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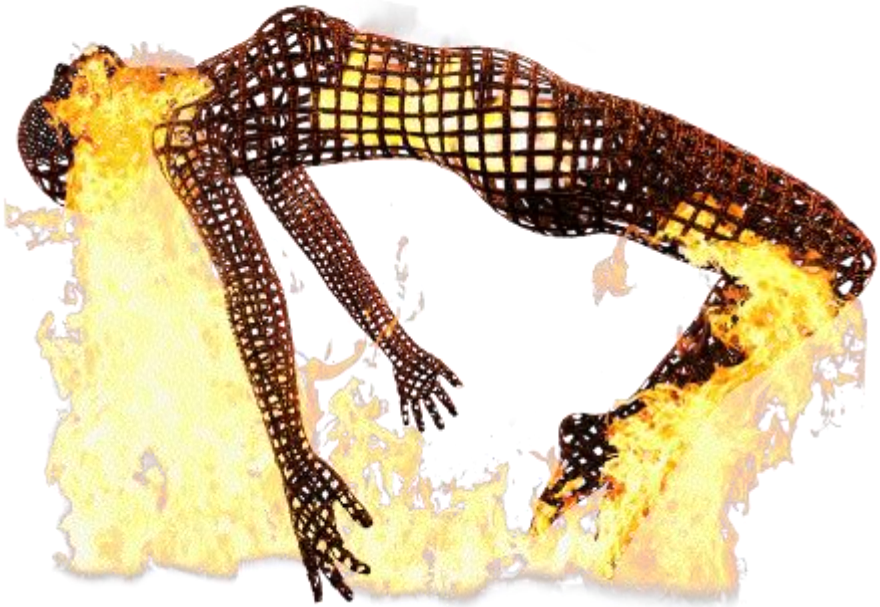
Deliverable 5 .3. 3 Toolbox for Equal Health Provision

Development of solutions on how to address the psychological effects on the medical staff of the beneficiary from the Covid-19 pandemic & burnout syndrome - CONSULTATION MANUAL

1 . PSYCHOLOGICAL CONDITIONS THAT MAY OCCUR AS A RESULT OF EXCESSIVE STRESS

This section examines two types of psychological conditions that can occur as a result of excessive stress and can have long-term effects on the mental health of healthcare personnel:

- Post-traumatic stress disorder, which can occur as a result of severe physical and accompanying mental stress on the part of medical staff when treating patients with Covid-19
- Burnout syndrome (occupational burnout), which may be a consequence of exposure over a long period of time to severe stress, in which the treatment of patients with Covid-19 may accelerate the process or intensify the negative effects



1.1. Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) is a type of anxiety disorder that develops in people who have experienced a terrifying or life-threatening event. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event. Most people who experience traumatic events may experience some difficulty in adapting and coping with what has happened. This is normal, as fear is an intense reaction and causes many changes in the body that usually improve over time. However, if symptoms worsen, last for months or even years and interfere with daily functioning, a diagnosis of "post-traumatic stress disorder" (PTSD) may be made.

PTSD symptoms are generally grouped into four types:

1. Obsessive memories
2. Avoidance
3. Negative changes in mood and thinking
4. Changes in physical and emotional responses

PTSD symptoms change over time and vary from person to person. They may begin within a month of the traumatic event, but sometimes may not appear for years after the event. These symptoms create significant problems in social, professional situations and interpersonal relationships. They may interfere with the ability to perform normal daily tasks.

Obsessive memories

Symptoms of intrusive memories may include:

- Recurrent, unwanted distressing memories of the traumatic event
- Experiencing the event as if it were happening again (flashbacks), disturbing dreams or nightmares related to it
- Heavy emotional suffering or physical reactions to something reminiscent of the traumatic event

Avoidance

Avoidance symptoms may include:

- Sufferers try not to think or talk about the traumatic event
- Avoidance of places, activities, or people that remind you of the traumatic event

Negative changes in mood and thinking

Symptoms of negative changes in mood and thinking may include:

- Negative thoughts about yourself, other people, or the world
- Helplessness before the idea of the future
- Memory problems, including an inability to recall important aspects of the traumatic event
- Difficulty maintaining close relationships
- Feeling isolated from family and friends
- Lack of interest in activities that were previously enjoyable
- Feeling emotionally **numb**

Changes in physical and emotional responses

Symptoms related to changes in physical and emotional responses (also called arousal symptoms) may include:

- Sufferers startle and frighten easily

- Self-destructive behavior, such as alcohol abuse or driving too fast
- Sleep problems
- Concentration problems
- Irritability, angry outbursts, or aggressive behavior
- Feelings of overwhelming guilt or shame

It is not yet known why some people develop PTSD and others do not. As with most mental health disorders, PTSD is caused by a complex combination of:

- Stressful experiences, including the number and severity of traumas the individual has experienced in his lifetime
- Hereditary mental health risks such as family history of anxiety and depression
- Hereditary traits of personality and temperament
- The way the brain regulates the chemicals and hormones the body releases in response and reaction to stress

Risk factors

PTSD can occur in people of any age. Under the influence of certain factors, a person becomes more susceptible to developing PTSD after a traumatic event, such as:

- Occupation that increases the risk of exposure to traumatic events (military, doctors, police)
- Having other mental health problems such as anxiety or depression
- Abuse of psychoactive substances, for example excessive alcohol consumption or drug use
- Lack of support from family, friends and social environment
- Relatives with mental health problems, including anxiety or depression
- A life filled with dangerous events and traumas
- The sight of a very sick person or a dead body
- Childhood trauma
- A feeling of terror, helplessness, or extreme fear

Types of traumatic events

The most common events leading to the development of PTSD include:

- Exposure to a military battle, battle
- Physical abuse in childhood
- Sexual violence
- Physical assault
- Assault with a weapon
- An accident

Some factors that may reduce the risk of PTSD include:

- Seeking support from other people, especially friends and family
- Finding a support group after the traumatic event
- Creating positive coping strategies and dealing with the traumatic event through the help of a specialist

Complications

PTSD can affect all areas of life – work, relationships, health and enjoyment of daily activities – and also increase the risk of other mental health problems such as:

- Depression and anxiety
- Drug or alcohol abuse
- Eating disorders
- Suicidal thoughts and actions

1.2. The burnout syndrome

The concept of burnout (burnout) is a term introduced by the American psychologist Herbert Freudenberger (1974) in the article "Overheating: the high price of high achievements". It defines a state of exhaustion and frustration, a complex of symptoms and behaviors accumulated as a result of prolonged occupational stress. The expression explains the process of deterioration of the physical and mental condition of social service workers who, after a year of work, became depressed, emotionally exhausted, nervous and irritable, cynical and suspicious of the people they work with.

More than three decades ago, the American Cristina Maslach (1981), professor of psychology at the University of California in Berkeley, USA, deepened research on the problem of burnout. She created and validated the first questionnaire to statistically calculate the presence, degree and severity of the three components of the syndrome.

In 2001 d. it identifies six main areas of inconsistency that lead to professional burnout:

- Requirements to the worker and his real capabilities
- Striving for independence in work and the degree of control applied
- Work effort and underestimation of contributions
- Absence of positive relationships with the work team
- Absence of fair relations at work
- Ethical principles of personality and job requirements

To these inconsistencies can be added features of the work environment leading to "professional burnout":

- A long working day with a heavy workload
- Lots of personal responsibilities and lack of work-life balance
- Impossibility for the worker to influence his work schedule, the degree of workload and the tasks he undertakes
- Lack of or difficulty in securing resources necessary for the work with which a person is charged
- Unclear about coping criteria and what exactly is expected of the worker (considered to be one of the main factors)
- A work environment with emotional or mental abuse by co-workers or superiors
- Monotonous or overly varied tasks - such work requires a lot of energy to keep the worker focused. Even too much variety can lead to burnout due to constant stress. It is necessary to collect the balance

In general , the symptoms of burnout can be divided into three groups: physical, mental and behavioral.

- Physical ones are described as lack of energy, chronic fatigue, frequent headaches, back pain, insomnia, high blood pressure, gastrointestinal problems, changes in appetite.
- Mental signs are frustration, anger, depression, feelings of helplessness, frequent mood swings, anxiety, loss of self-esteem and self-confidence.

- Mental exhaustion, withdrawal from relatives and friends , reduced criticality towards duties and responsibilities at work are noted as behavioral signs. Distancing leads to apathy, rigidity, irritability, to cynicism towards things that until recently were part of a person's value system. Abuse of drugs, cigarettes, drugs and alcohol is increasing. It can lead to an irreversible condition or to leaving work.

In most literary sources, the burnout syndrome is described as a combination of the following three main components:

- Emotional exhaustion - indifference, exhaustion, chronic fatigue to apathy. It is expressed in the feeling that you can no longer "give" of yourself, that you are fed up with the continuous experience of solving other people's problems and pains; it is all too common in the medical professions and is especially prominent in nurses;
- Depersonalization – exhibiting a negative attitude towards oneself and the recipients (clients, students, patients, colleagues), which can reach insensitivity, hostility, social withdrawal, dehumanization and cynicism;
- Low self-esteem, self-presentation in a professional aspect, reduced ability to work - feeling of a low degree of realization, that you are not doing well, that you are not good at your job, that you are failing - up to incompetence. It is characterized by a reduced interest in professional development and improvement. A person stops seeing the positive results he has achieved and emphasizes only the failures.

The development of the burnout syndrome goes through three stages according to Maslach:

- The first stage is the stage of disappointment and disbelief
- During the second stage, an irresponsible, cynical attitude towards colleagues and clients/patients develops
- The third stage is irreversible, rarely occurs - a person falls into a dead end and cannot manage his own life; mental and physical fatigue are permanently present ; the effects are permanent and professional help is useless

According to Herbert Freudenberger and Gail North, burnout involves a series of 12 phases, and each of them contains important information about the process:

- The inner need to prove ourselves: the need to prove ourselves can overshadow our personal well-being and inner needs, potentially leading to the start of the burnout process
- Taking on more and more work commitments: it is important to identify the early signs of burnout, such as a reluctance to delegate and an obsession with putting more and more effort into the workplace, driven by uncertainty and fear
- Neglecting one's own needs: this is the phase in which time is short, personal needs are neglected and self-healing practices begin to be applied
- Emergence of conflicts: conflicts related to work are rejected or rationalized and a phase is passed in which the individual avoids the need to face his main problems
- Revision of values: a shift in priorities takes place as work takes precedence over other aspects of life, affecting relationships, leisure and personal well-being
- Denial of emerging problems: this is the phase where denial sets in and people withdraw into their inner world, trying to survive despite the increasing sacrifices they are making
- Withdrawal: the individual deepens isolation, becomes extremely cynical, and the self-fulfilling prophecy phenomenon [1]of perceiving the world as hostile occurs

[1] A prediction that directly or indirectly causes its fulfillment by virtue of the prediction itself, thanks to the positive feedback relationship between belief and behavior .

- Strange behavioral changes: increased withdrawal from life, erratic behavior and loss of control over emotions and reality
- Depersonalization: lack of connection with self and others appears; a critical stage is reached when external help becomes necessary to stop the burnout process
- Inner emptiness: the feeling of emptiness, worthlessness appears, and often unsuccessful attempts at self-medication are applied to silence the emptiness
- Depression: an overwhelming feeling of hopelessness, despair and giving up on life appears, which can lead to further deterioration of the physical and mental state
- Burnout syndrome: this is the terminal phase where life loses meaning and immediate medical attention is crucial to deal with the potentially life-threatening consequences

Figure 1. The twelve phases of the burnout syndrome

Source : T he P resent Psychologist

The characteristics of burnout can be summarized as follows:

- Burnout is a phenomenon typical of professions with intensive interpersonal contacts and especially characteristic of medical professions
- Three dimensions are combined:
  - Emotional exhaustion
  - Depersonalization
  - Self-presentation

- There is a continuous development over time

- It has complex symptoms
- There is a complex of risk factors for development
- It leads to consequences on the whole person and his professional life
- Burnout lies between health and illness – from the final stages of burnout to mental illness is only one small step

Depersonalization

Depersonalization has been described as the ninth stage on the road to burnout. Since this term is relatively less known, below are its characteristics. This condition can also manifest itself in other life situations that are not related to the sequence of events leading to burnout.

Depersonalization-derealization disorder occurs after states of fatigue and overfatigue or as a result of hallucinogenic intoxication. In depersonalization, a person persistently or repeatedly feels that he is observing himself outside the body, and in derealization, he feels that the environment has changed.

Depersonalization-derealization occurs when a person always or often feels that they are outside their body, feels that things around them are not real, or both. Feelings of depersonalization and derealization can be very disturbing. The feeling is as if one lives in one's dream (in the matrix) .

Many people have a fleeting experience of depersonalization or derealization at some point. However, when these feelings continue to appear or never completely disappear and make it difficult for the individual to function , it is probably a depersonalization - derealization disorder. This condition is more common in people who have experienced trauma, such as violence, abuse, or other types of extreme stress.

Depersonalization - derealization disorder _ it can be serious and interfere with relationships with relatives and friends with colleagues in the work environment . In addition , it can interfere with other daily activities. The main treatment is psychotherapy, also known as talk therapy (psychotherapy). Sometimes medications are also used .

Symptoms of depersonalization include:

(1) You feel that you can see your thoughts, feelings, or body or parts of your body from the outside; for example, you may feel like you are floating in the air above you

(2) You feel like a robot or that you are not in control of what you say or how you move

(3) You feel that your body, legs, or arms seem distorted or out of shape; they may appear larger or smaller than usual

(4) You can feel that your head is wrapped in cotton

(5) Emotional or physical numbness of the senses or reactions to the world around you

(6) You feel that your memories lack emotion and may or may not be your own memories

Symptoms of derealization include:

(1) Feeling that people and your surroundings are not real; as if you are living in a movie or a dream

(2) You feel emotionally detached from the people you care about, as if you are separated by a glass wall

(3) Your surroundings appear out of shape, blurry, or colorless; all objects around you may appear to have only two dimensions – flat with no depth; your surroundings may appear brighter and be seen more clearly than usual

(4) There are thoughts about time that are not real, such as recent events that feel like they happened in the distant past

(5) Unrealistic perceptions of the distance, size, or shape of objects may be present

Attacks of depersonalization-derealization disorder can last hours, days, weeks, or months. For some people, these attacks develop into ongoing feelings of depersonalization or derealization, which can sometimes get better or worse.

Individuals suffering from depersonalization-derealization syndrome often improve without external intervention. Full recovery is possible for many, especially if symptoms are the result of treatable or transient stressful events. In other cases, depersonalization and derealization become chronic and refractory.

Even persistent or recurrent depersonalization or derealization symptoms may cause only minimal impairment if patients can distract themselves from their subjective feeling by keeping their mind occupied and focused on other thoughts or activities. Some patients are disabled by the chronic feeling of alienation, by the accompanying anxiety and depression.

Burnout syndrome brings direct and indirect harm to bio-, psycho- and social personal health and that of patients, leads to callousness in medical professionals, lack of sympathy, compassion and empathy, refusal of cooperation and support for the person in a health crisis. This affects personal and professional efficiency and leads to poor application of work skills.

2. SPECIFICITY OF DEPRESSIVE DISORDERS

2.1. Rhythmicity of depressive disorders

Two types of rhythms are most often identified in the course of depressive disorder.

Seasonal rhythm

Most often depressions appear in spring and autumn. The months of March-May and September-November are typical not only for the onset of depression, but also for other diseases (eg, duodenal ulcer). There are also some special forms of the disease that are associated with a deficiency of sunlight and a short day. Such a form is seasonal affective disorder (winter depression, atypical depression), which is characterized by irritability, hyperphagia, hypersomnia and, in some cases, increased libido.

Circadian rhythm

Most often, with depression, the mood is lowest in the morning. In depression, early awakening (eg 02:00 to 05:00 after midnight) is associated with extremely gloomy moods, thoughts (including of suicide), which are associated with the highest concentration of suicides in this part of the day. Gradually, as the day progresses, the mood improves, and in the evening it can reach the norm (euthymia), and less often, a discrete increase (mild hyperthymia). For this reason, meeting with a doctor in the second half of the day can lead to a diagnostic error.

2.2. Particular subforms of unipolar depression

Psychotic depression

This rubric includes patients with depression plus delusions and/or hallucinations. There are two main subtypes of psychotic symptoms – congruent (related to the general mood background, mainly guilt, ruin and hypochondriac) and incongruent (most often from the paranoid circle – persecution, impact, hostility, poisoning, etc.). Incongruent delusions determine a worse prognosis of depressive disorder. Psychotic depression is characterized by a more pronounced tendency to bipolar course (alternation of depressive with manic or hypomanic episodes). In the treatment scheme, in addition to antidepressants, antipsychotics are also used. ECT is a highly effective non-treatment method in these cases. Another approach is to combine antipsychotics with antidepressants (included at a later stage).

Melancholy

Melancholy is a form of depressive disorder that is characterized by severe severity (severe depression). In addition to other symptoms of depression, it is marked by pronounced retardation (or agitation) and vital signs - very severe insomnia (early awakening in the wee hours of the night), pronounced anorexia (weight loss of more than 5% of the initial body weight within 1 month), severe hyposexuality, suicidal thoughts often appear, food and fluid intake are reduced to stopping, etc. Anhedonia is also more severe in melancholia, and diurnal fluctuations are pronounced.

Atypical depression

Atypical depression is a relatively rare form. Some authors assume that it is due to sertonin deficiency. It is characterized by some specific features that distinguish it from typical forms:

- Hyperphagia
- Hypersomnia
- Weight gain
- Reactive mood (mood reacts to external stimuli)
- Extreme sensitivity to interpersonal relationships and especially rejection (hysteroid dysphoria)
- Sometimes there is also hypersexuality
- A feeling of heaviness in the limbs

Anxiety components of atypical depression include:

- Expressed anxiety
- Difficulty falling asleep
- Phobic symptoms
- Symptoms of sympathetic overactivity (including panic-like states)

Dysthymia

Dysthymia is an oligosymptomatic depression (with mostly depressed mood), but a marked tendency to chronification of the course (over 2 years).

Double depression

Double depression is a combination of chronic depression (dysthymia) with superimposed depressive episodes (fully manifested clinical picture).

2.3. Depression in women

Depression in women is twice as common. The causes of gender differences have been the subject of intense research in recent decades.

Table 1. Gender differences in depression

Factors	Gender differences
Generic family and usage	Girls are more often victims of sexual abuse in the family
Early-onset depressive and anxiety disorders	Women have depressive and anxiety disorders at an earlier age
Social roles and cultural norms	Role limitation is a prerequisite for limited choice, role overload is a reason for the development of depressive disorders in women
Adverse life events	They are not more common in women, but may be experienced differently due to different social circumstances
Vulnerability and coping style	No differences were found in both sexes
Social support	No gender differences were found
Genetic factors	There is no conclusive evidence for the contribution of genes to gender differences
Gonadal hormones	They have a partial effect on female differences
Adrenal axis and thyroid axis	Contrasting data on the adrenal axis and limited significance of the thyroid axis
Neurotransmitter systems	Uncertain data on differences

Source: Piccineli and Wilkinson, 2000.

The risk factors for suicidal behavior in women also have some peculiarities. It has been found that age under 30, abandonment by an intimate partner, living alone, pronounced and severe distressing events, substance abuse, personality disorder, combined with depression are conditions for the occurrence of suicide attempts.

For suicide, severe depression, alcohol intake, past suicide attempts, a suicide plan, divorce or widowhood, presence of chronic somatic diseases, feelings of hopelessness, panic disorder, pronounced and severe generalized anxiety combined with depression are important .

3. PREVENTION AND CONTROL OF PROFESSIONAL STRESS

Prevention and control of occupational stress include:

- Assessment of physical and mental stressors
- Assessment of the mode of impact of the stressor (direct/indirect)
- Assessment of the stressor–individual–group interaction effect
- Assess the level of occupational/combat stress
- Development of a specific plan for psychological interventions
- Conducting psychological interventions/consultations
- Analysis of results and feedback

3.1. Occupational stress and occupational burnout

Occupational burnout as a result of occupational stress is a state of physiological, emotional and mental exhaustion, characterized by chronic fatigue, feelings of helplessness and hopelessness, and the development of negative self-perception and negative attitudes towards work, life and other people.

The process of professional cremation is long, cyclical and consists of several phases:

1. Phase of professional involvement
2. Stagnation phase
3. Withdrawal phase
4. Crisis phase
5. Cremation phase

The factors of the working environment most often affecting the occurrence and development of occupational stress and leading to occupational burnout are:

- Professional overload
- Role ambiguity and role conflict
- Lack of control over the process and the result of the work
- Poor communication and lack of positive feedback
- Stressful interpersonal responsibilities
- Poor cohesion in the work team
- Dead end professional prospects
- High bureaucracy of the system

At the organizational level, professional burnout manifests itself through:

Alerts:

- Decreased motivation
- Frequent absences (especially due to illness)
- Frequent change of jobs
- Increased incident rate (e.g. death of a patient during a shift)
- Poor and/or reduced work functioning

Organizational implications include:

- Reduced professional efficiency
- Increased health care costs
- More absenteeism as a result of 'withdrawal behaviour'
- Excessive increase in working breaks

Strategies for Coping with Professional Cremation:

- Active and direct – changing the source of stress, confronting the causes of stress
- Inactive and direct – ignoring the source of stress, leaving the stressful situation
- Active and indirect – talking to a supportive person, getting involved in other activities
- Inactive and indirect – alcohol, drug abuse or other form of addiction

3.2. Complex coping strategies for stress response

Guiding principles:

- Proximity – specialized intervention should be carried out as close as possible
- Immediacy – immediate specialist intervention when symptoms appear
- Likelihood (expectation) – expressing positive expectations for recovery and return to the part
- Simplicity (clarity) – use of simple, short and efficient methods

3.3. Post-traumatic stress disorder (PTSD) according to the diagnostic criteria of the International Classification of Diseases

PTSD falls under section F43 of the International Statistical Classification of Diseases and Related Health Problems (Tenth Revision, WHO, 1992).

F43 . Severe stress response and adjustment disorders

This group of disorders differs from others in that it includes those that can be defined not only on the basis of symptomatology and course, but also on the basis of one of two causative influences - an extremely stressful life event giving rise to an acute stress reaction or a significant a life change leading to prolonged adverse circumstances resulting in an adjustment disorder.

Although not so severe psychosocial stress ("life events") can trigger the onset or contribute to the appearance of a very wide range of disorders classified elsewhere, their etiological significance is not always clear and in each individual case it can be established, that it depends on the individual, often idiosyncratic vulnerability (in other words - life events are neither necessary nor sufficient to explain the type and occurrence of the disorder) . In contrast, the disorders collected here always develop as a direct result of acute stress or prolonged trauma.

The stressful event and ongoing adverse circumstances are the primary and most weighty causative factor, and the disorder would not have occurred without their influence. Thus, mood disorders in this section can be viewed as a maladaptive response to severe or prolonged stress because they interfere with successful coping mechanisms and therefore lead to impaired social functioning.

Acute stress reaction (F43.0)

It is a transient disorder that develops without the manifestation of other mental disorders as a reaction to extremely strong somatic or mental stress and usually lasts from several hours to several days. Individual vulnerability and coping capabilities play a key role in the occurrence and severity of the acute stress response.

Symptoms vary widely, but usually include an initial state of "stupefaction" with some limitation of the field of lucid consciousness, narrowing of attention, inability to perceive stimuli, and disorientation. This state can be followed by further withdrawal from the environment to the point of dissociative stupor [2]or by agitation and hyperactivity (escape reaction) . Vegetative signs of panic anxiety (tachycardia, flushing, sweating) are often present . Symptoms usually appear within a few minutes of exposure to the stressful stimulus and disappear within two to three days (often within a few hours) . Partial or complete amnesia for the stressful event may be observed.

Post-traumatic stress disorder (F43.1)

It occurs as a delayed or protracted response to a stressful event or situation (short-term or longer) that is extremely threatening or catastrophic in nature and is capable of causing profound distress in almost any person. Predisposing factors such as personality traits (eg, compulsive, asthenic) or a history of previous neurotic illness may lower the threshold for the onset of this syndrome or aggravate its course, but are neither necessary nor sufficient to explain its occurrence.

Typical symptoms include episodes of re-experiencing the trauma in the form of flashbacks , dreams or nightmares, with a persistent feeling of " numbness " , emotional dullness,

[2]It is diagnosed on the basis of a severe reduction or absence of voluntary movements and a normal response to external stimuli such as light, noise or touch, in which there is no evidence of a somatic cause. In addition, there is evidence of a psychogenic cause in the form of recent stressful events or problems.

alienation from other people, lack of response to the environment, anhedonia and avoidance of activities and situations reminiscent of the trauma.

A state of vegetative hyperarousal with hypervigilance, increased start-reflex and insomnia is usually observed. Anxiety and depression often accompany the symptoms and signs described above, and suicidal ideation is not uncommon. There is a latency period of several weeks to months between the onset of the disorder and the trauma. The course is fluctuating, but in most cases recovery can be expected. In a small number of cases, the disease can become chronic, lasting for many years and lead to permanent personality change.

Adjustment disorder (F43.2)

It represents a state of subjective stress and emotional disturbance, usually disrupting social functioning, which occurs during a period of adaptation to significant life changes or to the consequences of a stressful life event. The stressor may affect the integrity of the individual's social environment (loss of a loved one, separation) or the broader system of values and social support (migration, refugee status) , or represent a significant transition or developmental crisis (starting school, becoming of a parent, failure to achieve a desired personal goal, retirement, etc.) . Individual predisposition or vulnerability has an important role as a risk factor for the onset and shaping of the symptoms of adjustment disorders, but regardless of this, the disorder would not occur without the presence of a stressogenic factor.

Manifestations are diverse and include depressed mood, anxiety and restlessness (or a mixture of these) , a feeling of inability to cope with the situation, to plan for the future or to continue existing in the current situation, as well as some degree of impairment in carrying out routine daily activities. activities.

In addition, conduct disorder may occur, especially in adolescents. A shorter or more prolonged depressive reaction may be a predominant feature, as may disturbances of other emotions and behaviors.

3.4. PTSD prevention and control activities

A. Direct supervisors of medical staff should monitor for:
At the individual level:

- Manifestations of maladaptive behavior varying in severity
- Experiencing feelings of alienation, hopelessness, or inexplicable guilt
- Feelings of pain, "abandonment" and low self-esteem
- Difficulty controlling one's own feelings of dissatisfaction, unmotivated aggression and hostility
- Emotional dullness, sadness
- Behavioral oddities
- Manifestations of risky behavior - abuse of alcohol and psychoactive substances, risky driving
- Various bodily complaints and discomforts
- Insomnia and suicidal thoughts

At group level:

- Frequent conflicts between menician workers on minor occasions
- Difficult communication, incl. in the process of giving and executing internal orders
- When identifying such conditions, medical workers should refer to the psychologists of the relevant medical institution

B. Specialized psychological insurance unit:

- Conducts psychological research of medical personnel and training in psychological skills
- Performs psychological counseling at the individual, group and organizational level and crisis interventions as indicated
- Researches and follows up together with the heads of individual units and specialized bodies for psychological insurance for the presence of manifestations of stress reactions/disorders
- If necessary, organizes and coordinates the conduct of family counseling work and offers measures for full readaptation and resocialization

C. The specialized bodies for psychological insurance:

- Conduct screening tests for manifestations of stress disorders in persons subjected to severe stress in the period up to twelve months after the crisis situation has passed
- Conduct individual counseling and/or group work when indicated and requested and, if necessary, refer identified employees with symptoms of stress disorder for counseling and possible treatment;
- When diagnosing post-traumatic stress disorder (PTSD), depending on their qualifications, they also apply psychotherapeutic approaches

4. STRATEGIES FOR THE PREVENTION OF POST-TRAUMATIC STRESS DISORDER

Every person needs a deep, basic confidence that the world they live in is safe and predictable! Crisis situations disrupt precisely this sense of security and predictability. The crisis suddenly, strongly and continuously **disrupts the normal flow** of people's lives and activities, as a result of which the external crisis can turn into an internal one.

In a critical situation, the participants most often fulfill one of two roles - that of a victim or a rescuer. Both can experience high levels of traumatic stress and subsequently develop post-traumatic stress symptoms. In such cases, approximately 1/5 of people develop PTSD. There is a latent period of several weeks to months between the onset of the disorder and the trauma.

When measures are taken, things end up being restored. Of great importance for the prevention of post-traumatic stress disorder (PTSD) is the preventive activity that takes place at the following levels: institutional, organizational, group and individual.

4.1. At the institutional level

At the institutional level, it is necessary to regulate and confirm positive practices for crisis action in order to protect the mental health of the medical staff.

4.2. At the organizational level

At the organizational level, the following actions should be taken:

1. **Ensuring that all staff are protected from ongoing stress and poor mental health during the crisis period means that they will be able to perform their functions better.** I should not forget that the crisis situation may not be short-lived and the emphasis should be on long-term professional capacity rather than periodic short-term crisis responses

2. **Ensuring high quality communication and accurate and up-to-date information to all staff.** Ensuring staff rotation in the healthcare facility, transferring them from high-stress roles to lower-stress roles and vice versa. The teams working in the "hotbed" of the crisis should be changed, if possible for shorter periods of time.

Working in pairs helps provide support, monitor stress and reinforce safety procedures. Organization of working conditions with scheduled breaks, provision of food, water, hot drinks, a place to change clothes and disinfection (if necessary). Implementing a flexible schedule for workers who are directly affected or have a family member who is affected by a stressful event. Activities to maintain a good psychological climate in teams and provide employees with the opportunity to provide each other with social support

3. **Facilitating access to mental health and psychosocial support services and informing employees where they can access such services.** Such services can be organized by the management of the health facility and offered to the employees.

   The activities carried out on them can be group and individual and can be conducted directly or offline through different platforms. They provide an opportunity for both staff and management to be consulted

4. **Training staff** , nurses, ambulance drivers, volunteers, people involved in crisis resolution to be trained in how to provide basic emotional and practical support to affected people using psychological first aid

5. **Provision of essential medicines for all levels of the health care system.** People living with chronic illnesses will need continuous access to their medications. The suddenness of events may prevent them from securing them, which is why they need access to them

6. **Provision of psychological assistance.** It represents the provision of counseling with a specialist both during the crisis and afterwards regardless of the presence or absence of traumatic experiences in the employees.

4.3. At the group level

At the group level, psychological first aid and psycho-social support should be provided and anti-crisis interventions should be carried out, which aim to help the person to recover.

They collect a complete experience of a stressful event and help the psyche to outgrow it, to continue after it more maturely and with minimal negative consequences.

Main activities are **demobilization, diffusion and debriefing** .

- **Demobilization**

The procedure aims to ensure that those involved in overcoming the incident have the opportunity, the 'permission' to 'switch off', to 'switch off', to subside the sense of urgency and agitation that has been actively activated and held as a result of their mobilization for emergency situation. After work, people are provided with an opportunity to rest, eat or drink before returning to duty or home.

The overall demobilization period is 30 minutes long, during which he provides a short ten-minute talk on the typical effects of critical incident stress and explains what signs and symptoms may occur .

- **Diffusion**

Diffusion is a brief discussion, overview, and reflection of events that have recently ended. It is carried out where it is most convenient, from one to three hours (rarely up to 12 hours) after the accident , and usually lasts between half an hour and one hour. Only the teams most affected are included. Diffusion is done with more experienced and more stressed groups,

who have already begun to make sense of the events themselves according to the debriefing model.

It talks about facts and events , and then about thoughts, feelings and behaviors at the same time - as a whole reaction , giving explanations for each of them. And here the training part is extremely important. Diffusion can take place daily, at the end of each shift, at the end of a stay at a given location, in large-scale crises, when the situation changes, or when new questions arise.

Diffusion should NOT include operational-administrative debriefing: what people should have done, errors, omissions and issues that are investigated and identified, feedback on the quality of work and performance of commitments.

- **Debriefing**

Group form of anti-crisis intervention in 7 steps, created by D. Mitchell and D. Everley (G. Everley , Jeffrey Mitchell , 1983) and aimed at emergency responders (paramedics, doctors, firefighters, police officers). It is a supportive, crisis-focused discussion in small homogeneous groups who have experienced a severe traumatic event together.

The debriefing is carried out when the traumatic experience and very recent - from one - three - to seven days after the event . After this time, it is assumed that mobilization has passed into demobilization, and it is not appropriate for people to return to acute traumatic events that the psyche has already begun to process.

Debriefing is especially important for people who have less experience in stressful situations and are more vulnerable to their effects.

Table 2. Demobilization, diffusion and debriefing for providing first psychological aid and psycho-social support

Factors	Demobilization	Diffusion	Debriefing
Target	Closing, closing the incident; Time's return to normality	Reduce tension, resolve conflicts, initiate rest.	Incident assessment, start of recovery, mobilization of resources
Usage	In large-scale critical incidents	In experienced and trained teams after an unusual and complex high stress event.	In distress, tension, complexity and unusualness of the event
When	Right after work is done before people are dismissed	Within 12 hours	3-7 days
By whom	Anyone who has responsibility for people	Experienced trainer	Debriefing team

4.4. On an individual level

I take care of myself. It is any activity that we consciously do to take care of our physical, mental or emotional health (time for ourselves) . These are practices for actively participating in creating and maintaining our own well-being and happiness, especially during periods when we are in stressful situations.

Self-care is a conscious choice on our part, and it's important to see it as such. It is necessary to look for specific opportunities for rest and recovery, to share with colleagues and friends, to increase their commitment to the situations we have to deal with. It is necessary to actively and purposefully work to create conditions for personal care.

The physical dimension of self-care encompasses safety, health, nutrition, movement, physical touch, and sexual needs. Practicing activities aimed at maintaining good physical shape leads to an increase in physical well-being, energy levels and self-esteem can increase.

Exercising physical activity. Physical exercises cause the body to release endorphins (the hormone of happiness), increase the general mood and improve the way you see the world. Training shifts attention from thinking about the accident to thinking about the body and its movements. Last but not least, exercise helps the nervous system shake off the numbing stress caused by the trauma.

Rhythmic exercises that involve the arms and legs, such as walking, running, swimming or dancing, are particularly effective. Instead of focusing on negative thoughts, attention is focused on how the body feels.

Healthy eating . It is recommended not to break the usual diet and not to skip any of them - breakfast, lunch, dinner, in order to maintain high energy and physical and psychological balance. Emphasis on foods rich in Omega 3 fatty acids has beneficial effects on emotional health. Harmful foods can worsen mood swings, so limiting them is preferable.

Full sleep . Lack of sleep can cause anger, irritability and low mood. Adhering to a bedtime routine accompanied by a relaxing ritual such as listening to soothing music or reading a funny book combined with a sleep duration of between 7 and 9 hours each night provides an opportunity for full recovery.

The emotional dimension of self-care helps us understand ourselves more, cope with challenges, and develop and nurture healthy relationships. When we are aware of our emotional state and emotional needs, we cultivate a greater sense of empathy, kindness, and love for ourselves and others.

Countering feelings of helplessness. Overcoming this feeling is the key to overcoming PTSD. Trauma makes a person feel vulnerable, so it's important to remember that they have strengths and coping skills.

One of the best ways to regain a sense of significance is to help others: to give up one's time for a meaningful cause; donating blood; giving help and support to a friend in need or making a donation to a charity.

Adherence to the usual rhythm of functioning as much as possible. Maintaining the daily schedule observed before the time of the crisis. This gives a sense of security and control over the situation.

Spending time in nature. Physical exercise is especially effective when combined with the solitude and peace that nature brings. Doing outdoor activities such as hiking, camping, mountain biking, rock climbing, rafting, skiing, and swimming in the ocean are powerful ways to manage PTSD symptoms.

The desire to learn and expand our knowledge contributes positively to our overall well-being. Mental health care is all about finding the balance between stimulating the mind and resting the mind, and this can be achieved through creativity, positive change and continuous learning. People who make efforts for their mental well-being are supporters of personal growth, but highly appreciate the opportunity to "switch off" and let their brain rest for a while.

Relaxation. Applying relaxation techniques such as meditation, deep breathing, massage or yoga. They trigger the body's relaxation signals and are a proven way to deal with any type of stress.

The spiritual dimension of self-care involves a personal practice that allows us to follow the values and beliefs that give us purpose. Engaging in activities that focus on spiritual care can help us find more meaning in life, develop a sense of belonging, and find a connection to something bigger than ourselves. The dimension of spirituality is important even if we are not religious. We can always organize our day so that we have time for spiritually oriented activities.

Avoiding alcohol and cigarettes . In the struggle to deal with difficult emotions and traumatic memories, a person may be tempted to "self-medicate" with alcohol or cigarettes. Many of the substances found in alcohol worsen the symptoms of PTSD. It is preferable to avoid these substances.

Maintaining active and full communication with relatives and friends. Meetings and conversations in a trusting environment help to ventilate negative emotions and experiences.

Relationships with the people around us are an important dimension of self-care. Building good and sustainable relationships with those around us helps us achieve the sense of belonging and acceptance we need to feel welcome in our community and environment.

Pursuing a hobby or interesting activity

These activities take us away from everyday problems, make us think about pleasant things and allow us to spend time with relatives and friends or to do a favorite activity on our own.

Individual consultation with a specialist

After people have been exposed to traumatic events, they tend to confuse the abnormality of the trauma with the abnormality of the self in reactions to ordinary situations. Traumatic therapeutic activity is therefore based on three principles:

- **Normalization principle** . Insofar as traumatized people are by definition reacting to abnormal stressful circumstances, they may confuse the abnormality of the trauma with the idea of their own abnormality. There is a general pattern of post-traumatic adjustment, and the feelings and thoughts it encompasses are normal, although they may be painful and perhaps not well understood by people who are not familiar with them.

- **Principle of partnership and personal dignity.** This means that therapeutic relationships must be built together, leading to the restoration of the individual rights of those who have been disadvantaged in their dignity and security.

- **Principle of individuality.** Everyone has their own unique path to recovery from PTSD

4.5. Therapeutic techniques for dealing with trauma

Behavioral therapy

According to the principle on which this therapy is based, it is not necessary to understand the underlying psychological causes of behavior change. Its main purpose is to form and

strengthen the ability for adequate actions, the acquisition of skills that allow improving self-control.

Cognitive psychotherapy

Cognitive-behavioral therapists assume that psychopathological abnormalities are the result of inaccurate evaluation of events, and therefore a change in the evaluation of these events should lead to a change in the patient's emotional state. Cognitive behavioral therapy teaches patients to respond differently to situations that trigger anxiety attacks and other signs of anxiety.

Irrational judgments that arise in the background of anxiety and indirectly support it are eliminated by challenging their significance. Cognitive therapy is based on the theory that a person's behavior is determined by his thoughts about himself and his role in society.

Psychodynamic psychotherapy

The psychodynamic direction emphasizes the role of conflicts arising from the discrepancy between personal values and the internal picture of the person about the world of reality of the traumatic situation. Therefore, correction in this psychotherapeutic direction consists in studying the system of values and needs of a person and how the behavior and the experience of the traumatic situation have violated them; in resolving the resulting conscious and unconscious conflicts; transforming destructive energy into creative energy in an atmosphere of understanding, acceptance and emotional comfort.

Bringing repressed events to the level of consciousness, their emotional reaction, frees a person from systematic amnesia associated with the tendency to avoid certain negatively colored memories and ideas. Projective techniques are widely used for this purpose. The work is also aimed at restoring self-esteem and self-control, developing a healthy level of personal responsibility, restoring the integrity of the self.

Carl Rogers' Client-Centered Therapy

Client-centered therapy focuses on helping the individual to realize the possibility of transforming his crisis state, to see new perspectives and opportunities to return to normal life. First of all, the consultant informs the patient about the need to observe psychological hygiene, changes his attitude towards other people - teaches him to separate the personality from its behavior.

Logotherapy V. Frankel

Logotherapy deals with the meaning of human existence and the search for that meaning. Trauma disrupts the normal course of life, deforms the life world, and creates a sense of loss of meaning in life.

Family post-traumatic therapy

The goal of psychotherapy is to harmonize family relations, improve mutual understanding in the family, and eliminate the negative emotional tendencies of the spouses towards each other.

Eye movement desensitization and processing method (DPDG [3])

The original psychotherapeutic method of desensitization and processing with eye movements was developed by F. Shapiro (USA). The method is based on the idea that all people

[3] DPDG = Desensitization and processing by eye movement .

have a special psychophysiological mechanism - an adaptive information processing system. Eye movements (or other alternative stimuli) used in DPD G are hypothesized to trigger processes that activate accelerated processing of traumatic experiences, analogous to what normally occurs during rapid eye movement (REM) sleep. sleep). A number of researchers believe that the REM (rapid eye movement) phase of sleep is the period when unconscious material, including those related to stress, emerges for adaptive processing.

The stages of sleep

The human body goes through two stages of sleep, (1) rapid eye movement (REM) sleep and (2) non-rapid eye movement (NREM) sleep, which is further divided into three phases, N1-N3. Each of the stages and phases involves variations in muscle tone, brain wave patterns, and eye movements. The body goes through all these stages and phases approximately 4 to 6 times each night, averaging 90 minutes each cycle.

Sleep quality and the time spent in each stage and phase of sleep can be altered by depression, aging, traumatic brain injury, medications, and circadian rhythm disorders.

Transitions between sleep and wakefulness are controlled by multiple brain structures that include:

(1) Hypothalamus: controls sleep onset
(2) Hippocampus: memory area active during dreaming
(3) Amygdala: emotional center active during dreaming
(4) Thalamus: prevents sensory signals from reaching the cortex
(5) Reticular formation: regulates the transition between sleep and wakefulness
(6) Brainstem: helps initiate REM sleep. The extraocular movements that occur during REM sleep are due to the activity of the reticular formation in the brainstem

Sleep occurs in four phases: N1, N2, N3 and REM. Stages N1 through N3 are considered non-rapid eye movement (NREM) sleep, with each stage representing progressively deeper sleep. Approximately 75% of sleep occurs in the NREM stage, with the majority of sleep occurring in the N2 phase. A typical night's sleep consists of 4 to 5 sleep cycles with a progression of sleep stages in the following order: N1, N2, N3, N2, REM. A complete sleep cycle takes approximately 90 to 110 minutes. The first REM period is short, and as the night progresses, longer REM periods and reduced time in deep sleep (NREM) occur.

N1 (Phase 1): Light sleep (5%)

EEG recording: theta waves - low voltage

This is the lightest phase of sleep and begins when more than 50% of the alpha waves are replaced by low-amplitude mixed frequency. Muscle tone is present in the skeletal muscles and breathing occurs at a normal rate. This phase lasts about 1 to 5 minutes and makes up 5% of the total sleep time.

N2 (Phase 2): Deeper sleep (45%)

EEG recording: sleep spindles and K-complexes

This phase represents deeper sleep as heart rate and body temperature drop. It is characterized by the presence of sleep spindles [4], K-complexes, or both. Sleep spindles are short,

[4] Sleep spindles represent an EEG marker for communication between reticular-thalamic and cortico-thalamic neurons with cortical neurons.

powerful bursts of neuronal firing in the superior temporal gyri, insular cortices, and thalamus, triggering calcium influx into cortical pyramidal cells. This mechanism is thought to be an integral part of synaptic plasticity. Numerous studies have shown that sleep spindles play an important role in memory consolidation, particularly procedural [5]and declarative [6]memory.

K-complexes are long delta waves that last approximately one second and are known to be the longest and most distinct of all brain waves. K-complexes have been shown to function in sleep maintenance and memory consolidation.

Phase 2 sleep lasts about 25 minutes in the first cycle and lengthens with each subsequent cycle, eventually occupying about 45% of the total sleep slot. Teeth grinding occurs during this phase of sleep.

N3 (Stage 3): Deepest non-REM sleep (25%)

EEG recording: delta waves – lowest frequency, highest amplitude

N3 is also known as slow wave sleep. This is considered the deepest phase of sleep and is characterized by signals of very low frequencies and high amplitudes known as delta waves. It is during this phase that a person is most difficult to wake, and for some people even loud noises (> 100 decibels) will not wake them. As people age, they tend to spend less time in this slow-wave sleep and more time in N2 sleep. Although this phase has the highest arousal threshold, if a person is awakened during it, there will be a transient period of mental fog, known as sleep inertia. Cognitive testing shows that people awakened during this stage tend to have moderately impaired mental performance for a period of 30 minutes to an hour. This is the phase in which the body repairs tissues, builds bones and muscles, and strengthens the immune system. This is also the phase in which sleepwalking, night terrors, and bedwetting may occur.

REM (25%)

EEG recording: beta waves – similar to brain waves during wakefulness

REM is associated with dreaming and is not considered a stage of restful sleep. While the EEG is similar to that of an awake individual, the skeletal muscles are atonic and motionless, except for the eyes and diaphragmatic respiratory muscles, which remain active. The breathing rate becomes more chaotic and irregular. This phase usually begins 90 minutes after a person falls asleep, with each of the REM cycles getting longer at night. The first period usually lasts 10 minutes, and the last lasts up to an hour. During the REM phase, dreams and nightmares occur.

Important features of REM sleep:

(1) Associated with dreaming and irregular muscle movements, as well as rapid eye movements

(2) A person is more difficult to be aroused by sensory stimuli than during REM sleep

(3) People tend to wake up spontaneously in the morning during an episode of REM sleep

(4) Loss of motor tone, increased use of oxygen by the brain, increased and variable heart rate and blood pressure are observed

(5) Increased levels of acetylcholine[7]

(6) The brain is highly active throughout REM sleep, increasing brain metabolism by up to 20%

[5] Procedural memory begins to form from birth and is responsible for practicing everyday activities that we do without thinking (eg tying shoes, brushing teeth, riding a bicycle, driving a car, etc.) . This type of memory is formed unconsciously and retrieved effortlessly.

[6]Declarative memory is the memory of the things we know we remember and can talk about and tell about, e.g. the knowledge of facts, general culture, typical situations and scenarios.

[7] Acetylcholine is a chemical substance that has the role of a neurotransmitter, acting as an intermediary between the nerve cells of the nervous system.

Studies show that people with depression have an increase in total REM sleep but a decrease in REM latency (ie, the time between sleep onset and the start of the first REM period).

According to modern psychology, after experiencing a trauma or a critical situation, two ways out are possible for a person. One is post-traumatic stress and the other is post-traumatic growth. The first, more familiar, is part of anxiety disorders, with symptoms such as severe anxiety, depression, intrusive thoughts, unpleasant memories, sleep disturbances and panic. Various studies show that this is not the only possible consequence of the difficulties experienced.

What is post-traumatic growth?

In psychology, the phenomenon of post-traumatic growth is also known - the experience of positive change as a result of the encounter with life crises ("What doesn't kill us, makes us stronger") . Research results show that despite the more common notion of PTSD, a person is statistically more likely to experience post-traumatic growth.

Posttraumatic growth is a period of opportunity and challenges the view that trauma means lifelong suffering and anguish. Through scientific data, it is proven that negative events, in addition to being destructive, can, moreover, more often be a ladder for personal development - the acquisition of virtues and qualities, the development of valuable abilities and skills, reaching a wiser and more aware attitude to life .

Growth begins with overcoming trauma and regaining mental and physical balance, but it doesn't stop there. The process goes beyond them to reveal more resilience, joy and possibilities in our lives. The science of post-traumatic growth does not claim that trauma is positive in itself, but that it can be a catalyst for positive change. Also, the process of growth and reaching positive change does not mean that negative feelings and emotions will not be present, but despite them, and even together with them, the fruits of a better life can be born.

Problems as gifts in disguise

The Chinese were right to denote the concept of "crisis" with the characters for danger and opportunity. This is not just positive thinking, but a fact of life and wisdom accumulated over millions of human lives. It's not just a matter of perspective, but natural mechanisms built into us that enable us to survive and reach new levels of maturity and development. I am glad that in the meetings I conduct, I have the opportunity to observe how this happens in practice with people.

Here are some key ways that post-traumatic growth manifests itself in people's lives:

1. Increasing love and the ability to express it in the form of acceptance, understanding, care and giving
2. Achieving new and valuable life-enhancing qualities and skills
3. Increasing emotional intelligence and better understanding of one's own and others' emotions and feelings
4. Increase in happiness and subjective well-being as a consequence of re-evaluating one's needs and wants
5. Increasing the ability to appreciate life and discovering its beauty and depth in different situations
6. Removing self-imposed limitations such as various fears, worries and beliefs
7. Reaching a higher view of life and discovering a deeper meaning
8. Achieving Greater Peace and Discovering Harmony Beyond "Good" and "Bad"

Here are some questions, the answers to which can stimulate the process of post-traumatic growth and increase the chances of a positive outcome from the difficulties:

1. If you imagine that a year has passed since this situation, what qualities and skills will you have developed in yourself?
2. If the situation cannot be changed and/or what happened cannot be prevented, what change needs to happen to you?
3. If you want to reach peace beyond circumstances, what must you do?
4. If there is a hidden opportunity in the problem, what might it be?

Many people who have experienced profound trauma not only show incredible resilience, but also transform themselves after such a traumatic event. Research shows that most trauma survivors do not develop PTSD, and many even show psychological growth after the experience.

Richard Tedeschi and Lawrence Calhoun coined the term "post-traumatic growth" to describe this phenomenon, defining it as a positive psychological change that occurs as a result of dealing with very difficult life circumstances.

Adverse conditions are driving growth in the following seven areas:

1. A better understanding of life
2. Higher appreciation and strengthening of close relationships
3. Enhancing compassion and altruism
4. Finding new opportunities or goals in life
5. Greater awareness and use of personal strengths
6. Enhanced spiritual development
7. Creative growth

Of course, most people who experience post-traumatic growth would prefer to avoid the trauma, and only some of these areas demonstrate greater post-traumatic growth compared to positive life experiences. However, most people who have gone through post-traumatic growth are often surprised by the transformational changes that occur, and unexpectedly, as a result of their attempts to make sense of the unexpected event.

5. PREVENTION OF AUTOAGGRESSIVE (SUICIDAL) RISK BEHAVIOR

Systematic work in the direction of suicide risk prevention includes the joint activity of psychological insurance specialists and managers from all levels of the hierarchy in the medical institution. The main components of this type of prevention include:

1. Accounting for environmental factors
2. Addressing the myths and facts of suicidal behavior
3. A clear understanding of the state of mind of suicidal individuals
4. Contact options
5. Identification of healthcare workers at suicidal risk
6. Reporting the level of suicide risk
7. Coping resources when at risk of suicide

5.1. Environmental factors

Life stressors

Very often, those who commit suicide have experienced stressful events within three months before committing suicide, such as:

- Interpersonal problems, such as conflict with spouse, intimate partner, relatives, friends, colleagues, superiors;
- Rejection, manifesting as separation from family and friends;

- Loss - financial loss, death of close etc.;
- Work and financial problems - job loss, retirement, financial difficulties, etc.
- rapid and abrupt societal changes
- Stressful factors, such as shame and fear of being accused of unprofessional performance of official duties, experience of failure (wrong diagnosis, death of a patient, etc.)
- Maladaptation processes and other mental problems

5.2. Suicide - myths and facts

Myths:

1. People who talk about suicide don't commit it
2. Suicidal individuals seek to end their lives at any cost
3. Suicide happens without warning
4. Recovery after a crisis means that there is no longer any risk
5. Not all suicides can be prevented
6. If a person once intended to commit suicide, he/she can always commit suicide

Facts:

1. Most people who commit suicide give certain "warning signals" of their intentions and actually seek help
2. The behavior of these individuals is ambivalent and contradictory
3. Suicidal individuals give ample indication of their intentions
4. Many suicides occur during a period of improvement when the person has the energy and will to turn desperate thoughts into destructive actions
5. The truth is that many suicide attempts are preventable
6. Suicidal thoughts can reoccur, but they are not permanent and may never reoccur in some people

5.3. State of mind of suicidal individuals

Three functions describe the state of consciousness of individuals with suicidal ideation:

1. **Ambivalence**

   Most people have mixed feelings about committing suicide. The will to live and the will to die ("to be over") are in an ever-changing battle. There is both an urge to escape the pain of life and a repressed sense of the desire to live. Many at risk for suicidal behavior don't really want to die - they're just unhappy with their lives. If support is provided and the will to live increases, the suicidal risk decreases.

2. **Impulsivity**

   Suicide is an impulsive act. Like any other impulse, the impulse to commit suicide is transient and lasts for a few minutes or hours. It is usually triggered by negative everyday events. By dealing with such crises and by buying time, the expert can help reduce the urge to commit suicide.

3. **Rigidity**

   When people are at risk of suicide, their thinking, feeling and actions are limited. They constantly think about suicide and are unable to perceive other ways/alternatives to get out of the problem. Their thoughts are filled with fatalism.

The majority of suicidal individuals share their suicidal thoughts and intentions. They often send "signals" and state their "wish to die", "feelings of worthlessness", etc. All these requests/appeals for help should not be ignored.

5.4. Possibility of contacts

How to reach a person at suicidal risk?

Very often the contact happens in a busy place, at home or at the workplace, where it is difficult to have a personal conversation.

1. It is important to find a suitable place to hold a conversation
2. The next step is allocating the necessary time

   Suicidal individuals usually need more time to reveal their pain and the practitioner must be mentally prepared to allow them to do so.

3. The most important task after that is to actually be heard

   Reaching out and listening to the person is in itself an important step in reducing despair. The goal is to bridge the gap created by mistrust, despair and loss of hope. This should give hope that things can change for the better.

How to communicate?

- Listen carefully, be calm
- Understand his feelings (show empathy)
- Show a non-verbal message of acceptance and respect
- Show respect for his views and values
- Speak honestly and sincerely
- Show concern, attention and warmth
- Focus on his feelings

How can we NOT communicate?

- Interrupt too often
- To be shocked or emotionally involved
- Say you're busy
- Be lenient
- Making annoying and vague remarks
- To ask misleading questions

A calm, open, caring and accepting, non-judgmental approach is necessary to facilitate communication.

5.5. Identification of suicidal individuals

Signals to look for in the person's *behavior* or in *their past* :

1. Withdrawn/solitary behavior, difficult emotional and impaired communicative functioning with family, colleagues and friends.
2. Mental illness
3. Alcoholism or frequent use of alcohol
4. Signs of anxiety or panic

5. Personality change, including irritability, pessimism, depression, apathy, or atypical behavior
6. Change in eating and sleeping habits
7. Previous suicide attempt or sharing of suicidal thoughts
8. Feelings of guilt, worthlessness and shame
9. Emotional loss - death, divorce, separation, etc.
10. Financial and material losses or inability to cover loan installments, accumulation of debts, loss of capital assets, etc.
11. Suicide attempts in the family history and close circle of friends
12. A sudden desire to settle personal affairs, such as repaying loans, drawing up a will, transferring property, etc.
13. Feelings of loneliness, helplessness, hopelessness, hopelessness and/or lack of meaning
14. Farewell letters or letters intended to justify actions and clarify relationships
15. Previous serious and/or chronic illnesses
16. Repeated talk of death or suicide

5.6. Assessment of suicide risk

The following factors are evaluated:

- Current mental status and presence of thoughts of death and suicide
- Current suicidal plan - how specific is the idea of HOW and WHEN the suicide will be carried out
- The resources of the person's real support system (family, friends, colleagues, etc.)

low risk

The person has short-term thoughts of helplessness, hopelessness, and/or meaninglessness, such as "I can't go on," "I wish I was dead," but no specific suicidal thoughts.

Required actions:

- Offer emotional support
- Work with negative feelings. The more openly a person shares about loss, isolation, and feelings of worthlessness, the more likely they are to influence the negative situation. When the emotional turmoil subsides, the person is likely to be more reflective. This process of reflection is crucial because no one but the particular individual can give up the decision to die and make the decision to live
- Focus on the positive, the strengths, by having him or her share how they have successfully solved problems in the past
- Meet at regular intervals and keep in touch
- If necessary, refer the person with a companion to a specialist psychiatrist

Medium risk

The person has suicidal thoughts and intentions, but does not plan to kill himself immediately.

Necessary actions:

- Offer emotional support, work with the person's suicidal thoughts; focus on the positive, strong points of the person. Continue with the steps outlined below.
- Use the hesitation. It should focus on the person's conflicting feelings about suicide so that the will to live will gradually increase.
- Offer alternatives - the professional should try to offer different possible alternatives, even if they are not ideal solutions, so that the person can reduce the fixation on suicidal thoughts.
- Engage the suicidal person in such a way that the execution of the suicidal act is delayed in time.
- Turn to family, friends and colleagues for support.

High risk

The person has a specific plan, has the necessary means to carry out the suicidal act and plans to carry it out.

Necessary actions:

- Stay with the face. Never leave him alone
- Talk carefully and remove medicine, melee and other weapons, insecticide, rope, etc. (remove the means of committing suicide)
- Communicate continuously with him/her by observing his/her verbal and non-verbal behavior
- Contact immediate supervisor and doctor, provide ambulance and hospitalization
- Inform the family and ensure their support

5.7. Resources for dealing with the occurrence of a risk of suicide and main highlights in the activities of psychological insurance bodies for suicide prevention

Usual resources/sources of support are:

- Family
- Friends
- Colleagues
- Executives
- Crisis centers
- Specialists

The main highlights of the activities of the psychological insurance bodies for the prevention of suicides are the following:

- Organizational - training of management staff on recognizing, influencing and guiding medical persons with risky (self-aggressive) behavior
- Optimizing the activity of risk behavior prevention committees (if any have been created)
- Group - assisting managers in managing group dynamics in departments (maintaining high cohesion, empathy, trust, etc.)
- Individual - planning and detailing work with representatives of the medical staff identified as at risk

6. PSYCHOLOGICAL TESTS, SCHEMES AND PROTOCOLS FOR RESEARCH AND ASSESSMENT OF MENTAL STATUS

The questionnaires and tests presented below are in accordance with Ordinance No. 6 of 2003 of the Ministry of Health, on the type and order of carrying out specialized medical and psychological examinations and periodic health examinations and the methods of their implementation (SG, No. 35 since 2003).

6.1. Psychological tests

Psychological tests are applied for the following personality areas:

a) Mental Competence:

- Intellectual level
- Cognitive processes

Raven, Wexler, Benton tests, complex analogies, pictogram, "10 words" technique - for the three units of memory, Schulte's board - for memory and attention, Benton's test - for brain pathology, Jakobson's methodology - for the mechanical auditory memory for numbers, "Interpretation", Ebbinghaus technique for exploring thinking, "sequence of events" technique, "classification" technique, "Excluding the 4th Redundant" etc.

b) Personality structure:

- Extroversion/introversion
- Emotional competence - emotional maturity and resilience, emotional commitment and loyalty to professional tasks and authorities, emotional resonance, level of situational and personal anxiety, emotional disorders (depression)
- Frustration tolerance and aggressive tendencies
- Self-perceived maturity and cognitive-behavioral maturity
- Behavioral persistence

Questionnaires for depression, anxiety and aggressiveness (Tsung, Spielberger , Beck, Buss-Durkey tests), self-assessment test, Minnesota test (MMPI), Eysenck test, self-esteem level methodology (Rosenberg) and others are used.

c) Socio-psychological functioning:

- Adaptability and effectiveness of defense mechanisms
- Level of personal self-control
- Professional motivation
- Effectiveness of strategies for dealing with problem situations
- Group (team) compatibility
- Predicting negative consequences of one's own behavior
- Stress level and coping strategies for occupational stress

Thematic apperceptive test, Rosenzweig and Leary tests, defense mechanisms questionnaire, scales for: self-control ability (Snider), motivation (Crown, Maslow), interpersonal relations and group compatibility, strategies for coping with problem situations, research of the typical ways of reacting in conflict situations (Thomas), stress resistance and social adaptation, etc.

6.2. Other specialized psychological tests:

a) Tests to study specific operational qualities:

- Routes - a specific test of K. Zlatarev for visual memory and observation
- AMT ("Dr. Shuhfried") - an adaptive matrix non-verbal test for assessing the level of general intelligence, based on deductive thinking, independent of cultural and social factors
- A3DW ("Dr. Shuhfried") - an adaptive test to assess three-dimensional spatial orientation and imagination
- Addition of numbers with switching - for working memory and arithmetic thinking, attention span, confidence
- Continuous self-paced and set-paced calculation - arithmetic thinking, working memory, attention span, vigilance
- MTA ("Dr. Shuhfried") - Mechanics and Technology Orientation (with animated items)
- 2HAND ("Dr. Shuhfried") - for visual-motor bimanual coordination and rate of acquisition of motor habits
- Tremometry – to assess fine coordination and emotional resilience
- Labyrinths of Chapuis (according to Mechkov - Bayer) - in four variants, for distribution of attention
- The 5 labyrinths (according to Mechkov) - for allocating attention
- Logic test - to determine the ability to find quantitative relationships
- Patterns - a non-verbal test of abilities to find patterns in observed symbols
- Symbolic-digital test (according to Mechkov) - of switchability of attention
- Platonov's knitwear - for stability of attention and observation

b) Tests for the study of personality factors and intelligence:

- MMG (“Dr. Shuhfried”) – assesses fear and hope motives in personal selection and other non-clinical situations
- 4DPI ("Dr. Shuhfried") - presents the personality structure regarding social integration
- EPQ – extraversion, emotional stability, psychoticism, social desirability.
- Giessen-Test – for individual and group diagnostics
- STAY–g–1,2 (C. Spielberger) – self-assessment of the level of situational and personal anxiety
- 16PF (R.Cattell) – 16-factor personality questionnaire
- Bus Durkey test - to assess aggressiveness
- Taylor's test - to assess the level of anxiety
- Zung test (with both options) – for anxiety and for depression
- MMPI – for clinical and non-clinical psychological diagnosis
- Frederick's Test of Emotional Maturity
- Bozhinova's test for basic temperamental characteristics
- Kokoshkarova's test for personality and neurotic personality tendencies.
- Mayer Brix test
- Skondi's test
- Lüscher's test
- Corsi test
- Leary test
- Raven's test - to determine IQ
- Amtauer test - to assess intelligence
- Wechsler test - to assess IQ

7. STRATEGIES FOR THE PREVENTION OF BURNOUT SYNDROME

Various strategies (ways) for prevention and coping with post-traumatic stress and burnout syndrome are known in the specialized literature, which are often close to strategies for coping with stress. These strategies fall into three groups:

- Internal - a person tries to cope by using, changing, mobilizing his own attitudes, resources, competences, personal characteristics that can protect or control the development of burnout
- External - refer to ways of coping through the resources of the environment (managers, organizational culture and politics, colleagues, relatives, psychologists, psychiatrists, etc.)
- Combining individual personal resources with the resources of the external environment, gradually arriving at the creation of a model for organizational health, taking into account the interaction between individual characteristics such as motives, abilities , competence, personal characteristics, on the one hand, and organizational characteristics such as structure, working conditions , reward systems, organization politics on the other hand

7.1. Domestic prevention strategies

An individual's stress tolerance is a product of many different factors, including their physical and mental health. The acquisition and maintenance of health-promoting behaviors such as exercise, proper diet, adequate rest, and abstinence from excessive alcohol and caffeine use should be encouraged. Because it can be extremely difficult to change habits when one is under stress, it is important that these health-promoting behavior styles are adopted before one develops burnout.

In the field of psychological counseling, a diverse set of techniques and thought patterns are recommended to help prevent burnout, such as:

- Developing one's own effective ways to deal with stress in its various forms;
- Development of attitudes and values that do not connect happiness, life satisfaction, personal effectiveness only with the profession. Adopting the philosophy that professional success is only one way for a person to feel significant and valuable, that it is not healthy for success to be "at the cost of everything";
- Development of other interests outside the main activity;
- Bringing variety to daily work without necessarily waiting for the approval of higher authorities;
- Satisfactory social life, presence of friends (preferably from other professions) with whom well-balanced relationships exist;
- Strive to achieve goals without necessarily being a winner, as well as the ability to lose without being self-deprecating and aggressive;
- Health care, following an appropriate sleep and eating regimen, using relaxation techniques;
- Building a positive self-esteem, without it being entirely dependent on the approval of others;
- Taking thoughtful, measured responsibility. Taking on too much responsibility causes us to blame ourselves for things that aren't really our fault, and we overburden ourselves. Thus, we do not give others the opportunity to assume their responsibilities;
- Finding a hobby that gives you personal pleasure;
- Reading not only professional literature, but also other types of literature - simply for pleasure, not for its usefulness;
- Developing the ability not to rush neurotically and to give oneself enough time to achieve the desired results, etc.

Here are some recommendations in the shorter term:

- **Change your daily routine**

Restructure the way your work day looks. Whether you're in a job where you're on the go all day or it's monotonous and monotonous but still leaves you feeling tense, stressed and exhausted, the most effective way to change that is to quit it and find work you love and enjoy doing. Of course, changing jobs is far from a practical and easy-to-achieve decision – especially when you're still grateful to have a job that helps you pay your bills and cover your day-to-day expenses. Whatever the situation, there is always something you can do to improve your state of mind.

- **Find the value in what you do**

Even in the most mundane and seemingly simple activities, you may find how and with what she helps others, such as a product or service they need. Focus on the moments of your work that make you feel good and smile - it could even be the conversations about any topic with your colleagues at lunch. Changing your attitude and attitude towards work can help you regain a sense of purpose and control.

- **Create workplace friendships**

A strong workplace relationship can help reduce monotony and counteract burnout. Contacting and joking during the day with friends can help relieve the stress of failure or difficult work, improve work efficiency, or simply relax during a hard day.

- **Find balance in your life**

If you hate your job, look for meaning and fulfillment elsewhere in your life - family, friends or hobbies. Focus on that part of life that brings you pleasure and positive emotions.

- **Become more self-loving and set your boundaries**

Don't give too much away. Learn to say no to requests and requests that limit your vacation and family time. It is this "no" that will allow you to say "yes" to the things you really want to do.

Take a day off from technology. Set aside time to completely disconnect from your laptop, phone, and email.

If you spend a large part of your working time responding to the requests and wishes of others or only performing tasks that you have been ordered to do, the risk of burnout is high. More and more leaders of successful companies recognize the importance of giving their employees time to implement their projects, ideas and tasks.

In your work, focus on the most important and priority tasks in the morning, before the lunch break. In this way, you can set aside some time at the end of the working day to work on something interesting, innovative, creative or simply favorite for you. So, with small steps, every day, you can realize your personal project.

- **Nurture your creative side**

Creativity is among the most powerful antidotes to burnout syndrome. Try starting something new or rekindling your hobby. Choose an activity that has nothing to do with your

job. Take time to relax. Techniques like yoga, meditation, and deep breathing can be more helpful than you think. Try it!

Meditating for just about 10 minutes a day will contribute to increased concentration and improved mood. You can also meditate at your workplace.

- **View your successes and failures**

Take time at the end of the work week to analyze all the difficulties and successes you encountered during that period. Write down the goals you set and what you achieved. This will help you understand how you should proceed next. You may even find a solution to a potential problem before it occurs.

You can write down all your answers as short notes in your own notebook or use the notes feature on your phone. In fact, the idea is to separate yourself from the "battlefield" and look at your work from the side. In this way, you can separate yourself from your problems and determine what you need to do to deal with them. And if, despite all your efforts, you still feel on the verge of burnout, maybe it's good to think about whether this is your career path.

- **Improve your health - help yourself through a healthy diet**

Minimize sugar and refined sugars. Others that can adversely affect your mood include caffeine, trans fats, and foods containing preservatives or hormones. Eat more omega-3 fatty acids to boost your mood. Avoid nicotine. Smoking may seem relaxing, but nicotine is a powerful stimulant that leads to higher levels of stress.

Drink alcohol in moderation. Alcohol temporarily reduces anxiety, but too much can cause anxiety. Vitamins and supplements. Therapy with vitamins and supplements can contribute to supporting the body, with an existing nutritional deficiency. There are also numerous herbs that can improve energy stores and support immunity.

- **Get enough sleep**

Feeling tired can exacerbate burnout and contribute to irrational thinking. A good night's sleep is a powerful weapon against stressful situations during the day.

- **Do exercises**

Exercise may seem like the last thing you want to do when you're on the brink of burnout, but in fact, it can greatly improve your mood. Try walking, running, swimming, dancing and even martial arts. Get together with friends and organize "fitness days". With this, you will have fun, relax and maintain tone and shape at the same time. If you don't have access to a gym, home workouts can also be extremely helpful. Aim to exercise for 30 minutes or more a day, or do several short, 10-minute bursts. Walking for 10 minutes can improve your mood for two hours.

- **Take a break**

If burnout seems inevitable, try to completely separate yourself from your work for a while. Go on vacation outside the city, indulge in your hobby or your family - no matter what you choose, it is important that it brings you peace and joy. Use the time to recharge your batteries and consider next steps to recover from burnout.

In fact, the good news is that all of this can happen starting today, even the hour you read this. Take time for yourself and your family to experience something positive.

7.2. External prevention strategies

By determining the main consequences of the impact of "burnout", it is necessary to pay attention to prevention measures. Prevention is a concept related to the main characteristics of burnout: *exhaustion, depersonalization, reduction in effectiveness and productivity* .

Prevention is based on the factors that generate and promote healthy working conditions and preservation of mental health in the workplace. Such factors can be active coping strategies – focusing on the problem, positive evaluation and self-evaluation of the personality, internal motivation, etc. Active coping strategies aim to transform the situation and indirectly affect emotions. Although treatment is possible, prevention is preferable.

Burnout prevention can take different forms and be implemented at different levels. To a large extent, it can be aimed at raising and improving personal strategies, as well as introducing organizational restructuring. Early identification of the risk of deformations of the "burnout" phenomenon guarantees protection from its influence, which in the process of interaction between the parties is extremely important for the effectiveness of social assistance.

Prevention, which is implemented through psychogenic prophylaxis and rehabilitation, has its own logic, essence, consistency. As a rule, there are two directions of preventive and corrective work:

- *Prevention* includes training in social (communication) skills; learning and mastering the habits of self-management and self-control
- *Rehabilitation work* with those experiencing the symptoms of "burnout" implies: restoration of psychoenergetic potential; update of personal resources; rediscovering the meaning of professional activity; regaining self-confidence

Professional help with burnout can be divided into two types of therapy:

- Working with people who are at risk of developing occupational burnout syndrome (OSB)
- Minimizing the influence of an organizational factor that would lead to the emergence of STDs

Professional and personal approaches to dealing with STIs are closely related. The effectiveness of prevention at work depends on some measures of its management. They can be applied at the management level, i.e. managers can watch for early signs of exhaustion in their subordinates and/or for the presence of specific stressors leading to burnout. A large part of early prevention strategies also generate preventive protective activities. Therefore, if a manager can recognize the distinctive signs of burnout syndrome in an advanced stage, then prevention depends entirely on his correct actions.

It is important to emphasize that the loss of initiative, the appearance of apathy and other similar manifestations in some employees are not always due to unwillingness to work. The path to apathy is always the same. At the first disappointments in the workplace, the employee reacts sharply to it, clearly showing his commitment. When the expected success does not come, a vicious cycle begins in which the sufferer retreats. This movement soon led to a drop in pace, and hence criticism from the immediate supervisor.

All this pushes the worker even further down, which inevitably puts him in the spiral of apathy, from which it is extremely difficult to get out, since the process is accompanied by a number of health problems. A person becomes not only aggressive, but also cynical in his relationships with colleagues and clients, because he does not feel comfortable within himself, and this is evident in his relationships and behavior.

The main factors that prevent the development of STIs are:

- Developing knowledge and skills
- Improvement of working conditions and rest conditions at the workplace
- Change in pay; social protection; increasing motivation
- Creating conditions for psychological relief from stress after a hard day's work
- Improving the psychological atmosphere in the team

On the other hand, the ways to stop the development of STI at an early stage can be very different, starting from:

- Introducing novelties in the work of a given person (creating new projects and their implementation without waiting for approval from management)
- Leading a healthy lifestyle and sports activity
- Ability to self-evaluate without considering the opinions of others
- Ability to achieve success at work gradually, by giving enough time to achieve a positive result in work and life and come to increase responsibility to everyone and everything
- Participation in seminars and conferences
- Periodic joint work with colleagues with different professional experience, as well as finding a hobby that brings joy and satisfaction

It can rightly be said that the problem of dealing with STI and burnout - the syndrome of professional exhaustion or its prevention syndrome is multifaceted, and this requires the analysis and solution of a number of complex problems of an organizational, normative, qualification, behavioral, ethical and psychological nature . In order to overcome STIs, the main factor is the personality and the need to know oneself, to make a real assessment of the conditions of the surrounding environment by adapting one's own behavior and avoiding inadequate situations. A properly constructed socio-psychological climate, wide contacts with friends, a good family environment, mutual respect and traditions, on the one hand, and factors related to working conditions, have a good effect.

Workload, as already mentioned, is seen as one of the main precursors to the occurrence of "burnout" among employees in an organization. In order to analyze the workload, respectively the level of stress in an organization, and hence the probability of the occurrence of burnout syndrome, it is necessary to carry out periodic measurement. Workload measurement is an analysis of the ratio between the volume of work performed (values according to certain performance indicators) and the efforts invested in it (human resources) .

The measurement is necessary in order to determine the functions and tasks for the implementation of which:

- Best efforts are being made
- There is an opportunity to reduce the effort, without reducing the quality of the final result
- It is necessary to increase the number of employees in order to ensure the achievement of the necessary results in quantitative and qualitative terms

When analyzing the workload and determining the optimal number of employees in relation to the functions and activities of the individual units in an organization, a methodology can be developed, the application of which would significantly support the performance of this activity. When developing it, different sources of information can be used, such as legal acts and strategic documents regulating the organization's activities; internal documents related to the performance of functions and activities (instructions, orders, functional characteristics), etc. Because in many organizations there are no existing practices for
measuring the workload of individual units, the following methodology can be proposed, including:

- Review and analysis of documents - strategic and internal documents of the organization, regulations, documents related to activities and functions and workload, documents related to time worked, employee reports, documents related to salary and other expenses for labor
- Focus groups with representatives of individual units in the organization to analyze the working hours of employees and the types, frequency and duration of operations necessary to perform the functions of the units

- Conduct structured meetings with department heads to clarify employee working hours for the types, frequency, and duration of operations required to perform departmental functions
- Development of a questionnaire to department heads and employees in order to collect information about their subjective opinion about the workload in the organization as a whole
- Use expert judgment in making recommendations based on the workload analysis and developing an action plan to implement the recommendations

The fact is that most organizations lack established practices for workload analysis or staffing needs planning. In many of them, there are significant differences in the workload of both individual employees and organizational units. This often necessitates the need to transfer staff numbers from off-peak to busy activities in order to reduce differences in workload.

On the other hand, large time costs are often observed, which can be reduced by implementing new technologies, techniques and better organization of the information system. In general, there are differences in organizations regarding the workload of individual employees, i.e. some are over-loaded and others are significantly under-loaded, which will be confirmed with a high degree of certainty if the methodology proposed above is used.

In the above context, the following actions may be recommended:

- In order not to change the number of personnel in the organization, an additional analysis of the workload in individual units can be done and the possibility of transferring positions from relatively less busy units to the more busy ones can be considered
- Actions should be taken to ensure that all employees have the necessary knowledge, skills and qualifications to perform their duties
- On the basis of the received information about differentiation in the workload of employees, proposals can be made for its reduction by the heads of individual units in the organization
- In order to increase the efficiency of the use of available staff, internal staff transfers can be undertaken between individual units within the organization without affecting the business being carried out

The implementation of the specified actions can be preceded by a thorough analysis of the necessary technological, technical and organizational conditions, as well as on the basis of detailed work processes. The following action plan to implement the proposals can be followed here:

Stress monitoring is often used in practice, which is a systematic search for risk factors in the workplace and determination of risk groups of employees. Once there is such a method, it is possible to develop a similar one for the burnout syndrome for each organization, including the following stages:

- ***First stage*** – involving all employees at the very beginning of the process

  In this stage, it is of particular importance to inform the employees about the process itself, their role in it and to build continuous feedback on the final results. At this first stage, it is necessary to carefully plan the process of monitoring the STI - whether the process covers all employees or certain risk departments.

  Questionnaires or questionnaires can be developed to analyze problems related to the conditions and content of work, professional requirements and social interactions in collectives. It is important to determine who and how will analyze the data, how and with whom the results obtained will be discussed and what measures will be taken.

- ***Second stage*** – conducting a survey in the organization

The survey can be carried out by a specialist in occupational medicine, by an employee of the human resources department or by a working group specially created for the case.

Based on the obtained results of the study, the main steps for changing the working environment and reducing the probability of occurrence of STDs should be identified. Such actions can be:

- Setting new tasks and goals, support from others, finding activities outside work (hobbies, sports, spheres of realization that bring recognition and satisfaction)
- Reaching a state of professional exhaustion syndrome or "at the edge of strength", it is necessary to pay attention to this type of work fatigue and take actions to prevent it. In this case, the so-called called "sabbatical" - a certain period of time - a month or sometimes a year - in which an employee breaks away from his work. The term sabbatical comes from Hebrew and the word "Shabbat", which is the seventh day of the week, in which no work is done, but rest

In general, workers who initially take advantage of this type of leave belong only to academia, where university professors periodically take six months or a year of leave, a time during which they withdraw from their active work to develop their scientific idea or just for relaxation. This idea is also adopted by a number of organizations in which the problem of burnout is becoming increasingly large. This can be in the form of paid leave, partially paid or, most commonly, unpaid leave. Most often, this type of break is resorted to by people in managerial positions or valuable personnel for an organization, who will thus be detained for a longer period of time.

In Bulgaria, not the pure type of sabbatical is more popular, but its variant, in which the workers themselves initiate a longer vacation and take unpaid leave. In both cases, it is important that free time is planned so that workload can be replaced by active rest.

Mental health implies a general emotional balance, the ability to self-control, the ability to quickly adapt to difficult situations and the ability to overcome them. Qualities such as self-control, self-esteem and the ability to control personal emotions are extremely important. Self-control, which in psychology is taken as a mark of a person's emotional and social maturity, is of fundamental importance. It should be clarified here that self-control is not only a quality of a given person, but it is also a factor for regulating behavior in an extreme situation.

Research proves that there is a positive relationship between job satisfaction and a low level of professional burnout. Taking this into account, it is recommended that actions be taken in the organization to increase employee satisfaction. This requires researching existing and proven approaches and selecting the most appropriate one such as:

- To take action to create a supportive and accepting professional environment, i.e. employees to identify with the organization and accept its goals

  All this will lead to a low level of STI, as creating an understandable, meaningful and non-threatening environment would protect workers from emotional exhaustion

- The management of the organization to take actions to create a favorable working climate

  One of the ways to create a favorable working environment is by increasing the qualifications of workers using various training methods. This will provide an opportunity to discuss various professional issues and case studies and find a possible solution. During this type of discussion, it is important that everyone understands and feels that they are not alone, that there are other employees who are in similar situations.
- The governing body shall provide assistance and support to its employees through:

- Getting to know their personal characteristics and the symptoms of STIs so that those more prone to it can be diagnosed and recognized
- Making each employee feel valued and giving positive feedback for their efforts
- Measuring the results of the work done using clear and specific goals and objectives, well-defined success criteria and continuous feedback, which will really lead to a sense of personal effectiveness
- Creating conditions for diversifying work and professional appearances through easier access to participation in projects and qualification programs, which will turn employees into significant and valued experts

Against the background of what has been said so far, several specific guidelines follow in order to prevent or reduce the level of stress among employees in a given organization, namely:

- Improving the socio-psychological climate by improving interpersonal relations, involving employees in various social meetings with a view to uniting the team
- Improving the physical working conditions by creating a safe environment, providing for the necessary rest breaks
- Clarity and specific guidelines regarding the responsibilities and duties of the individual employee
- Ability to maintain a balance between personal life and organizational life, which contributes to better work performance
- Possibility of better awareness and coordination regarding the joint activity, by building interpersonal trust
- Encouraging social activity in human potential, through recognition or praise immediately after the achieved individual result
- Providing equal opportunities for growth in the hierarchy and security among employees
- Holding more frequent meetings allowing free sharing of views, ideas by the employed persons regarding the labor process
- Organization and distribution of work duties according to individual abilities, i.e. to be delegated in a way that suits the individual abilities of the individual (group), in which they will feel as efficient and relaxed as possible.
- Availability of feedback during the performance of the assigned tasks, where in the event of a difficulty, the given employee can be assisted in a timely manner in relation to the specific situation
- Organization of different types of trainings, enabling the acquisition of new competences and skills on the occasion of the introduction of new practices in the work process

The indicated opportunities for managerial impact are intended to focus the attention of the management mainly on the provision of social support in terms of human capital, which compensates to the greatest extent the manifestation of stress and has a favorable impact on the course of the labor process

7.3. Combined prevention strategies

The emergence and development of the "burnout" syndrome is an important interaction between individual characteristics and the particularities of the given organization. This largely explains the fact that in the same unit, some servicemen are affected by burnout, while others are not.

Stress management expert Paula Davis-Lack offers seven strategies for preventing burnout:

- Increasing personal efficacy

- Personal efficacy represents the belief in one's abilities to achieve various personal goals and tasks. People who have higher personal efficacy are less likely to be victims of stress. The most direct and effective way to improve personal efficacy is through overcoming difficulties. Another option is to build a "model", ie. watching how another copes with obstacles
- Determining the things one needs in one's job

In May 2013, the Harvard Business Review published an article describing the six things hundreds of employees want from a dream company:

- To be able to express themselves
- To say what is really happening
- To develop their abilities continuously
- For their company to carry out a useful activity; - their daily work should be rewarded; - that there are no stupid rules at work. Availability of creative contacts - burnout syndrome prevents good performance, increases rigid thinking and reduces the ability for flexible and creative thinking. Even if a person does not have the opportunity to develop his creative thinking in a work environment, outside of it he should maintain creative contacts that will keep him engaged and motivated
- Self-care – an individual should take time for themselves, to relax with family and friends
- Creating a supportive environment - maintaining social contacts and people with whom to discuss difficulties at work
- Strong "footing on the ground" - mainly in the prevention of the burnout syndrome.
- Increasing positive emotions - they improve
- creativity and endurance, help focus decision-making
- The American Psychological Association recommends the following strategy for dealing with Burnout Syndrome
- Setting new goals and tasks - here it is important for the individual to answer the question: "Whose ideals am I following, my own or someone else's?"
- Help from others - it is necessary to discuss this topic with friends, family members or a psychotherapist in order to define new professional and life goals and find strength for their realization. At the same time, it is important that he develops these goals himself, so that he does not succumb to outside influence and accept wrong and unattainable tasks again
- Finding activities outside of work so that professional activity is not the only source of success and joy in life. These are the various hobbies, sports - spheres of realization, bringing recognition and satisfaction, so that possible failures in the professional sphere can be compensated by successes in other areas significant for a person

7.4. A strategy for early diagnosis and interventions related to reducing burnout

Burnout can be minimized through realistic training in which medical staff are taught how to deal with the stressors of the work environment. The importance of preparation can be seen from a study that found that doctors with more training rated more presented clinical patient scenarios as less stressful than their less trained counterparts. A similar study of caregivers found lower levels of burnout among those who had more training in working with people with cognitive impairment.

In the training of healthcare professionals, serious emphasis is placed on their professional training and competence, which is completely understandable. More training on how to deal with conflicts with colleagues, superiors or inferiors, how to make difficult managerial or

organizational decisions and how to improve horizontal and vertical communication can better positively influence the psychological climate of the organization.

Preparation and experience can moderate the stressogenicity of some events, but others are so stressful in principle that even increased experience and knowledge cannot alleviate their effect. In the physician study mentioned earlier, training reduced the stressogenicity of events that had previously been defined as moderate or low stress, but did not reduce the stressogenicity of events that had been defined as high stress. A supportive work environment can alleviate the effects of high-stress events.

Managers can do much to alleviate burnout by establishing conditions that stimulate the formation of higher morale and cohesion. Good communication between employees and managers is critical to the prevention of stress and burnout.

Improved communication between managers and staff can help increase demands and workloads to be seen as inevitable and meaningful.

Managers can reduce the importance of conflict by creating clear job descriptions and making sure that organizational goals and rules are clearly understood by employees.

The work of medical professionals sometimes requires longer working hours; however, they should be given enough time to recover. Additional duties should preferably be kept to a minimum. These measures are likely to have the added benefit of increasing employees' perception that their managers care about them.

Individuals who have control over the time they devote to their work must be taught that working longer and harder does not always lead to greater productivity. Employees must learn to pace themselves so that they can maintain an optimal level of functioning, conserving energy to deal with stressful situations as they arise.

In jobs that involve dealing with patients, burnout can be alleviated by reducing hours of stressful patient contact. This reduction can be achieved by mixing patient contact with administrative work or other types of work, by encouraging attendance at professional meetings, and by encouraging participation in work-related courses.

Medical staff whose work involves emotionally demanding relationships with patients may benefit from support groups or counseling with mental health professionals. In one hospital, a consultant psychiatrist helped burn unit staff to improve their working environment. Using the Work Environment Scale, the psychiatrist assessed the staff's perceptions of the work environment as well as their preferences for an ideal work environment. Through a series of twice-weekly meetings, the psychiatrist sought to reduce the discrepancy between the actual and preferred work environment by discussing staff members' perceptions of the work environment and helping them plan and implement workplace changes. The effectiveness of the intervention was demonstrated by a reduction in discrepancies between staff members' perceptions of the actual and preferred work environment.

Another way to minimize burnout in healthcare workers is to ensure that they receive feedback on the positive outcomes of their work. One way to provide this feedback in high-stress healthcare professions is to invite former patients and their families to informal social gatherings. At these "graduation meetings", healthcare workers have the opportunity to see that patients they have treated in the past have improved as a result of their care. This reinforces the belief of health workers that their work has meaning and is well valued. Interaction with patients outside of healthcare will provide the added benefit of counteracting the development of depersonalization.

Since the presence of negative conditions and the absence of positive conditions in the workplace are independent of each other, efforts to reduce burnout should not only be aimed at reducing negative work-related experiences, but also enhance positive experiences. This approach suggests the importance of formally recognizing exceptional performance at work both informally at an interpersonal level and formally through the use of rewards and incentives. Employees who perceive their work as stimulating and rewarding are less likely to develop burnout.

A frequently used strategy for reducing stress levels is the coping strategy, which is aimed at maintaining the balance between the external environment and the personality by satisfying certain demands in the adaptation process. R. Lazarus describes three main characteristics of coping:

- Resolve problems that arise
- Mastery and
- Dealing with negative emotions

On this basis, two main strategies are formed to reduce the stressful impact on the personality:

- Problem-focused strategies aimed at solving specific problems and
- Emotionally -focused, aimed at emotional regulation

Lazarus and Folkman created a methodology for researching different coping strategies. They found eight key factors for reducing burnout:

- Seeking social support
- Distancing
- Avoiding situations
- Self control
- Confrontations
- Acceptance of responsibilities
- Positive review
- Smooth problem solving

Some authors believe that problem-focused strategies are more effective than avoidant ones through emotion management. Other researchers believe that the use of direct strategies at high levels of stress is more likely to backfire.

Group work, shaped as a self-help group in the workplace, has a proven positive impact on reducing the stressful environment. The method of Balint groups is a group method in its essence, in which doctors (general or narrowly specialized), psychotherapists and psychoanalysts are trained in the relationship between doctor and patient. The method consists in gathering 10-12 people once a week for two hours under the guidance of one or two analysts. There, practitioners exchange their thoughts and ideas on specific cases to someone in the group in order to obtain a side view of the case that is independent of the personal emotions and experiences of the doctor/analyst/psychotherapist. The purpose of this method is to allow the specialist himself to better understand the phenomena of transference (of significant feelings from childhood on the personality of the analyst) and countertransference (in which the therapist, as a result of the therapeutic session, begins to transfer his own unconscious feelings to the patient).

According to Balint, the reversal of countertransference occurs by filling the "fundamental lack" (absence of independent external evaluation) in the analytic process. The method became very popular and entire associations started to be created that deal with it, the first being the Balint Medical Society of France (1967), the Balint Medical Society of Great Britain (1969). Subsequently, such societies were established in Italy (1974), Germany, Belgium and Russia (1994). This method is also applied in Bulgaria. It would be irrelevant if it is not combined with a proper organizational-administrative approach. For the serviceman, for example, it is important to feel support not only in the microgroup or team in which he works, but also from his direct supervisors.

According to Carolyn Potter, the problem of burnout can be effectively addressed, both for staff and patients, by implementing a burnout prevention model at ward or team level. The authors found a correlation between the duration of coping methods (short-term and long-term techniques) used by emergency department physicians and nurses and the degree of burnout they experienced. To some of the short-term coping techniques, the authors list: crying; daydreaming;

the use of food and various nutritional supplements; longer sleep than usual; ability to "look at" work situations with a sense of humor.

A number of studies confirm that doctors with high levels of emotional exhaustion used short-term coping techniques more often, and those with high levels of depersonalization used coping techniques less often (Carolin Potter). In the same study, a strong relationship was found between the higher level of fulfillment of work duties by doctors and the application of long-term coping techniques, including and the ability to look at everyday situations with a sense of humor (short-term technique). These results are similar to the results for emergency department nurses.

In order to reduce occupational stress, emotional exhaustion and frustration, some authors recommend continuing medical education (CME) to acquire modern communication techniques and skills when working with seriously ill patients and to apply a holistic approach to patient care, where a balance between modern medical technology and achievements in science and practice and humanism.

Of importance for a preventive program to reduce and prevent the destructive conditions of the burnout syndrome on vulnerable groups of employees is their training and upbringing to detect the first signs and symptoms for early detection of the syndrome.

An approach proposed by authors who have extensively studied the influence of environmental factors in emergency departments and the development of medical staff burnout syndrome is the management of violence and aggression on the part of patients and their relatives. Controlling these two conditions is an important step in limiting stress, emotional exhaustion and personal isolation of medical staff. In this regard, staff training is offered related to the acquisition of various skills to deal with aggression, violence and role conflict management.

Increasing the power resource of medical personnel, through their education and self-awareness in a positive and high self-esteem, will allow them to more easily cope with the goals of daily work and with the challenges of the health system. Ambiguity of the roles of medical professionals leads to a decrease in satisfaction and a stronger experience of stress. Similar conclusions were drawn by Carol, who, according to the author, found that low levels of control and autonomy determined higher levels of burnout in the studied groups of emergency department specialists.

8. BURNOUT PREVENTION PROGRAM FOR HEALTH CARE PROFESSIONALS

Based on the literature data and studies, it is concluded that single, individual and episodic burnout prevention measures are not as effective as well-organized and institutionalized prevention programs, which have a mandatory or recommended nature. Therefore, at all levels in hospital facilities, a preventive program for medical staff burnout should be implemented on an ongoing basis. This requires a broad-spectrum approach, which is built on the following horizontal levels – institutional level, sector level, group, team level and individual level.

The program also includes four functional vertical levels – administrative, qualification, group-individual and activities.

Table 3. Burnout prevention program for medical professionals

Level	Administrative - level	Qualification - level	Group individual level	Level activities
Sectoral level – clinic, department	Sectoral program for individual departments and regulations with an emphasis on policies related to the prevention of aggression	Professional evaluation of the work psychoclimate and effectiveness of the prevention of team weaknesses	Group trainings for cohesion, coping with stress. Individual work with the medics who have not managed to integrate into the structure. Group and individual counseling	Periodic external monitoring
Group, team level	Department Rules; selection of representative and facilitator	Group training		Group events
Individual - level	Assessing individual behavior	Individualized training and ways to resolve problem behavior	Individual approach and consultations from an internal or external expert	Individual participation in group activities. Increasing the role of the individual employee in the overall work

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