

МЕДИЦИНА, ПЕДАГОГИКА И ТЕХНОЛОГИЯ: ТЕОРИЯ И ПРАКТИКА

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Modern interpretation of psychodiagnostics and psychocorrection of extreme situations

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Abstract: This article classifies the general mechanisms of providing qualified psychological services to military personnel who are in need of psychological help as a result of various social factors. Providing psychological support to military personnel who are under mental stress at work, the process of understanding the events after the effects of the stressful situation have ended, and various methods of providing them with psychological support are explained. The article provides an overview of approaches, theories, and controversial issues and problems related to psychological care. The concept of mental exhaustion is revealed in connection with semantic concepts such as trauma, stress, loss, transit.

Key words: trauma, stress, motive, professional deformation, affective situation, military regulations.

Psychodiagnostics in extreme situations has its own characteristics. In such circumstances, due to time constraints, standard diagnostic procedures cannot be used. Actions, including actions of a practical psychologist, are determined by an emergency plan.

Traditional methods of psychological influence are not used in many extreme situations. All this depends on the goals of psychological influence in extreme situations: in one case, you should support, help; in others, for example, rumors, panic should be stopped; negotiate in the third.

The main principles of providing assistance to people who have suffered mental injuries as a result of extreme situations:

- urgency;
- proximity to the place of events;

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- waiting for the normal situation to be restored;
- unity and simplicity of psychological effect.

Urgency means that the victim should be helped as soon as possible: the more time passes from the moment of injury, the higher the probability of developing chronic diseases, including post-traumatic stress disorder.

The meaning of the proximity principle is to provide care in a familiar and social environment, as well as to minimize the negative consequences of "hospitalization".

Waiting for normalcy to return: A person who has experienced a stressful situation should be treated as a normal person, not as a patient. Hope it will return to normal soon.

The unity of the psychological effect means that its source must be the same person or the procedure for providing psychological assistance must be unified.

Simplicity of the psychological effect - the victim should be removed from the injured area, food, rest, a safe environment and the opportunity to listen should be provided.

In general, the emergency psychological care service performs the following main functions:

- practical: providing direct urgent psychological and (if necessary) pre-medical medical care to the population;
- coordination: ensuring communication and interaction with specialized psychological services.

The situation of a psychologist working in extreme conditions differs from the usual therapeutic situation in at least the following aspects.

- Work with groups. It is often necessary to work with groups of victims, and these groups are not artificially created by a psychologist (psychotherapist) based on the needs of the psychotherapeutic process, they are created by life itself due to the dramatic situation of the disaster.

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- Patients are often in an acute affective state. Sometimes you have to work when the victims are still under the influence of a traumatic situation, which is completely unusual for ordinary psychotherapeutic work.

- The social and educational level of many victims is often low. Among the victims, you can find many people who, due to their social and educational status, will never find themselves in a psychotherapist's office in their lives.

- Heterogeneity of psychopathology among victims. In addition to traumatic stress, victims of violence often suffer from neuroses, psychoses, personality disorders and, most importantly, a number of problems caused by the disaster itself or another traumatic situation for professionals working with victims. This means, for example, lack of means of living, lack of work, etc.

- The presence of a sense of loss in almost all patients, because victims often lose loved ones, friends, favorite places to live and work, etc., which creates a nosological picture of traumatic stress, especially the depressive component of this syndrome.

- Difference between post-traumatic psychopathology and neurotic pathology. It can be said that the psychopathological mechanism of traumatic stress is fundamentally different from the pathological mechanisms of neurosis. Thus, it is necessary to develop strategies for working with victims, which cover both cases of "pure" traumatic stress and the complex interaction of traumatic stress with other pathogenic factors of internal or external origin.

The goals and tasks of emergency psychological care include prevention of acute panic reactions, psychogenic neuropsychic diseases; increase the adaptability of a person; Psychotherapy for emerging borderline neuropsychiatric disorders. Providing urgent psychological assistance to the population should be based on the principle of intervention in the superficial layers of consciousness, that is, work with symptoms, not syndromes.

Psychotherapy and psychoprophylaxis are carried out in two directions. First with a healthy part of the population - in the form of prevention:

- a) acute panic reactions;
- b) delayed, "retarded" neuropsychic diseases.

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The second direction is **psychotherapy** and psychoprophylaxis of persons with advanced neuropsychic diseases. The technical difficulties of conducting rescue operations in emergency zones can result in victims being completely isolated from the outside world for long periods of time. In this case, psychotherapeutic help is recommended in the form of urgent "information therapy", the purpose of which is to psychologically support the vitality of people who are alive, but completely isolated from the outside world (earthquakes, destruction of houses). the result of accidents, explosions, etc.).

The purpose of "information therapy" is to reduce the feeling of fear among the victims, because it is known that in crisis situations, more people die from fear than from the impact of a real fatal factor. After the victims are freed from the rubble of the buildings, it is necessary to continue psychotherapy (and primarily amnesia therapy) in an inpatient setting.

Another group of people **to whom psychotherapy is applied** are the relatives of the dead and the living. We use all psychotherapeutic measures for them:

- behavioral techniques and methods aimed at eliminating psycho-emotional agitation, anxiety and panic reactions;
- existential methods and techniques aimed at accepting the state of loss, eliminating mental pain and searching for mental and psychological opportunities.

Another group of people **for whom psychotherapy is used** the emergency area are rescuers. The main problem in such situations is psychological stress. It is this situation that has a significant impact on the demands placed on emergency services professionals. The specialist should have the ability to quickly identify symptoms of psychological problems in himself and colleagues, have empathic skills, be able to organize and conduct training on psychological relaxation, stress relief and emotional tension need Acquiring psychological self-help and mutual support skills in crisis and extreme situations is of great importance not only for preventing psychological injuries, but also for increasing stress resistance and readiness for rapid response in emergency situations.

First aid rules for psychologists:

1. In a crisis situation, the victim is always in a state of mental agitation. This is normal. The optimal level of arousal is moderate. Tell the patient

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immediately what you expect from the therapy and how long it will take to solve the problem. Hoping for success is better than fearing failure.

2. Do not take immediate action. Look around and determine what kind of help (besides psychological) is needed, which of the victims needs help the most. Allow about 30 seconds for one victim, about five minutes for multiple victims.

3. Be clear about who you are and what functions you perform. Find out the names of those who need help. Tell the victim that help is coming soon and that you care.

4. Carefully make skin-to-skin contact with the victim. Take the victim's hand or tap him on the shoulder. It is not recommended to touch the head or other parts of the body. Take a position at the same level as the victim. Do not turn your back on the victim.

5. Never blame the victim. Tell him what steps to take to help him in his work.

6. Professional competence creates confidence. Tell us about your qualifications and experience.

7. Give the victim confidence in his own authority. Give him a task he can do. Use it to give the victim a sense of self-control.

8. Let the victim talk. Listen to him actively, pay attention to his feelings and thoughts. Repeat something positive.

9. Tell the victim that you will stay with him. During the separation, find a substitute and show him what to do with the victim.

10. Involve people close to the victim to help. Guide them and give them simple tasks. Avoid any words that make someone feel guilty.

11. Try to protect the victim from unnecessary attention and questions. Give specific tasks that are interesting.

12. Stress can also have a negative effect on the psychologist. It makes sense to relieve the tension that occurs during such work with the help of relaxation exercises and professional supervision. Facilitation groups should be led by a professionally trained moderator.

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In most cases, another classification of the next stages or stages of the dynamics of the condition of people after traumatic situations is proposed:

1. "*Acute emotional shock.*" It develops after a state of torpor and lasts from 3 to 5 hours; general mental tension, excessive mobilization of psychophysiological reserves, increased perception and speed of thought processes, manifestation of reckless courage (especially in saving loved ones), while simultaneously reducing the critical assessment of the situation, but maintaining the ability to act purposefully is described. The emotional state during this period is dominated by a feeling of depression, accompanied by dizziness and headache, palpitations, dry mouth, thirst and difficulty breathing. Up to 30% of those examined, with a subjective assessment of the deterioration of their condition, simultaneously note an increase in performance by 1.5-2 times or more.

2. "*Psychophysiological demobilization.*" It lasts up to three days. For most of the respondents, the beginning of this stage is associated with the first contacts with the bodies of the injured and the dead, understanding the scale of the tragedy ("awareness stress"). It is characterized by feelings of confusion, panic reactions (often of an irrational nature), a decrease in morally normative behavior, a decrease in the efficiency of activities, well-being and a sharp deterioration of the psycho-emotional state. and to him some changes in motivation, depressive tendencies, attention and memory functions (as a rule, the examined could not remember exactly what they did on those days). Most of the respondents at this stage complain about nausea, "heaviness" in the head, discomfort in the gastrointestinal tract and decreased (or even absent) appetite. The same period also saw the first refusal to carry out rescue and "cleaning" operations (especially related to the removal of the bodies of the dead), a significant number of wrong actions in the management of motor vehicles and special equipment. includes an increase. from emergencies.

3. "*Resolution phase*" - 3-12 days after the disaster. According to subjective assessment, mood and well-being gradually stabilize. However, according to the results of observations, in most of the examined, a decrease in emotional state, limited contact with others, hypomia (face like a mask), a decrease in intonation color of speech and slowness of movements remained. By the end of this period, there is a desire to "speak" which is carried out selectively, directed primarily at

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persons who have not witnessed the natural disaster and who are accompanied by some kind of excitement.

At the same time, dreams appear that were not present in the previous two stages, including disturbing and nightmares, which reflect the impressions of tragic events in different ways.

Against the background of subjective signs of a slight improvement in the condition, a further decrease in physiological reserves (for example, hyperactivation) is objectively noted. Incidents of redundancy are on the rise. Average indicators of physical strength and performance (compared to normative data for the studied age group) decrease by 30%, and hand dynamometry by 50% (in some cases up to 10-20 kg) . Average mental activity decreases by 30% and symptoms of pyramidal interhemispheric asymmetry syndrome appear.

4. "*Recovery phase.*" It begins about the 12th day after the disaster and is most clearly manifested in behavioral reactions: interpersonal communication is activated, the emotional color of speech and facial reactions begin to normalize, jokes that cause an emotional reaction for the first time after the disaster. it can be noted from others, simple dreams are restored. Taking into account foreign experience, it is possible to predict the development of various psychosomatic diseases associated with disorders of the gastrointestinal tract, cardiovascular, immune and endocrine systems in people who are the source of a natural disaster. Another classification distinguishes three stages:

1. Pre-exposure, which involves feelings of threat and anxiety. This stage is usually found in earthquake-prone areas and areas where hurricanes and floods are frequent; Often the threat is ignored or unacknowledged.

2. The impact phase lasts from the beginning of the natural disaster to the time when rescue operations are organized. Fear reigns in this period. The increase in activity, the manifestation of self-help and mutual support immediately after the end of the effect, is often called the "heroic phase". Panic action almost never happens, except if escape routes are blocked.

3. The post-impact phase, which begins a few days after the disaster, is characterized by the continuation of rescue operations and the assessment of the problems encountered. New problems related to social disorder, evacuation,

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family separation, etc. allow a number of authors to consider this period as "the second natural disaster".

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