nervous tension, behavior changes and causes health problems in the form of short-term and long-term stress reactions. Timely pre-medical, psychological and, in the subsequent stages, medical is the key to overcoming the consequences of these stress reactions. But, of particular importance, at the present stage, is the help of combat fatigue and combat stress during hostilities. In such conditions, the timeliness of comprehensive care for victims will solve not only the issue of rehabilitation, but also their socio-psychological adaptation to peaceful living, prevention of the so-called "Afghan syndrome".

2. Specific objectives:

o be able to provide home care to victims of emergencies

o be able to provide home care to victims of behavioral disorders,

o be able to provide home care to victims of combat stress,

o be able to provide home care to victims during an acute reaction to stress and stress disorders.

o recognize the behavior of people in emergencies;

o be able to carry out technologies for the prevention of post-traumatic stress sections;

o providing home care for combat stress and combat fatigue.

Competences and learning outcomes, the formation of which is facilitated by the discipline (the relationship with the normative content of training of higher education, formulated in terms of learning outcomes in the Standard).

According to the requirements of the standard, the discipline provides students with the acquisition of competencies:

-integral: The ability to solve typical and complex specialized problems and practical problems in professional activities in the field of health care, or in the learning process, which involves research and / or innovation and is characterized by complexity and uncertainty of conditions and requirements. The ability of the individual to organize an integrated humanitarian educational space, the formation of a single image of culture or a holistic picture of the world.

-general: The ability to apply knowledge in practical situations. Ability to exercise self-regulation, lead a healthy lifestyle, ability to adapt and act in a new situation. Ability to choose a communication strategy; ability to work in a team; interpersonal skills. Ability to abstract thinking, analysis and synthesis, the ability to learn and be modernly trained. Definiteness and perseverance in terms of tasks and responsibilities.

-special (professional, subject): Ability to carry out medical and evacuation measures. Ability to determine the tactics of emergency medical care. Emergency care skills. Skills to perform medical manipulations.

Basic knowledge, skills, abilities necessary for studying the topic (interdisciplinary integration):

Names of previous disciplines	Acquired skills

1. Human anatomy 2. Medical and biological physics 3. Medical chemistry 4. Physiology	Analyze information about the topographic and anatomical relationships of human organs and systems. Have knowledge of the physical basis and biophysical mechanisms of action of external factors on the systems of the human body. Identify the types of chemical equilibrium for the formation of a holistic physico-chemical approach to the study of vital processes of the organism. Apply chemical methods of quantitative and qualitative analysis. Analyze human health under different conditions.

Tasks for independent work in preparation for class and in class.

The list of the basic terms, parameters, characteristics which the student should master at preparation for employment:

Term	Definition
1. Psyche 2. Mental processes 3. Mental states 4. Stress 5. Stages of stress 6. Combat shock reaction 7. Among the combat shock reactions are distinguished	it is the ability of the brain to reflect objective reality in the form of feelings, ideas, thoughts and other subjective images of the objective world. The human psyche is manifested in the following three types of mental phenomena: mental processes, mental states, mental properties. these are short-term processes of receiving, processing and exchanging information (for example, sensations, perceptions, memory and thinking, emotions, will, etc.). reflect relatively long-term emotional experiences that affect human life (mood, depression, stress). psycho-emotional state of a person due to the emergence of too much stress caused by a real threat to life, fear, anxiety, anger, the need for urgent decision-making. anxiety, resistance, exhaustion this is the initial normal response to abnormal combat stress. mental shock, stupor, motor arousal, anger, crying, hysteria, panic fear,

8. Combat stress розрізняють 8. Бойовий стрес	nervous tremor, helplessness, delusions and hallucinations the process of mobilization of all available capabilities of the body, immune, protective, nervous, mental systems to overcome life-threatening situations.

Theoretical questions for the lesson:

- What is stress, its types?
- What determine the stages of stress?
- Mechanisms of stress resistance formation in medical workers.
- Technologies for the prevention of post-traumatic stress disorders.
- Combat stress and combat fatigue: signs, prevention and basic principles of home care in combat (shelter and evacuation sector) and non-combat conditions.

Practical work (tasks) performed in class:

1. Implementation of home care in combat.
2. Implementation of home care in peacetime.
3.Identify disorders of combat shock reactions.

Topic content:

In victims with post-traumatic stress disorder, especially in the most severe forms, changes are manifested at all levels of mental functioning. People often feel fear, do not believe in their own strength to overcome the disorder. Fear and despair affect the organization of psychological care, especially in its initial stages. Working with a psychologist is often perceived as a threat, as another traumatic event. Clients have doubts about the professional abilities of the psychologist, have doubts about his sincerity, friendliness. These protective mechanisms of the victim's behavior significantly complicate the work of providing psychological assistance. It is difficult to succeed without overcoming these barriers.

It should also be emphasized that the effectiveness of psychological care depends on a combination of different approaches, methods and techniques.

Stress resistance is a general personality trait characterized by the ability Stress resilience is a general personality trait characterized by the ability to withstand stressors over a period of time necessary to organize new conditions in which the stressor will not be threatening [Anokhina S., 2007, 58] . Stress resistance ensures high efficiency and maintains the health of young people. In situations of possible stress, additional ways out of stressful situations should be identified. Stress resistance will ensure high efficiency and contribute to the preservation of human health, if he thinks creatively in solving their problems.

Typical reactions of medical workers to various traumatic events

In recent years, there has been a clear increase in injuries among the population. This is due not only to an increase in the number of "domestic injuries", traffic accidents, accidents, but also natural and man-made disasters. Local armed conflicts also lead to numerous injuries, gunshot and mine injuries, including among civilians. Terrorism has taken on an international scale. The tendency to increase terrorist acts is observed all over the world, which leads to the need to solve this problem at the interstate level.

Every year it becomes more and more obvious that every medical worker, no matter what his specialty, can at any time be faced with the need to provide emergency medical care to those affected by an emergency.

From a medical point of view, an emergency is understood as a situation resulting from a catastrophe in which the number of victims in need of emergency medical care exceeds the possibilities of its timely provision by local health forces and means, and requires both external and

medical care. and a significant change in the forms and methods of daily work of medical institutions and staff.

From this definition it follows that in an emergency (emergency) to provide emergency care to those affected by the disaster can be mobilized all health workers, most of whom will have to perform unusual (or completely unusual) for them work - as the nature of medical and diagnostic measures and intensity. For example, a urologist will have to help with gunshot wounds to the extremities, a therapist - to resuscitate, a procedural or dressing nurse to help the surgeon during surgery or anesthesiologist during anesthesia, etc. Such work to provide medical care to a large flow of victims, as as a rule, it is performed in the conditions of acute shortage of time, and sometimes - and lack of medical and diagnostic possibilities. This requires not only high theoretical and practical training. Important extreme concentration, a sense of responsibility, the ability to make quick, non-standard, independent decisions.

In order not to get lost in such conditions, to make your contribution to the provision of assistance to the most effective, it is necessary to be guided by some general principles of providing such assistance, to have a good idea not only of its medical but also organizational aspects.

There are 3 phases of assistance to disaster victims.

The first phase (isolation). Its duration is determined from the moment of the catastrophe to the beginning of rescue operations (minutes, hours, days). It is characterized by the fact that assistance to the affected population from the outside is impossible, the scale of the disaster has not yet been assessed, and the vulnerable population solves the problem of survival by providing self - and mutual assistance.

The second phase (rescue). At this time, rescue operations are being carried out by detachments arriving from areas not affected by the disaster, medical formations are being deployed to provide emergency medical care, sorting and concentrating the victims, life support manuals, and evacuation. The duration of this phase is 10-12 days.

The third phase (recovery). The victims are evacuated to safer areas, where there are all the conditions for a full examination, further treatment and further rehabilitation at the level of modern advances in medical science and practice.

The whole process of medical care for mass injuries can be divided into the following components.

Medical reconnaissance of the emergency zone. It consists in the preliminary determination of the population, the state of the medical service, reconnaissance, the presence and condition of roads, settling tanks, and others.

Search and rescue. Usually these functions are performed by emergency rescue formations of the unified state system of emergency prevention and liquidation. Search and rescue operations are carried out for several hours or days.

The mechanism of stress resistance formation in medical workers

The mechanism of formation of occupational stress in doctors is a combination of high control over the manifestations of adverse reactions, high levels of anxiety, pessimism and reduced ability to integrate behavior in stressful situations associated with professional activities.

2. Stress resistance in physicians is associated with low hostility, high levels of altruism, self-acceptance, the ability to use intellectual potential in stressful professional situations and internal orientation of the locus of control.

3. Increased subjective discomfort in physicians associated with workers' situations, associated with an increase in the number of somatic complaints, as one of the manifestations of affective disorders associated with stress at work.

4. Doctors in a state of occupational stress revealed disharmony cope with behavior, the structure of which is characterized by the use of coping "self-esteem", "cooperation" and "self-blame", "aggression", as well as active use of psychological defense "regression".

5. Doctors who subjectively experience a state of stress at work, and doctors with objectively registered high levels of occupational stress, found a similar personality structure. It is characterized by emotional lability, rigidity, low self-acceptance and externality in the field of interpersonal relationships.

6. The severity of occupational stress in physicians is associated with work experience. The indicators of the factor "occupational stress" in doctors with more than 15 years of experience are significantly higher than the same indicator in doctors whose experience is less than 15 years. In physicians with more than 15 years of experience, the subjective assessment of emotional discomfort does not correspond to the objectively registered severity of occupational stress due to the active use of psychological protection of "displacement".

7. Being a woman is a risk factor for occupational stress in doctors. The number of women doctors with a high level of occupational stress is 1.5 times higher than the number of men with similar rates.

8. The intensity of occupational stress in psychiatrists is significantly higher than in surgeons. This is due to differences in the structure of protective-coping behavior and the level of self-acceptance. The structure of the mechanisms of psychological protection of surgeons is characterized by a more intensive use of protection "denial". The structure of coping behavior of psychiatrists is dominated by maladaptive coping "hopelessness". Surgeons have a higher level of self-acceptance compared to psychiatrists.

Practical recommendations:

1. It is recommended to organize a system of training aimed at developing stress resistance in doctors, especially with experience of 5 to 15 years.

2. To identify the initial stages of the formation of occupational stress in physicians with experience up to 5 years, it is recommended to conduct psychodiagnostic screening.

3. It is advisable to include in the system of pre- and postgraduate education of doctors a set of classes aimed at informing them about the mechanisms of formation and clinical characteristics of occupational stress, as well as the development of resistance to occupational stress.

4. It is recommended to develop a system of individual psychological counseling for doctors who experience occupational stress, reduced professional efficiency and who report health disorders.

5. Given the literature data on high somatic morbidity of physicians and our data on the violation of doctors' perception of their health, it is advisable to more actively diagnose somatoform disorders in order to prevent somatic pathology.

Technologies for the prevention of post-traumatic stress disorders

It was found that in recent years in domestic and foreign science conducted research on the prevention of PTSD in servicemen, in particular, their role in the motivational, adaptive and communicative process. However, the scientific literature does not investigate the possibility of preventive measures to prevent PTSD in servicemen who have undergone hostilities.

The main purpose of the experimental study was to study in practice the impact of preventive measures on changes in PTSD in servicemen.

In accordance with the task, the experimental study was carried out in three stages.

At the first stage, a confirmatory experiment was performed. The experimental sample consisted of 161 servicemen with an average length of stay in the combat zone of 12 months aged 19 to 40 years.

Based on the theoretical analysis of the problem and the hypothesis of the thesis, at the stage of the ascertaining experiment the following tasks were set:

1. Choose a method for detecting PTSD in servicemen who have fought.

2. Carry out a qualitative and quantitative analysis of the results obtained during the diagnostic techniques.

In the second stage of the experimental study, a formative experiment was performed. The experimental sample consisted of 44 servicemen aged 19 to 40 years, of whom 22 people were included in the experimental group and 22 people - in the control group.

At the stage of the forming experiment the following tasks were solved:

1. To form an experimental sample on which the marked program will be tested.

2. Develop and test a program focused on providing assistance after a traumatic incident in order to prevent PTSD.

3. Justify the criteria for evaluating the effectiveness of the developed program.

4. Approve the program and evaluate the effectiveness of the formative experiment.

At the third stage of the experimental study, a control experiment was performed. During the control experiment the following tasks were solved:

1. Carry out a control measurement for the manifestation of PTSD symptoms.
2. Carry out a comparative analysis of the results of the formative and control experiment.
3. Check the reliability of the differences between the indicators of the ascertaining and control experiment by the method of mathematical statistics.

Based on the purpose and objectives of the experimental study, the following techniques were used:

I. Diagnostic and statistical guide to mental illness DSM-4, designed to detect PTSD [2].

Specific clinical signs of DSM-4

The subject experienced an event that goes beyond ordinary human experiences, and which would cause great suffering to almost everyone. For example, a serious threat to one's own life or health; danger threatens his children, loved ones or other close relatives and friends; sudden destruction of a house or society; serious injury or murder (death) as a result of an attack or accident, an event with another person in front of his eyes. And was accompanied by a feeling of fear, panic.

1. The traumatic event is persistently experienced again in one (at least) of the following ways:

• repeated and obsessive memories of an event that reveal suffering.
• recurring dreams associated with this event and causing suffering.
• A sudden action or feeling as if a traumatic event had happened again.
• severe mental suffering during events that symbolize or resemble aspects of the traumatic event, including the anniversary of the injury.

2. Constant avoidance of stimuli associated with trauma, or numbness as a result of a generalized reaction (no injury is observed), which can be judged on the basis of at least three of the following factors:

• Efforts are made to avoid activities or situations that evoke memories of trauma;
• inability to remember important aspects (psychogenic amnesia)
• significant interest in important matters;
• feelings of isolation or alienation from others;
• limited range of affect (eg, inability to love)
• feeling of lack of prospects in the future;
• efforts are made to avoid thoughts and feelings associated with the trauma;

3. Persistent manifestations of increased activation (which was not present before the injury), as indicated by at least two of the following;

• difficult to fall asleep or sleep;
• irritability and outbursts of anger;
• difficulty concentrating;
• excessive vigilance;
• increased tremor reaction;
• a physiological response to an event that symbolizes or resembles any aspect of a traumatic event.

Despite the fact that these criteria have long been used in the diagnosis of PTSD, there is still a critical analysis and verification of their validity, hence some differences in the views of American and European scientists. You can consider some other symptoms that are not included in the description, but are characteristic of PTSD. For example, the appearance of acute attacks of fear during which there was a mental injury

Clinical symptoms of PTSD can be divided into two groups:

1. Symptoms "invading" the human psyche - obsessive memories, nightmarish recurring dreams, flashbacks.
2. Symptoms that protect a person, helping him to avoid the recurrence of psychotraumatic situations in the future - increased shudder; avoiding feelings, thoughts, similar places and people; problems with relaxation and falling asleep, etc.

II. Debriefing as a method of group psychological assistance to an individual has been traumatized during the performance of official duties [2; 38].

III. Comparative analysis.

IV. The method of mathematical statistics is Wilcoxon's T-test.

2.2 Analysis of the results of the study of the formative and ascertaining experiment

At the stage of the ascertaining experiment, DSM-4 was used to diagnose PTSD in servicemen participating in armed conflicts.

The data obtained indicate that as a result of hostilities, 41% received mental injuries, 19% have partial symptoms of PTSD, and 40% have no signs of PTSD. The reaction to a combat trauma after being withdrawn from the combat zone and entering a calm environment can be delayed and manifest itself in a few days, weeks, months or even years. During the period of participation in hostilities, vital emotions are released and subcortical instinctive mechanisms are activated.

In the second stage of the experimental study, a formative experiment was performed. At this stage of the study, the author's program "Support for servicemen who went through hostilities" was developed.

The program developed by us is based on the following principles:

The principle of "personality-oriented orientation" of corrective developmental measures, based on the unconditional positive acceptance of the personality of the subject, his activities, as well as the recognition of the right to error. The result is the actualization of the internal mental and individual-personal reserve of each subject, stimulating adequate emotional functioning, activation of the need for self-realization and self-expression.

The principle of "trust", which implies the faith of the teacher-psychologist in the identity and uniqeness of each subject. The results of work on the principle of "trust" are a comprehensive disclosure of personality, the subject's faith in their own strengths and capabilities.

Classes are held with a subgroup of subjects no more than 10-12 people.

Psychological debriefing is a group discussion of an extreme situation that helps to understand the causes of stress and to understand the actions needed to address those causes. This tool allows you to solve the following problems:

- reducing the level of emotional perception of an extreme situation;
- reducing the level of individual and group psychological stress;
- regulation of the moral and psychological state of the participants.

The best time for a debriefing is two days after the event.

Practice shows that psychological debriefing should be carried out in compliance with the following conditions:

- the presence of a separate room, isolated from any noise;
- the number of participants should not exceed 10 people (optimally 5-7 people) - from the number of police officers who have previously been in similar extreme situations. With more participants, the group is divided into subgroups with its "leader".

Psychological debriefing is carried out according to the method of "round table". You can use audio and video recordings of situations and events. Before the debriefing, it is advisable to conduct a rapid diagnosis of the post-stress state of the participants, which will help to clarify the situation in the group and determine the tactics of working with individual members.

The debriefing process consists of three parts:

a) "ventilation" of feelings in the group and stress assessment by leaders;

b) discussion of "symptoms" and providing psychological support;

c) mobilization of resources, provision of information and planning of further assistance.

In general, there are 5 to 7 mandatory phases in the work of the group

1. The introductory phase involves explaining to the presenter the goals, objectives and rules; relieving participants of anxiety about the novelty and "unusualness" of the procedure. The optimal time for admission is 15 minutes.

The facilitator then determines the rules for debriefing in order to minimize the anxiety that may arise in the participants.

The basic rules to follow include the following:

a) introduce yourself and express your own attitude to the event under discussion; if the participant does not want to discuss a certain fact, it is not necessary to force him to do so; everyone else listens carefully to what everyone present says;

b) maintain confidentiality: what happens or is discussed in the group is not taken out;

c) not to criticize others;

d) everyone speaks on his own behalf, about his own experiences, actions (in the first person), and not about others;

e) the psychologist warns the participants that they may experience negative feelings again, but this is the task of debriefing - to learn to overcome real negative emotional states;

e) although the group works without a break, this does not mean that it is forbidden to go out for a certain period of time.

2. The fact phase is aimed at telling each participant what happened to him: what he saw, where he was and what he was doing. This is how you can restore the full picture and chronology of events.

The duration of the phase of factors may vary. But the longer the incident lasted, the longer the phase should be.

One of the main tasks of debriefing is to give employees a more objective view of the situation in order to block the anxiety and discomfort caused by the distortion of the real picture of what was happening.

3. In the phase of thoughts, emotions and feelings. The presenter asks to move from the description of events to the story of inner experiences and psychological reactions to them. It is very important to remember the first impressions that flashed in your head, thoughts, impulsive actions and emotional reactions. Questions that open this phase can be, for example, such as "What were your first thoughts when it happened?".

At the end of this phase, the impressions of the participants at the scene can be discussed. The questions that may be asked are: "Your impressions of what was happening around you when the events were just beginning and during their development?", "What did you think and feel?".

4. The phase of symptoms involves discussing the manifestations of mental stress, which were observed by participants as changes in their behavior. The result is a list of symptoms that describes the range of psychological consequences of a critical incident in a particular group. Each participant has the opportunity to understand and be aware of their condition, as well as to tell about the symptoms that they have not told anyone before.

It is worth noting that the post-stress state of employees sooner or later creates a certain impact on family life, and the employee may feel that his family is unable to understand what he went through. As a result, the search for understanding leads to colleagues who have experienced the same events.

5. The information phase is aimed at explaining to participants the nature of post-stress states as "normal reactions to an extreme situation"; discussion of options and means of overcoming them and possible negative psychological consequences in the future. In the form of a mini-lecture, the psychologist reports on the types, signs and consequences caused by stress. In such cases, it is useful to record the information provided on leaflets and provide it to debriefing participants as handouts.

6. The phase of "closing the past" and "new beginning" is aimed at summarizing the past. Rituals of "closing the past" exist in every culture (memorials, anniversaries, visits to places associated with certain events, etc.), but they also involve their own creative participation, for example, many of those who survived the disaster, later dedicate their lives to help to avoid new catastrophes or reduce their traumatic consequences, use their experience in providing assistance, participate in the activities of voluntary rescue teams, etc.

7. The readaptation phase helps to discuss and plan for the future. One of the main goals of debriefing is to create a feeling of inner psychological comfort. It is also useful to discuss in which cases the participant should seek further assistance. The following indicators may be decisive: if the symptoms do not decrease after 6 weeks, if the symptoms increase later, if the employees are not able to perform their functional duties adequately, or if conflicts and misunderstandings arise in the family.

The psychologist should focus on the end of the debriefing, which, in turn, gives the process completeness and logical coherence.

However, it should be noted that the debriefing itself does not exhaust the need to provide individual professional psychological assistance to law enforcement officers.

Behavioral disorders that occur in military personnel during hostilities include combat stress (initial manifestation of behavioral disorders), combat fatigue and post-traumatic stress disorder (PTSD), as well as reactive states as the most severe forms of combat psychiatric pathology. Experience shows that behavioral disorders account for 10 to 50% of all sanitary losses in modern local wars.

Combat stress and combat fatigue is a normal primary response to abnormal (stress) factors of combat. During war, people are under constant physiological (eg, poor nutrition, temperature changes, lack of proper personal hygiene, etc.) and psychological stress (eg, constant danger, caution about possible improvised explosive devices or snipers, or injuries or death of comrades), and it is obvious that most of them will have some reactions. These reactions often manifest as hyper-fear (strong reaction, for example, to a loud sound), excessive vigilance (the fighter is always on guard and ready to act), bad dreams / horrors, irritability, sleep problems, etc. Although all this sounds rather negative, some of these reactions are considered adaptive, in particular, hyper-timidity and excessive alertness, as well as other reactions of combat stress, such as increased physical strength, increased endurance, self-competence, etc. (ie not all stress reactions are negative).

Combat stress is a general term that covers all possible reactions of servicemen to combat conditions. The term "combat fatigue" is used to describe any combat-related stress response that needs help. Most military personnel who show signs and symptoms of emotional or psychological disorders do not have mental health problems, but rather try to overcome the stress of military operations.

In ICD-10, the diagnostic headings F 43.0 "Acute stress response" and F 43.1 "Post-traumatic stress disorder" are in section F 43 "Severe stress response and maladaptation". This distinction from psychiatric disorders allows us to define combat fatigue as a normal condition that develops in normal people under the influence of abnormal circumstances.

An important role is played by the ability of servicemen and their immediate environment (first of all, commanders, doctors, psychologists) to adequately assess the human condition, to identify those symptoms that indicate the development of stress. Combat stress is initially manifested as an individual's inability to perform their direct duties. Among the most characteristic features are the abandonment of the battlefield, unexplained absence, etc. Those fighters who experience combat fatigue are more likely to have recurrence of symptoms, so the more immediate help is provided, the better the chances of a speedy recovery. Psychological factors (personal characteristics) can delay or complicate rehabilitation after such conditions. Any behavior of the military, which for a long time differs from the usual for him before, can be an early sign and symptom of combat stress.

For timely diagnosis it is not necessary to keep in mind all the possible signs and symptoms of combat stress, it will be much more useful to remember one simple rule: "Know your peers and be prepared to notice any sudden, prolonged or progressive changes in their behavior that pose a potential threat to the safety and operation of your unit. "

The process of separating servicemen with combat fatigue from a relatively small number of people with real mental disorders is called neuropsychiatric sorting. The main indicator that the observed symptoms are not a sign of psychiatric pathology is the preservation by the serviceman of a sufficiently critical assessment of what is happening and the ability to purposeful activity.

When assessing a fighter's condition in a tactical setting, always think about safety. If there are doubts about one's own safety, the safety of the serviceman or his entourage, the danger must be reported to the commander. Make sure his weapon is removed and he is under constant escort.

Combat fatigue can be classified as mild or severe. Assistance will depend on the complexity of the symptoms and the tactical situation. Mild combat fatigue - minimal, minor dysfunction, symptoms are present, but do not significantly affect the performance of direct duties; complaints are more subjective than objective, the tactical situation allows you to leave the fighter.

Severe combat fatigue - obvious violations that affect the performance of direct duties or a tactical situation does not allow you to stay in the unit.

Basic principles of working with combat stress.

I. After making sure of your own safety, the safety of the victim and others, assess the condition of the victim according to the SAVS algorithm. Make sure no hidden physical injury or damage has been missed. Some injuries and illnesses can cause emotional and behavioral changes and their symptoms will resemble reactions to combat stress (head injury, contusions, gas inhalation, hypoglycemia, fever, withdrawal syndrome, poisoning, hyper- and hypothermia, dehydration, etc.).

II. Take emotional disorders as seriously as physical injuries. If a serviceman seriously sprains his ankle when he falls, no one will expect him to get up immediately and run. A fighter's emotions can also be temporarily strained due to excessive combat stress or other traumatic events. Do not demand that he immediately take himself in hand and continue to serve. Some people may gather at once, while others may not. A serviceman whose emotional stability has been compromised received the same real injury as the one who sprained his ankle. Unfortunately, many people think that only what they can see, such as a wound or bleeding, is real, they tend to think that emotional and mental disorders are fictional, that a person with combat stress is not really sick or wounded, and that they can cope with your condition using only willpower.

III. Divide the victims according to the severity of stress reactions.

Mild combat stress

Table 1 shows some criteria for mild combat stress.

Table 1

Criteria for mild combat stress

Physical manifestations	Emotional manifestations
Trembling Nervousness Cold sweat, dry mouth Insomnia Accelerated heartbeat Dizziness Nausea, vomiting or diarrhea Exhaustion Look nowhere Difficulties in thinking, speaking and communicating	Anxiety, indecision Irritability, complaints Forgetfulness, inability to concentrate Horrors It is easily startled by noise, movements, flashes. Tears, crying Anger, loss of confidence in yourself and your friends

Providing home care for mild combat stress.

1. Continue the combat mission, focus on the immediate important tasks.
2. Expect a serviceman with signs of mild combat stress to perform the assigned duties.
3. Keep calm at all times; give clear instructions and monitor their implementation.
4. Inform the serviceman that his reaction is normal and nothing extremely wrong is happening to him.
5. Tell him the necessary information about the tactical situation, goals, expectations, give him support. Control the spread of rumors.
6. Try to restore the victim's self-confidence, talk about success.
7. Involve him in productive activities (when he is not resting) through training, maintenance of equipment, machinery, etc.

Do not involve servicemen with signs of combat stress to evacuate the wounded - this can increase the level of trauma!

8. It is possible to temporarily transfer to a non-combat base with a slight restriction of direct duties and the provision of rest.
9. Provide him with food, water and sleep as soon as possible.

10. Make sure the serviceman maintains personal hygiene.

11. Allow him to speak, do not belittle his feelings, grief or anxiety. Give practical advice and listen to him.

Criteria for severe combat stress Table 2

Table 2

Physical manifestations	Emotional manifestations
Constantly moving around	He speaks fast and / or strangely
Shudders at any sudden sound or movement	Argued; acts recklessly
Tremble, shake	Does not react to danger
He cannot move his arm or leg without visible physical reasons	Memory loss
Loss of sight, hearing or sensation	He stutters a lot, mutters or can't speak at all
Physically exhausted; crying	Insomnia; severe nightmares
It numbs during firing or becomes completely motionless	Sees or hears what does not exist
Sways, oscillates	Sharp emotional changes
Panic, running under fire	Apathy
	Hysteria
	Insane, strange behavior

Providing home medical care for severe combat stress (see Algorithm "Assistance in behavioral disorders").

1. If the behavior of a serviceman endangers the mission, threatens himself or others, it is necessary to immediately report the danger to the commander! Once you are sure of your own safety, the safety of the victim and others, make sure that no hidden physical injury or damage has been missed.

2. If the fighter is upset, talk to him calmly, persuade him to cooperate.

3. Apply physical restraint only when necessary to ensure safety or transportation**.**

4. Assure everyone that his symptoms are more likely to be a reaction to stress and he will get better.

5. If stress reactions persist: move the soldier to a safe place. Do not leave him alone, have someone he knows with him at all times, inform the senior officer, make sure that he is examined by one of the medical staff.

6. Let him do some easy tasks.

7. Convince the serviceman that he will get better and return him to his duties as soon as he gets better and he will be ready for it.

Not patient status!

In order for servicemen with combat stress not to enter the role of the patient, it is necessary to adhere to the following principles:

- to leave the uniform to servicemen, to emphasize the need to adhere to military ethics and discipline;
- to ensure the presence of servicemen with combat stress reactions separately from seriously ill or wounded patients;
- limit medication as much as possible, except for severe sleep disorders;
- not to evacuate or hospitalize a serviceman unless absolutely necessary;
- do not make premature diagnoses.

Prevention of combat stress

Combat fatigue is inevitable during combat, but a large number of casualties can be prevented. Studies show that in well-trained and cohesive units, only one in ten suffers from combat stress, even in heavy combat. This is much less than usual: on average, one in four or five in moderate-intensity combat and one in two or three in combat during intense combat. Knowing what tactical and general conditions contribute to the increase in cases of combat fatigue, it is necessary to take measures to reduce the impact of these factors. You can overcome combat stress: hard, realistic training, which increases self-confidence, and care for each other**.**

Materials for self-control:

Problem.

Patient P., 43 years old. At the initial consultation complains of weakness in the legs, weight loss, dry mouth, thirst, general weakness, fatigue, low mood, internal anxiety, worry, sleep disturbances.

As a child, he did not lag behind his peers. He served in Afghanistan for 7 years. After the service he married. He has two children - a 9-year-old daughter and a 12-year-old son. He practically does not take part in the upbringing of children. The wife works as a primary school teacher. The patient is currently a conscript. He received a second education - higher law (studying in the 6th year).

No pathological changes were detected in the somatic and neurological statuses.

After the problems that first arose 3 years ago at work, memories of service in Afghanistan began to emerge. He tries not to mention it and not to tell his wife or friends. He had nightmares, increased anxiety, and irritability. I am not completely satisfied with family life. He believes that there is a lack of mutual understanding.

During the conversation contact. There is anxiety, focusing on their painful feelings. Mood background is lowered. He is very concerned that a higher-paying position has been given to his colleagues. Memory not impaired.

1. Disorders of which mental processes are observed in the clinical picture of the disease in the patient?

2. What is the possible diagnosis of the patient and what are the diagnostic criteria for this disorder?

3. What led to this disorder in the patient?

Test tasks

1. Patient B., 28 years old. He was admitted from the combat zone to the psychiatric clinic of the regional VIC in a state of acute agitation. In the General Chamber is not restrained. He is in constant motion, quickly runs from corner to corner, tries to hit his head on the door in a hurry, scratches his face and neck, punches him in the chest. The facial expression is frightened, the eyes are wide open, sometimes squinting or rolling up. The eyelids tremble slightly. Often the face is distorted by a painful grimace. He shouts out individual phrases and words, utters them intermittently, in a patter, constantly changing the intonation of his voice: he speaks in a barely audible whisper, then begins to shout frantically, shrieks. Sometimes he chants words or automatically utters rhyming expressions approved from childhood. His statements refer to the situation of war, express fear, resentment, indignation and fear: "For what? ... Ugu.i.aga .. (howls) I do not want to die. .I'll kill so many ... reptiles .. (suddenly jumps up, knocks on the door with his fists). Let live… Let live (beats himself with his hands). No death! ... No death! ... For what? For what?". He cries, breaks his arms, tears his hair. The eyes are full of horror and fear, the face is distorted. He calms down for a while, then becomes excited again with fragmentary expressions. "My brothers. Everything! .. The end! For what? ... They will kill. They are digging. They are already digging. End. Amen! ... (quarrels obscenely). Let's live! ” etc. What condition is described? Make a differential diagnosis.

A) Catatonic schizophrenia.

B) Acute stress reaction. Reactive psychosis with acute speech confusion *.

C) Adaptive disorder.

D) Manic episode.

2. Post-traumatic stress disorder (PTSD) is characterized by all these symptoms, except:

A) PTSD occurs as a result of a mine injury *.

B) The patient has been exposed to a stressful situation, short-term or long-term, extremely threatening or catastrophic, which can cause general distress in any person.

C) The patient constantly re-experiences the effects of stress in obsessive reminiscences, vivid memories or recurring dreams.

D) Manifestations of PTSD symptoms occur no later than 6 months after the stressful event.

3. What signs of the general adaptation syndrome are superfluous in the presented list:
A) Stage of "anxiety" (mobilization).
B) Stage of resistance.
C) The stage of depletion.
D) Stage of psychosis *
Standard of answers to tests:
1.B
2.A
3.G.

Literature
Basic references

1. Medicine of emergency situations: textbook for students of higher medical educational establishment of IV level of accreditation/ V.V. Chaplyk, P.V. Oliynyk, S.T. Omelchuk, V. V. Humenyuk. - Vinnytsia: Nova Khuna, 2012. – 343 p.

Additional references:

1. Accident and emergency medicine: study guide/ O. M. Pronina, V. V. Shevchenko, S. I. Danylchenko; Ministry of Public Health of Ukraine, Central Methodical Office, UMSA. – Poltava: ASMI, 2015. – 145 p.
2. Hospital surgery /Edited by L. Kovalchuk, V. Saenko, G. Knyshov et al. – Ternopil: Ukrmedkniga, 2004. – 472 p.
3. Bullok B. Pathophysiology and Alterations I Function. – Illinois Boston-London: Second EditionGlenviev, 1988. – 521 p.
4. The Washington Manual of Sugery/ Third Edition/ Gerard M. Doherty, M. D., 2002. – 777 p.
5. Short Practice of Surgery/ 24th Edition/ R. C. G. Russel., 2004. – 1552 p.

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