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Уважаемые коллеги!

Влияние карантина, вызванного COVID-19, на психическое состояние граждан – вопрос не простой. Первая и основная сложность состоит в том, что никто в Украине (как и, насколько мне известно, в мире) не проводил клинико-статистических исследований, посвященных анализу психоэмоционального состояния населения вследствие COVID. Поэтому все мои высказывания будут носить предположительный характер, исходя, так сказать, из опыта моей повседневной работы как руководителя более чем тысячекоечного психиатрического учреждения, а также информации, черпаемой из сообщений Министерства здравоохранения Украины и СМИ в целом.

Практика показывает, что обращений к психиатрам в связи с ухудшением психического состояния из-за карантина нет. Нельзя полностью исключать вероятность отдельных случаев обращений граждан к врачам по этому поводу, но массовым, значимым явлением эти обращения не стали. Отдельные высказывания о тревоге, снижении настроения, опасениях за свою жизнь и жизнь близких в связи с COVID носят исключительно бытовой характер и по факту не требуют специальных врачебных консультаций и помощи.

Более важным в данном карантине, как показывает опыт, является не столько страх за здоровье свое и своих близких, сколько производные карантинных мер в виде одномоментных и кардинальных изменений социальных форм жизни граждан – изменения графиков и условий работы транспорта вплоть до его полного закрытия, закрытие учреждений досуга, невозможность индивидуального и семейного отдыха (повседневного и отпускного), нарушение перспективы карьеры, образования, значительные финансово-экономические проблемы и многое другое. Нет массовых реакций депрессий и нарушений адаптации и в связи с этими явлениями, но в бытовом аспекте именно эти факторы являются предметом реальных переживаний и тягот людей. Именно они расцениваются гражданами как реальная угроза их существованию.

Фактическую информацию о контагиозности и смертности от COVID-19 мы будем знать, вероятно, не раньше чем через несколько лет. Но уже сегодня каждый из нас, имея самостоятельный опыт жизни в карантине и возможность анализа происходящего, может самостоятельно ответить по крайней мере на два вопроса: соответствует ли уровень карантинных запретов в государствах в связи с COVID-19 уровню реальной угрозы здоровью и жизням граждан этих государств от данного заболевания и в какой степени и насколько



качественно выполняются карантинные требования гражданами и специальными службами в реальной жизни?

В конечном счете мы приходим к выводу, что есть мнение ВОЗ и национальных МЗ, есть рекомендации санитарно-эпидемиологических служб и есть решения правительств, которые не обсуждаются и подлежат неукоснительному выполнению. И последняя надежда законопослушного индивида, живущего по законам логики и здравого смысла, что на уровне правительств будут приниматься решения, соответствующие реальной картине явлений и интересам граждан.

Мишиев В.Д., главный редактор
Киев, август 2020

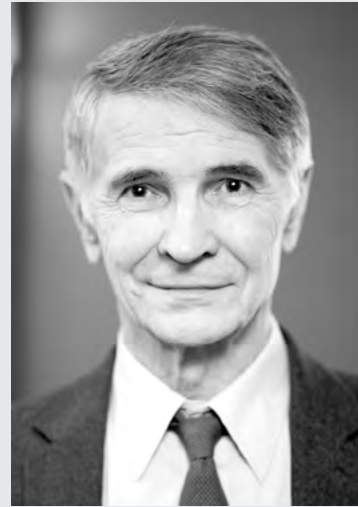


Уважаемые коллеги!

Возвращаясь к теме, затронутой во вступительном слове к № 2 журнала за 2020 год, следует отметить, что 3-й выпуск содержит уже несколько статей, посвященных разным проблемам пандемии коронавируса. Здесь есть и обзоры, и оригинальные исследования. Проблема того заслуживает и, несомненно, найдет отражение в последующих выпусках журнала. В большинстве стран и регионов разрабатываются и уже действуют различные исследовательские программы, нацеленные на уточнение клинических, эпидемиологических, психологических, социальных, а также психопатологических последствий. Последние, судя по некоторым наблюдениям, также неизбежны у части перенесших относительно тяжелые формы заболевания. Отмечаются когнитивные, психовегетативные, довольно стойкие астенические расстройства, некоторые сенсорные феномены, в частности утрата обоняния как один из первых признаков заболевания. У пациентов даже при легких формах коронавируса часты тревожные расстройства. Имеется необходимость и в разработке мер психологической поддержки медицинского персонала, работающего в специализированных отделениях и подвергающегося высокому риску заражения.

Непредсказуемы возникновение и локализация наиболее крупных очагов поражения. Опыт разных стран неоднороден, а порой противоречив, как и рекомендации профилактики – индивидуальной и популяционной. Целесообразна постоянная, настойчивая просветительская работа среди населения с четкими рекомендациями и с учетом конкретных условий. А для врачебного сообщества важен обмен опытом по всем проблемам, связанным с медицинскими, психологическими и иными аспектами пандемии.

Краснов В.Н., главный редактор
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Уважаемые коллеги!

В своем сегодняшнем обращении я хочу уже в который раз обратиться к теме, которую считаю для нас с вами одной из главных и определяющих – сегодняшней роли и месте нашей специальности как в иерархии медицинских дисциплин, так и среди социальных приоритетов в целом. Именно от этого зависит отношение к психиатру у населения, уровень нашего профессионального и личного самоуважения, а также финансирование отрасли государством, уровень жизни наших коллег, степень их удовлетворенности профессией, приток в профессию новых специалистов и многое другое.

Вполне очевидно, что отношение общества и государства к той или иной медицинской специальности прямо зависит от двух основных причин – прежде всего тяжести социально-экономических последствий этих заболеваний, а также от сформировавшихся в общественном сознании взглядов, отношений и предубеждений. За примерами далеко ходить не надо – вряд ли кто-то поставит под сомнение высокий приоритет сердечно-сосудистых заболеваний или онкологической патологии. К сожалению, вряд ли кому-либо в наших странах известен тот факт, что психические расстройства сегодня обходятся государству дороже, чем все онкологические заболевания, вместе взятые.

Важной причиной такого отношения является и то, что если сердечно-сосудистые заболевания куда чаще бывают прямой причиной смерти пациента, когда связь эта лежит на поверхности, то для значительного большинства психических расстройств такая связь не характерна, а социально-экономические последствия заболеваний более косвенные, не так бросаются в глаза и куда больше растянуты по времени. Потери эти тем не менее огромны, и о них куда больше, чем сегодня, должно быть информировано как общество в целом, так и специалисты самых разных областей, принимающие экономические решения. Давайте будем работать в этом направлении – в разных формах, на разных уровнях, но постоянно и последовательно.

В историческом плане нашей специальности здесь всегда не везло – к числу приоритетов здравоохранения в наших странах она никогда не относилась, а финансировалась и финансируется, как правило, по остаточному принципу.

Между тем в последние десятилетия во многих странах роль психиатрии в общей системе здравоохранения, как и мероприятий по охране психического здоровья в обществе в целом очевидно растет – при этом речь идет не только о более полном выявлении и своевременном лечении традиционных форм психической

патологии, но и о повышении роли нашей профессии при многих соматических заболеваниях.

Яркая иллюстрация этому – ситуация этого года, вызванная пандемией коронавируса. Хотя каких-либо принципиально новых, неизвестных ранее форм психической патологии, сопутствующих этой инфекции, обнаружено и не было, однако связанные с болезнью психические, психологические и поведенческие изменения у огромных масс населения оказались столь значительны, что радикально повлияли как на общественную жизнь, политическую ситуацию, экономику, так и на работу системы здравоохранения в целом. Не будет, на наш взгляд, преувеличением утверждать, что психические и психологические последствия пандемии в плане социально-экономическом оказались куда тяжелее и длительнее, чем последствия для соматического здоровья населения.

Вывод из этого очевиден: увеличение количества и удельного веса специалистов в области охраны психического здоровья: психиатров, психотерапевтов, медицинских психологов – и их роли в оказании населению медицинской и психологической помощи в подобных ситуациях совершенно необходимо, как и повышение уровня подготовки в этой области врачей иных лечебных специальностей, участвующих в оказании помощи в подобных ситуациях. Это, в свою очередь, будет способствовать росту авторитета нашей специальности и ее представителей среди других медицинских дисциплин.

Евсегнеев Р.А., главный редактор
Минск, 4 августа 2020



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Servicemen in the Phantom Pain «Captivity»: Associative-Narrative Analysis of the Problem

Военнослужащий в «плeну» фантомной боли: ассоциативно-нарративный анализ проблемы

Abstract

The article is devoted to the peculiarities of functioning of psyche of the servicemen, who have lost their limbs as a result of combat injury and are experiencing phantom pain. It was found that the mental state of a serviceman, who had a traumatic limb amputation, can be identified with a state of acute grief. The fact of amputation leads to the collapse of all life prospects of a serviceman, reassessment of one's self, significant decrease of the level of claims, and often to the loss of the meaning of life. The peculiarities of phantom pain manifestation through the body and speech of the patient were revealed. Phantom pain "strengthens" the body, provides it with "physicality", and signals to the person that "pain has a body". It was showed that 50 to 80 % of patients with amputated limbs experience phantom pain within 25 years after amputation.

The study included 16 soldiers with combat injuries of various severity, which led to amputation of the limb. The methods of observation, associative experiment, and narrative interview were implemented.

Post-amputation phantom pain was reported in 69% of left-sided and 31% of right-sided amputations. It was found that the patient, who is feeling the amputated limb, continues to consider it a complete organ, but with pain. The presence of pain intensifies the feeling that the lost limb was not damaged. Phantom pain is localized in a special form of expression – a symbol, and it is irradiating.

The narrative stories about the feelings associated with phantom pain reveal to psychologists and medical staff the peculiarities of behavior of people, who live with this pain. It was revealed that servicemen with an amputated limb feel neglect and hatred, concerning the compassion of colleagues, friends, and relatives, and experience a deep sense of loneliness, which leads to a kind of internal isolation. It was found that the invisible (illusory, ghostly) signs of phantom pain are much more dangerous than a real injury. It was showed that patients with phantom pain can often experience denial, passive protest, alienation, projection as specific varieties of psychological protection.

It was proved that phantom pain activates the "intruding memories" that had traumatized the serviceman, and generate, in turn, a permanent internal discomfort. Phantom pain has devastating effects that are difficult to understand and decode.

Keywords: amputated limb, phantom pain, mental state, mental trauma, psychological protection, actualization, phantom pain language.

Резюме

В статье раскрыты особенности функционирования психики военнослужащих, которые потеряли конечность в результате боевого ранения и переживают фантомную боль. Выяснено, что психическое состояние военнослужащего, который перенес травматическую ампутацию конечности, отождествляется с состоянием острого горя. Факт ампутации приводит к краху всех жизненных перспектив военнослужащего, переоценке собственного «Я», существенному снижению уровня притязаний и часто к потере смысла жизни. Установлены особенности выражения фантомной боли через тело и речь пациента. Фантомная боль «скрепляет» тело, обеспечивает его «телесность» и сигнализирует человеку о том, что «боль имеет тело». Показано, что фантомную боль испытывают от 50 до 80% пациентов с ампутированными конечностями в течение 25 лет после ампутации.

Для участия в исследовании привлечено 16 военнослужащих с боевыми травмами различной степени тяжести, которые привели к ампутации конечности. В качестве инструментария использован метод наблюдения, ассоциативный эксперимент и нарративное интервью.

Послеампутационный фантомный болевой синдром констатирован в 69% левосторонних и 31% правосторонних ампутаций. Выявлено, что пациент, чувствуя ампутированную конечность, продолжает ее считать полноценным органом, но с болью. Наличие боли – активизирует чувство неповрежденности утраченной конечности. Фантомная боль локализуется в особой форме выражения – символе и носит иррадирующий характер.

Нарративные рассказы об ощущениях, связанных с фантомной болью, открывают психологам и медицинскому персоналу особенности поведения людей, живущих с этой болью. Установлено, что военнослужащие с ампутированной конечностью ощущают пренебрежение и ненависть к сочувствию со стороны друзей и родных лиц, переживают глубокое чувство одиночества, что приводит к своеобразной внутренней изоляции. Раскрыто, что невидимые (иллюзорные, призрачные) признаки фантомной боли составляют большую опасность, чем настоящая рана. Показано, что пациенты с фантомной болью часто прибегают к отрицанию, пассивному протесту, отчуждению, проекции как специфическим разновидностям психологической защиты.

Доказано, что фантомная боль активизирует «непрощенные воспоминания», которые привели к травматизации военнослужащего и которые в свою очередь порождают постоянный внутренний дискомфорт. Фантомная боль в своей основе содержит разрушительное воздействие, которое сложно поддается пониманию и декодированию.

Ключевые слова: ампутированная конечность, фантомная боль, психическое состояние, психическая травма, психологическая защита, актуализация, речь фантомной боли.

■ FORMULATION OF THE PROBLEM

The pain of war can be felt for a long time by its participants. There has been an armed conflict in Ukraine for almost six years. In a document dated February 25, 2019, the Office of the United Nations High Commissioner for Human Rights estimated the total casualties in Eastern Ukraine at 40–43 thousand, including 12.800–13.000 dead and 2.500–3.000 wounded people. According to internationally recognised studies of military conflicts, 90–95% of combatants have medical (nervous-related) and social problems in future.

The statistics show that one in four combatants, having no physical injury, suffers from neuropsychiatric disorders, and one in three among

the injured and disabled [8]. But this is only a part of a giant iceberg that is formed after a soldier leaves the active phase of combat. Other consequences, such as psychosomatic illnesses, begin to manifest within a few months, after returning to normal living conditions. According to the leading experts of the Military Medical Academy of Ukraine, combatants (compared to healthy people) are two to three times more likely to have such diseases as hypertension, gastritis, peptic ulcer and duodenal ulcer. The general health status of such servicemen is characterised by weakness, dizziness, disability, headaches and heartaches, sexual disorders, insomnia, phobias, fears, and disabled people suffer, in addition, from the problems associated with injuries and traumas.

In 2018, in the 23 regions of Ukraine, 5006 combatants were defined as those, having disabilities. This is 665 servicemen more than last year; 89.5% of them were recognised as persons with disabilities due to the protection of their Homeland, and 10.5% were recognised as persons with disabilities due to general illness, as in 2017. According to the severity of disability, the patients were divided into the following groups: the first disability group included 120 persons (2.4% of the total number of disabled persons), II – 1520 persons (30.4%), III – 3362 persons (67.2%). Participants in the area of hostilities were the members of the Anti-Terrorist Operation (ATO) and Joint Forces Operation (JFO) (77.3% recognized as persons with disabilities) [8].

An extremely difficult psycho-traumatic factor for a serviceman is a limb amputation that affects the entire spectrum of his or her behaviour upon returning to a peaceful life. In Ukraine, this problem has become particularly acute in the last six years due to the emergence of large numbers of servicemen with amputations. In the structure of sanitary losses in modern armed conflicts, limb injuries encompass 52–67%. 6–8% of them are accompanied by a traumatic amputation [8].

The mental state of a serviceman who suffered a limb amputation as a result of combat injury is classified as acute grief. The fact of amputation is experienced as a deeply personal tragedy, which has a tremendous devastating effect on his behaviour. The limb amputation is regarded as the collapse of all his life prospects, plans, and hopes of a serviceman. Recent research results have shown that upon returning from war, a veteran who has had his limb amputated loses three basic notions: self-identification, purpose, and social circle [8]. At the behavioural level, this is manifested in the reassessment of one's self, a significant reduction in the level of harassment, in the search for a social niche, and, sometimes, in the loss of the meaning of life. No matter how psychologically trained a soldier is, the fact of amputation is perceived as a personal catastrophe [1]. The cases of suicidal attempts among military personnel upon the understanding of the inevitability of limb amputation serve as the evidence of the above-mentioned statement. Such situations require the serviceman to strain all mechanisms of allo- and intrapsychic adaptation, great internal work, endurance of grief.

The limb amputation is not painless. The soldier's posture changes and, as a result, the tension on other parts of the body increases, including a healthy limb, shoulders, neck, upper back. There are frequent cases when physical pain is displaced by phantom. According to neurobiologist V. Ramachandran, 50 to 80% of patients with amputated limbs experience

phantom pain [15, 16]. R. Sherman, examining several thousand soldiers who lost limbs in the hostilities, found that about 70 % of them continued to experience phantom pain for 25 years after the amputation [17]. According to J. Marbach and K. Raphael, phantom pain can even occur after tooth, chest, bladder, uterus, or genital removals [9].

For the last twenty years, the main vector of the research on phantom pain has been directed towards the establishment of neuroplastic changes that have occurred in the human brain after amputation [4, 6]. At the same time, there have been only a few research works that reveal the psychological changes, that cause phantom limb pain and determine the behaviour of the amputee soldier in general [5].

To sum up, we can say that the ability of a serviceman to experience phantom pain in a lost or paralyzed area of the body raises a number of problematic questions, the answers to which are rooted in the fields of valeology, medicine, psychology, philosophy and several other sciences. Identified features should also be taken into account during the organisation of rehabilitation activities with the participants of ATO and JFO.

The analysis of the recent research and publications proves that the problem of phantom limb pain is quite common and attracts the attention not only of medical practitioners, but also of psychologists, philosophers and other scientists. In philosophy, the notion of phantom pain is decoded within the prototype of the mind-body interaction dilemma [2, 12]. According to M. Merleau-Ponty, the value of the body (the subject of the body) is an undervalued substance due to the predominance of the tendency according to which it is regarded as an object, which is ordered by the transcendental mind to perform various functions. In this regard, the human mind is the spiritualisation of the body, which is perceived as holistic, even when its individual parts are amputated, and the phantom pain is an experience manifested by the relationship between present and previous personal experiences [12].

While broadening the idea, concerning the ambiguity of the experience of phantom limb pain, M. Merleau-Ponty states, that phantom pain is a manifestation of a congenital complex, and the phantom limb itself may come from the individual experience of situations, internalised by the memory [12].

Phantom pain is an "invisible sign of a lost area of the body" [13]. According to F. Nortvedt and G. Engelsrud, who rely on the results obtained in cognitive neuroscience, the study of phantom pain should be directed towards a deep understanding of the brain functioning features [14]. By presenting the theory of "neuromatrix" (the template of the whole), R. Melzack noted, that neural networks play a leading role in both cognitive and emotional perception of pain [11]. F. Nortvedt and G. Engelsrud point out that even children born with a congenital limb deficiency can have a phantom feeling and experience limb pain that they have never had [14]. This primarily proves that the "neural pattern of the body" is partially genetically determined [10].

By identifying the features of expressing pain through the body and speech, F. Norhvedt and G. Engelsrud found out how strong the interconnection between these expressions and phantom pain was. According to their data, the experience of phantom pain enables a person

to form an image and to experience feelings of an intact limb. "Phantom pain strengthens the body, provides it with" physicality "and thus signals to the person that the pain has a body". It is a peculiar experience that transforms and alters a person's perception of himself, his attitude towards others [14].

In order to find answers to the questions outlined in a number of modern theories, as well as guided by the personal research interest in the subject, we have defined the purpose of the article. It is aimed at the clarification of psychological features of the perception of the world by the servicemen who have lost their limbs due to combat injury and are experiencing phantom pain; peculiarities of psychological support for people, who are experiencing phantom pain.

The organisation and methodology of the research

With an aim to realise the purpose of the research, a special study was conducted for seven months (from October 2014 to April 2015) on the basis of the Military Medical Clinical Center of Professional Pathology of the Personnel of the Armed Forces of Ukraine. The respondents were servicemen of the Armed Forces of Ukraine (16 people), male, of various military ranks aged from 26 to 47 years. All 16 servicemen received combat injuries of different severity, which led to the limb amputation. At the time of the study, they were undergoing rehabilitation and were experiencing phantom pain. The interaction with the patients of the rehabilitation department was carried out in close cooperation with the medical staff of the Center, who had considerable experience in dealing with phantom pain.

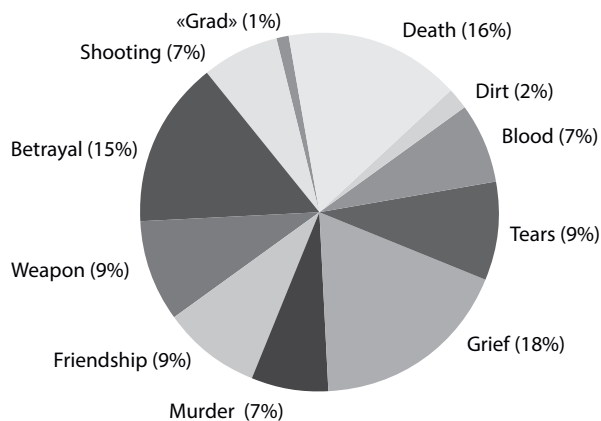
We used observation, associative experiment, and Fritz Schütz's narrative interview, which lasted for 50–80 minutes, as main research methods. The main focus in decoding narratives of servicemen, who are experiencing phantom pain was to establish how they perceive their previous and present bodies, as well as how they decode pain in the context of their previous and present experiences.

During each narrative interview, the interviewer only generally directed the serviceman's story about phantom pain. The patient openly and thoroughly disclosed his feelings concerning phantom pain. In the course of the study, we wanted not only to create an atmosphere of trust and openness and thereby establish the most meaningful moments of the patient's story, to support his hope for a quick and effective recovery, but also to plunge into his mental state at an empathic level. Patients' responses were continually supplemented by medical staff's stories regarding their interactions with patients experiencing phantom pain.

■ THE RESULTS AND DISCUSSION

The use of associative experiment in the study of amputee servicemen allowed to establish the semantic nucleus of the investigated people, as well as to reveal the patient's current state, his/her life experience, evaluation and views concerning the future. In the associative experiment, we used five key incentives: home, life, happiness, future, war. This choice was based on the experience of a similar survey conducted with war veterans in Croatia.

The temporal and substantive analysis of the associative experiment showed that associations of military personnel with amputated limbs to the word "war" differ significantly from the answers to other keywords. We have identified 11 most commonly used answers to the word (figure). Among



Associations of military personnel with amputated limbs to the word "war"
 Ассоциации военнослужащих с ампутированными конечностями к слову «война»

them: grief (18%), death (16%), betrayal (15%), friendship (9%), weapon (9%), tears (9%), murder (7%), blood (7%), shooting (7%), dirt (2%), BM-21 "Grad" ("Hail") (1%).

The high percentage of such an association as betrayal (15%), compared to other associations, can be explained by the explicit aggressiveness of the amputee servicemen towards those who, in their opinion, are the cause of their unhappiness. These were both commanders who had "thrown" the unit in a battle without proper artillery training, and comrades-in-arms who did not secure the departure of the special forces group. Thus, serviceman L. with high amputations of both legs after two months of treatment was convinced that doctors amputated one leg by mistake. Serviceman Yu., with an amputated left leg, was at the front line for only one day. As a result of the injury, the tourniquet was put on, the elasticity of which the serviceman had to adjust every two hours, but neither he nor the available medical personnel did not do that. This resulted in amputation. Aggression of such patients was manifested in an unmotivated rudeness towards medical staff and psychologists. Patients who had a similar behavioural strategy rarely experienced signs of intrapsychic adjustment, which would allow them to adapt to new living conditions.

Patients' responses to keywords were characterised by different latency periods and emotional saturation. The delay time of military personnel with amputated limbs to keywords also varied. Associations with the word «war» (309 ms) are characterised by a short latency period and high negative emotional saturation. Instead, patients' responses to the keywords «house» (643 ms), «life» (759 ms), «happiness» (837 ms), «future» (812 ms) are primarily associated with the concepts such as «ruin» (62%), «basement» (54%), «crack» (71%), and is also characterised by a long latency period and unproductive associations (stereotypical statements dominate in many answers).

The semantic analysis of the associations shows the serious changes and destruction of the semantic nucleus of the serviceman, who had their

limb amputated. Patients were confused, experienced loss of life prospects, frustration, had little idea what they could do and how to live after release from the hospital. In this context, it should be emphasised that, unlike a sick or injured person, a serviceman, who was seriously injured in the ATO-JFO, had to carry a double burden – a fact of physical mutilation and involvement in combat actions.

Phantom pain and hemispheric interaction

The results of our study suggest, that in case of injured servicemen with an amputated limb, phantom pain originates in a complex way. In the etiopathogenesis of this phantom pain a whole complex of psychological factors matters: from disruption of intercultural interaction to disruption of the body scheme. This can be proved by the different frequency of phantom pain in the right and left limbs, reported by servicemen. As a rule, we reported 69% of left-sided and 31% of right-sided amputations as "painful hallucinosis" (post-amputation phantom pain syndrome).

The uneven frequency of phantom syndrome can be explained by the functional asymmetry of the brain, which lies in sensory "specialisation" of the right and left hemispheres. The dominant hemisphere (left in right-handed people) is responsible for processing symbolic (verbal – logical or linguistic) information. The subdominant hemisphere (right in left-handed people) is responsible for receiving and processing imaginative, emotional signals. Pain impulses, with extremely high emotional saturation, are mostly "remembered" by the subdominant hemisphere, which causes a large frequency of phantom syndrome on the left half of the body. Observations also indicate the complex nature of cortical departments of various analysers, that are connected with the origin of phantom pain. The mechanisms behind the development of pain are likely to be complex interactions between the analysers and the activation of old sensory engrams. This proves the importance of psychotherapeutic action on the psyche of a serviceman who is experiencing phantom pain, harmonising intercultural interaction and teaching him the techniques of autosuggestive action.

Phantom pain as a sign of body integrity

Patients with an amputated limb treated their phantom sensations as an integral part of their body. Following on from the observations of F. Nortvedt and G. Engelsrud, our studies also confirmed that the patient, who feels an amputated limb, continues to perceive it as a proper organ, but with pain. The presence of pain seems to intensify the feeling, that the lost limb was not damaged.

Serviceman M., who after the injury had his lower leg amputated, described the feeling of phantom pain:

"This pain is like an intruder for me. I feel it not only in my "knee" and "in my right toes", but I also spontaneously returned to that tragic morning of September 2014. On the one hand, the phantom pain reminds me that I can control my tank again, and, on the other hand, it brings back all the horror I have experienced. Phantom pain prevents me from forgetting it all ...".

As you can see, phantom pain is localised in a special form of expression and is irradiating. It restores not only the integrity of the body (signalling that the pain has a body), but also an ambivalent hope for a successful professional future.

For 62% of respondents with amputated limbs, phantom pain caused complications with falling asleep and generally led to sleep disorders. At the same time, according to the analysis, the injured servicemen's dreams were quite peaceful. They dream of themselves being healthy, and in those scenes, there are necessarily locomotor acts that have a special emotional saturation, and did not occur in dreams before the amputation: soldiers walk on fresh, morning dew, run on the road, play football, etc. It is interesting, that servicemen, who also received injuries of the different degree of severity, but had no limb amputation, usually had dreams, the content of which reflected traumatic experiences associated with the moment of injury.

Symbol as a special language of phantom pain

Once, when F. Nortvedt and G. Engelsrud were working with people, who were paralysed and had amputations, the scientists found out, that phantom pain was expressed in the form of a special language – symbolic. Describing the manifestation of phantom pain, their patients accurately visualised it [14]. In spite of all the cruelty of the symbols used by our respondents in their stories, which covered the excessive suffering they had to endure as a result of gunshot wounds, burns, and tortures in a captivity, one of the patients described his pain as a large anthill. His hand was in the middle of it. At the same time, one of the servicemen mentioned that the ants were moving through all the blood vessels of the fingers. While recounting his feelings caused by phantom pain, the serviceman constantly scratched and rubbed his arm above his elbow, though he did not feel any discomfort in this area.

The expression of phantom pain by the means of symbolic language should be regarded as one of the strategies for dealing with it in everyday life. The narrated story about the feelings associated with phantom pain reveals to psychologists and medical staff the peculiarities of the behaviour of people living with this pain.

Phantom pain as a form of imaginary restriction and doubt

Patients, who are experiencing phantom pain, quite often try to understand how to experience pain in a particular part of the body that no longer exists. For most of them, pain is always a living reflection of experience and a constant dualistic dilemma between the ability to endure physical pain and phantom pain [14]. We will analyse, how this dilemma was expressed in a narrative interview by serviceman F., who was held in captivity, had to endure various types of torture, and who, as a result of an explosion, triggered by trap-wire, had his left leg amputated to the knee. Serviceman F. expressed his doubts about the dilemma of pain that he felt in his amputated leg as follows:

"When I first felt the phantom pain, I thought it was just my imagination. My injury ached incredibly. But now it is gone, so there should be no pain. I have already completely mastered the prosthesis and could walk upright. With the help of a prosthesis, I tried to fool my brain. After all, it is not clear in trousers that my leg is not real. Unfortunately, I only managed to relieve pain for four days...

For me now, phantom pain is associated with the sadness that I experience after losing a friend or family member. It's a ghostly pain. However, it keeps reminding me that my leg is lost forever. When I watch a

football match, I immediately think that I will never be able to play football again. It worries me a lot".

An analysis of this narrative interview reveals that phantom pain can be amplified as a result of the constant reminder of a lost limb. In some places, such reminders may lead to anxious experiences that restrict a person from being engaged in certain activities, create constant internal discomfort, and estrange from the world.

The way phantom pain makes an amputee soldier face his previous life of an able-bodied individual is deeply existential [14]. His body is no longer his body, that is, it is not the same it used to be. This is his previous, but distorted body. Such intrusive thoughts can devastate his energy potential and lead to disadaptation in the social environment, manifestations of "emotional burnout" syndrome and loss of meaning in life.

Serviceman D. associates his phantom pain with an evil enemy who continues to destroy his peaceful everyday life. He often claimed that he would "gladly" give up his body if it could make him free from phantom pain. The comments clearly demonstrate this state of despair: "What is gone should no longer be"; "It's even stronger than the mental pain, which I can't handle".

Serviceman F. compared the loss of a leg with the loss of a close relative. Taking this patient as an example, we can say that phantom pain is able to change the value-orientation sphere. Patient critically evaluates his or her previous life experience. In particular, he notes: "Previously, I did not play football, just because I could not buy sports shoes. But I had two legs ... I didn't realise it. I have associated these benefits with certain things that I did not have (sports shoes). Their purchase should make me happy. Now I understand how happy I was then and how unhappy I am now".

As we can see, the traumatic experience plays an important role in the life of an amputee soldier and leads to the feelings of marginalisation and deep sadness. The idea "I am alive" seems to be fading. Phantom pain is a constant reminder of a lost limb and takes a soldier into a "double painful prison". That is to say, it is a literal pain, that is associated with the loss of a limb, and is exacerbated by psychological "pain".

Phantom pain activates specific forms of psychological protection

Servicemen, with amputated limbs, feel neglect (disgust), and in some cases even hatred of colleagues, friends and relatives. This sometimes leads to denial, passive protest, alienation, projection, which are specific types of psychological protection.

By means of denial, the patient tries to avoid new information concerning the features of phantom pain manifestation, because it may be incompatible with those ideas that he had already created. Attention is diverted as a result of denial. Its direction changes in a way that a serviceman, with an amputated limb, becomes especially inattentive to the spheres of life and events that may cause grief and double trauma. Denial restricts the thoughts of an amputee soldier. As a result, he may not notice a number of obstacles as he will treat them as those, that he may easily overcome. This is a kind of internal emigration. We will illustrate this with the example of serviceman S. who had his left leg amputated (from a medical history): "Trying to overcome the phantom pain and getting used to the prosthesis, the serviceman S. refused to meet his relatives until he manages to walk upright. After a significant improvement, patient S., spending time with his wife, mother and two sons,

denied any pain in the amputated leg. Remaining for a short period of time alone with his sons, serviceman S. trying to prove verbal information about the lack of discomfort in his movements and actions decided to demonstrate his psychomotor skills, which were well developed before the amputation, activities on the crossbar. As a result, at the last stage of the exercise (jump from the crossbar), serviceman S. fell and broke his left arm".

The above-mentioned narrative exemplifies that the protective mental reaction of this patient is facing complete denial, even though the events are quite obvious. Unlike other protective mechanisms, denial leads to the selection of information, rather than transforming it from unacceptable to acceptable.

An early form of protective behaviour of a serviceman who has an amputated limb is passive protest, manifested in the refusal to communicate even with the loved ones, excessive manifestations of independence. Passive protest is usually manifested in the so-called hospitalism syndrome. The patient seeks to deviate from any external actions whenever it is possible. In practice, this may be manifested in a non-motivated refusal to take the necessary action. It can also form a special system for explaining why an accident happened to him and not to someone else.

Alienation, as a special form of psychological protection for a serviceman with an amputated limb, is often manifested in the form of isolation, reclusion of the personal areas associated with traumatic factors in the serviceman's consciousness. The thinking of an amputee (regarding the local subjective evaluation) in the event of splitting becomes alienated. However, some sets of events are perceived separately by the patient, the connections between them are not updated and therefore not analysed.

According to the above-mentioned information we can see that isolation provokes the disintegration of the ordinary functioning of consciousness: its unity is splitted. There appear separate consciousnesses, the one before amputation and the one after amputation. Each of them exists independently, can possess its own perception, memory, attitudes.

Alienation protects the amputee soldier by protecting his ego from phantom pain, which provokes unbearable experiences. This means, that the alienation in the behaviour of the amputee has both negative and positive sides. In its protective role, it acts as an internal anesthesia, enabling it to shield itself from the insane physical and mental suffering caused by phantom pain [7].

The results of our observations of the behavioural reactions of amputee soldiers show that for many of them there is a kind of psychological protection as projection, manifested in the unconscious transfer of unacceptable feelings, desires and aspirations of others (often fellow officers). We can decode this as the unconscious rejection of one's own unacceptable thoughts, attitudes, desires and the empowerment of others to shift responsibility for what is happening within his ego to others.

There have been frequent cases, when an amputee begins to accuse others of being annoyed, while experiencing annoyance himself, declares that he is ignored, ostracised, although in fact he estrangers himself and blames others for his own mistakes. The side-effects of the projection, that we have observed in dealing with military personnel with amputated limbs, are irony, sarcasm, hostility [18].

Patients' desire to continue fulfilling their functional duties, despite a strong phantom pain sensation, proves a particular state of ambivalence. A significant percentage of patients with amputated limbs (39%) showed a strong will to continue their lives, believing that they can be interesting and exciting, despite the excessive pain. As F. Nortvedt and G. Engelsrud pointed out, the desire for life is so strong and demanding that it reduces suffering [14]. At the same time, most of our military personnel (61%), with amputated limbs, almost do not use cognitive and behavioural strategies to overcome phantom pain, that can potentially distract, relieve from the feeling of pain and give an opportunity to rethink the role of pain in an individual's future life.

■ CONCLUSIONS

The fact, that a person was engaged in combat activities, has a negative impact on a person's mental health, resulting in neuropsychiatric disorders and often causing physical harm. The most influential negative psycho-traumatic factor for a serviceman is the amputation of limbs, as it means the collapse of all his life prospects, a re-evaluation of his/her ego, a significant decrease in the level of harassment, and often the loss of the meaning of life.

The results of empirical research show that phantom pain is an experience that transforms and alters the serviceman's perception of himself and his attitude towards the world. Phantom pain deprives an amputee serviceman of rest throughout the day and night. A close retrospective of the past and quite early habits represent their desire not to give up and restore a previous way of living.

Phantom pain at its core has devastating effects that are difficult to understand and decode. Amputee servicemen feel hatred, a deep sense of loneliness and find themselves estranged from the society. The state of loneliness in some cases leads to a kind of internal isolation of servicemen who are sure that the reality of phantom pain cannot be felt, understood and experienced by neither the medical staff nor their relatives. These patients think, that the invisible (illusory, ghostly) pain is much more dangerous than a real injury.

Phantom pain catastrophizes a serviceman, forming a maladaptive-cognitive style of his behaviour, which is expressed in excessive accentuation on the anticipation of negative results in the future. In some cases, catastrophizing can deepen chronic pain and activate related disorders [3]. Phantom pain activates the "intruding memories" that had traumatised the serviceman and generates, in turn, a spectrum of anxious experiences that limit the serviceman's worldview, create permanent internal discomfort and make him a recluse.

We consider that the prospects for further research lie in the development of programmes for social and psychological rehabilitation of military personnel – participants of combat operations who have lost their limbs and are experiencing phantom pain. These programmes will be based on the individual and group psycho-correction work, the main element of which should be logotherapy aimed at overcoming the life crisis, search for a new meaning of life, as well as anti-crisis psychotherapy, behavioural psychotherapy and the ability of servicemen to manage their functional state, with an aim to eliminate depressive symptoms, reduce the intensity and prevent the phantom-pain syndrome.

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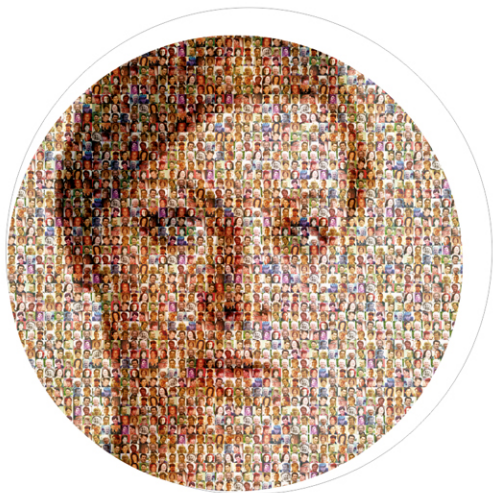
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