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The Mental Health of Combatants

Andrey Soloviev, Elena Ichitovkina and Marina Zlokazova

Abstract

The chapter deals with the theoretical, methodological, and practical aspects of combatants' mental health as participants in hostilities, in the context of psychosocial environment characteristics and the transformation of personal characteristics in the process of stress service. The emerging situational and dynamic nosological and subclinical changes are described, which do not lead to social disintegration during the service. The study of the power structure of employees' catamnesis for 10 years of service was conducted with an assessment of social adaptation to peaceful life from clinical and psychological positions. The efficiency of complex therapy for persons with post-traumatic stress disorder and adaptation disorders is estimated, and the features of the organization of stage-by-stage rehabilitation with a team poly-professional approach are described. The methods allowing to predict the formation of borderline mental disorders (BMD) in this contingent are offered. The directions of medical and psychological support of combatants with the creation of a fundamentally new diagnostic, psychoprophylactic structure—the Center of Mental Health—to improve the quality of psychological and psychiatric care and monitoring of participants of the fighting mental state are systematized.

Keywords: combatants, borderline mental disorders, prevention, therapy, rehabilitation

1. Introduction

Preservation of mental health and extension of professional longevity of combatants are the most urgent task of departmental psychiatry, as they are the most important element of public health, largely determining the economic and social well-being of the nation.

When considering the mental health of combatants in the context of the characteristics of the psychosocial environment and the dynamics of personal characteristics in the process of stress service, many authors note the presence of situational and dynamic subclinical changes that do not lead to social maladaptation in the usual conditions (in the circle of colleagues) [16], but significantly worsen the family sphere of functioning and contribute to a decrease in the quality of life.

Issues of psychological prevention of the formation of borderline mental disorders (BMD) and destructive and addictive behavior of combatants come to the fore in their social and psychological significance: suicidal and antisocial actions, use of drugs, and alcohol abuse [5].

The structure of mental disorders in combatants in recent decades is characterized by a predominance of acute psychogenic pathological disorders with a significant reduction in the number of reactive psychosis. Over time, the structure of the social and medical consequences of wars for persons involved in extreme situation

(ES) begins to prevail in the BMD, which lead not only to a decrease in the quality of life but also premature disability [6].

Combatants' BMD are characterized by a wide range of mental illnesses from mild affective disorders and post-traumatic stress disorder (PTSD) to severe personality disorders.

The Russian army began fighting in the North Caucasus region (NCR) against the separatists on December 11, 1994—it was the most massive and brutal war in the history of modern Russia. On August 31, 1996, the fight ended with the signing of the Khasavyurt agreement. However, the end of the conflict did not bring peace and tranquility.

Kidnappings and murders of people, terrorist attacks on the territory of Russia led to the second stage of the military confrontation with the need to involve professional employees—members of law enforcement agencies. Fighting clashes took place in the territory of some republics—Chechnya, Ingushetia, Dagestan, and Kabardino-Balkaria. According to the general staff of the armed forces of the Russian Federation, during the period of hostilities in 1994–2009, the irretrievable losses of the Russian security agencies in the North Caucasus amounted to killed and dead of more than 8500, prisoners and missing of 510, and wounded of more than 70,000 people.

The dynamics of personal changes in combatants indicates the deterioration of their mental health; there are emotional and behavioral stress, hyperactivity, a tendency to aggressive reactions, signs of social maladaptation, psychasthenic features, introversion, and emotional coldness, which contribute to the change of social functioning and social disintegration in the absence of clinically expressed psychopathology [14]. Therefore, it is necessary to detect these violations early and carry out medical and rehabilitation measures with subsequent monitoring of mental health of the participants of the fight.

2. Borderline mental disorders in combatants

Among the clinical forms of BMD, to identify the combatants, the most common are an organic disorder with personality disorders, affective disorders and organic mental syndrome (F06, F07 according to *ICD-10*), somatoform disorders (F45), PTSD (F43.1), adjustment disorders (F43.2), and chronic changes of personality after the experience of catastrophe (F62.0).

Combatants' BMD are significantly different from civilian neuroses on the specifics of the formation of the clinical symptoms and clinical manifestations; it is consistent with the formation of neurosis on the background of acquired and eventually increasing “accentuation of combatant” [17]. Earlier, the sudden onset of psychopathological symptoms was described against the background of external well-being, in acute conflict situations, often reflecting the internal feelings of a combatant [6].

From the point of view of S. Sukiasyan [14], BMD formed under the influence of combat mental trauma have similarities with neuroses in civilians. He distinguishes the following differences due to the etiopathogenesis of the disease and its dynamics: (a) the cause of the disease is characterized by an extreme occurrence, (b) the disorder occurs simultaneously from a large number of people, and (c) stress experienced by a person that is considered senseless leads to feelings of guilt for what happened with another person (death, injury, etc.).

According to M. Aksenov et al. [2], psychogenic neurotic states in persons of dangerous professions are presented by structured and relatively stable borderline disorders in their “classical” forms of manifestation (hysterical, dissociative, depressive, obsessive, anxiety-phobic, asthenic patterns, “neurosis of exhaustion”).

A distinctive feature of combatants' BMD is the presence of an alcohol component, which is an integral part of the structure of mental disorders and before the

formation of symptoms of dependence. In comorbid alcohol and drug disorders, there is no stage of formation of dependencies, in the structure of violations prevailing mainly psychopathic component. Drug dependence is more common among combatants who have had occasional drug use during fighting, who have not had sufficient socialization in peaceful life, and who had clinical signs of PTSD with a lack of timely treatment.

A special role among all combatants' BMD is given to PTSD. Psychotraumatic events of combat nature can lead to the formation of chronic forms of PTSD, often occurring exclusively at the subclinical level, while disrupting the social functioning and quality of life in the participants of the fight. The following clinical variants of anxiety, explosive, dysphoric, depressive, somatoform, and conversion are described [4].

Descriptions of the clinical picture of PTSD include polymorphic asthenic, obsessive-phobic, and anxiety-depressive symptoms. According to J. Alexander [1], rare fully phenomenologically defined clinical variants of PTSD, there is a tendency to combination with the socio-stress disorders.

Manifestations of post-traumatic stress disorder are often protracted, forming an average of 2–6 months after exposure to a traumatic situation. Personality disorders caused by battle mental trauma continue to be one of the most difficult areas of military psychiatry, both in clinical and diagnostic and in medical and expert aspects. Shortcomings in diagnostic approaches in the early stages lead to the identification of diseases at the stage of “deep implantation” of psychopathological symptoms in the personality, which later becomes the cause of the formation of pronounced personality disorders with subsequent disability of combatants.

Ignoring the symptoms of borderline mental disorders or their late detection, a formal approach by specialists in their diagnosis leads to the formation of chronic neurotic disorders, which significantly reduces the quality of life of combatants, increases the risk of manifestations of various forms of deviant behavior (antisocial, suicidal, addictive) [10].

To explore the mental health of combatants involved in fighting in the North Caucasus, a continuous survey of 1537 men—employees of power structures of Russia returned from the trip after the execution of service and combat tasks in the special conditions as a member of integrated fighting units in the period 2006–2009—was carried out. Among all surveyed on the level of mental health identified after participating in the hostilities, believable: (a) Seven hundred twenty-five persons (45.7%)—healthy combatants, whom the therapy was not required, and rehabilitation assistance was not provided. (b) Four hundred ninety-seven people (31.3%)—persons who for 6 years prior to the survey according to the data of the outpatient cards were identified with short-term affective behavioral responses (TABR); during this survey of clinical data on the presence of formed BMD in this group which was not revealed, they were provided with psychocorrectional assistance by psychologists at the place of service. (c) Three hundred fifteen people (19.8%)—they were identified with adaptation disorders (RA) and PTSD; in this regard therapy and medical and psychological rehabilitation were carried out.

Three hundred eleven combatants were identified as having different TABR, which were recorded in the outpatient records of combatants by psychiatrists or neurologists during the 6-year period preceding our study (Group 1). These states occurred in the form of short-term emotional-maladaptive states and behavioral disorders and belonged to the pre-painful level (305 people). In Group 2 clinically formed BMD were revealed: AD was observed in 166 people (54.4%), among them are short-term depressive reaction (F 43.20)—35 (21.1%), prolonged depressive reaction (F 43.21)—31 (18.6%), mixed anxiety and depressive reaction (F 43.22)—35 (21.1%), violations of other emotions (F 43.23)—21 (12.6%), with prevalence

of behavior disorders (F 43.24)—34 (20.5%), and mixed disorder of emotions and behavior (F 43.25)—10 (6.1%). Clinically designed PTSD was diagnosed in 139 people (45.6%) including anxiety type—36 (25.9%), explosive—33 (23.9%), somatoform—38 (27.6%), and conversion—31 (22.6%).

Our data confirm the studies of many authors who note the high prevalence of BMD among combatants around the world (especially in recent decades), which is associated with the extreme nature of service and participation in the settlement of ethnic conflicts [12, 17].

The combatants from the AD had emotional disorders in the form of anxiety and depression, periodically arising dysphoria of different severities depending on the clinical variant of the AD. All combatants registered a violation of interpersonal communication with a pronounced irritability, hot temper, and distrust of others.

Dreams of combat content in all combatants with PTSD presented painful scenes with a sense of threat to life (“could not defend”; “shot, but the bullets flew by”; “the corpses of the dead came to life”); dreams were accompanied by fear and vegetative symptoms (heartbeat, sweating). Depression, oppressive tension that is not a characteristic of earlier, increased sensitivity to everyday stimuli (loud sounds, the smell of gunpowder, gasoline), alertness, suspicion, and “over vigilance” were noted. There was a fear of open spaces with a sense of threat from the outside (squares, markets, and lawns were associated with “stretch marks,” fear of undermining, unfinished buildings with the threat of sniper fire, death, pits on construction sites with “graves,” and mass death of people).

Clinical manifestations of PTSD differed depending on the course of the disease. In combatants with an alarming type of PTSD, the structure of the disease was dominated by the symptoms of the neurotic circle: unmotivated anxiety, frequent mood changes, sleep disorders (difficulty in falling asleep, early awakenings, lack of a sense of rest after a night’s sleep), lethargy, weakness, and “heaviness in the head.”

In persons with an explosive type of PTSD, pronounced irritability and discontent were observed. They were characterized by resentment, vindictiveness, hostility to others, a tendency to solve everyday problems with the help of physical force, alertness, suspicion, vulnerability, and negativity. On the background of the overall tension, reducing the adaptive capacity of the neurotic tendency to impulsive reactions traced the difficulty in volitional control of negative emotions in everyday life; various forms of maladaptive behavior, such as excessive alcohol consumption and episodic use of psychoactive substances (PAS), were observed.

The structure of somatoform-type PTSD was dominated by pain in the region of the heart, in the course of the gastrointestinal tract. There was a pronounced hypochondriac fixation on these symptoms and an alarming expectation of their amplification, which forced patients to contact general practitioners, at the same time, periodically stated functional cardio-pathologies, dizziness, neuralgia, sleep disorders, headaches, nausea, vomiting, urological manifestations, and sexual dysfunction.

In combatants with a conversion type of PTSD in the clinic, the symptoms of increasing excitement with a lack of criticality to the disease prevailed, acute demonstrative reactions to external stimuli associated with the main traumatic factor, unmotivated initiative, increased chatter, inflated self-esteem, and the search for “perpetrators of the tragedy” with the desire for revenge. There were episodes of affective narrowing of consciousness with bouts of rage, physical aggression, and lack of guilt.

Analysis of clinical symptoms in TABR and BMD combatants showed that PTSD symptoms, such as reliving traumatic events and nightmares, were observed in both groups of combatants but were significantly more frequent in Group 2. “Flashback” symptoms with pronounced psychosomatic manifestations in the form of tachycardia, sweating, and increased blood pressure with repeated trauma are recorded in both groups but most often in combatants with BMD. Hallucinations when falling asleep

were only observed in individuals of Group 2. Dissociative manifestations to trigger the incentives in the structure of symptom re-experiencing the traumatic event are significantly more prevalent in individuals with the TABR in history.

Phobic reactions to trigger stimuli were found in groups with approximately the same frequency. Avoidance of thoughts, feelings, and people (everything that reminded about the injury) was revealed in both groups of respondents, but the frequency is significantly higher in persons with BMD (Table 1).

It should be noted that combatants with TABR were significantly more likely to have psychogenic amnesia in the structure of the avoidance symptom than those with BMD.

Symptoms	TABR		BMD		P	
	n = 311	%	n = 305	%		
At the moment of threat	Amnesia	0	0	1	0,3	0.345
	Fear	0	0	1	0.3	0.456
	Disorganization of behavior	5	1.6	6	1.9	0.367
	Narrowing of consciousness	0	0	6	1.9	0.458
Repeated experiences	“Flashback” symptoms	79	25.4	195	63,9	<0.001
	Nightmares	58	18.6	136	44,6	<0.001
	Hallucinations when falling asleep	0	0	10	3.3	465
	Phobic reactions on the trigger incentives	3	0.9	4	1.3	0.478
	Dissociative symptoms on the trigger incentives	12	3.9	6	1.9	<0.05
Avoidance	Thoughts, feelings	11	3.5	38	12.5	< 0.05
	Human action	69	22.9	143	46.8	<0.001
	Psychogenic fugue	12	3.9	4	1.3	< 0.05
	Reduced interest in previously Significant events	9	2.9	92	30.2	<0,001
	Sense of detachment, isolation	7	2.3	29	9.5	< 0.05
	The decrease in the level of Emotional response	34	10.9	89	29.2	<0.001
	The feeling of lack of perspective	0	0	12	3.9	0.478
Excitations	Sleep disturbance	89	28.6	198	64.9	< 0.05
	Irritability	78	25.1	264	86.5	< 0.05
	Temper	96	30.9	214	70.1	<0.001
	Violations of concentration of Attention	32	10.2	139	45.6	<0.001
Signs of social and labor maladjustment	9	2.9	45	14.6	<0.001	

Note: P is calculated using Pearson's χ^2 , and intergroup differences were significant at $p < 0.05$.

Table 1.
 Frequency of post-traumatic symptoms and stress disorders in combatants with BMD and TABR (%).

Symptoms of emotional deficits with social introversion, such as a decrease in interest in previously significant events, a sense of detachment and isolation, and a decrease in the level of emotional response were found in both groups of respondents but were significantly more often present in people with BDM. A sense of lack of perspective was present in individuals with only clinically formed BDM (**Table 1**).

In the combatant with TABR, clinical symptoms included maladaptive emotional and behavioral responses with symptoms characteristic of PTSD, but their duration and severity were significantly shorter and did not fit into the clinical criteria of the disease. In persons from the group with PPR, clinical symptoms were more pronounced, long-lasting, and polymorphic.

3. Features of therapy and rehabilitation of borderline mental disorders in combatants

Active and timely diagnosis of adverse mental health conditions in combatants, rehabilitation, and therapeutic measures is an urgent task of the departmental health [15].

Many researchers noted the importance of developing new approaches to the treatment and rehabilitation of combatants with BMD. Inconsistency in psychodiagnostic approaches and terminology often leads to disagreements of specialists and is an obstacle to the modern provision of the necessary complex medical and psychological care.

Rehabilitation is a complex of consistently held measures of medical, social, psychological, and pedagogical nature, aimed at the restoration of the individual to the level of her social activity.

An important aspect of the success of BMD therapy is a personality-oriented approach that takes into account premorbid personality characteristics [7]. Combatants with harmonious traits, BMD treatment, and social readaptation are more successful in the near and in the remote period after participation in the war.

Psychotherapists identify the main directions of psychotherapy of combatants with combat mental trauma: restoration of a sense of value of life, control over their emotions, and restoration of destroyed social positive attitudes [12]. At the same time, the proposed techniques of work, long-term enough that in real conditions of service with existing employees is almost impossible to implement.

At an early stage, as the practice of military conflicts in Afghanistan, the Persian Gulf, Vietnam, shows, it is advisable to carefully identify combatants who have received battle mental injuries and to maintain confidentiality, as the mechanism of “psychiatric stigma” is included. “Fatigue after a fight” in most cases is transformed into PTSD, which is a natural reaction of a person who finds himself in a war.

O. Yurkovsky fully described the stages and types of rehabilitation treatment of combatants with BMD, which include a set of medical, psychological, and social measures in inpatient and outpatient settings. The rehabilitation of patients with PTSD in the form of organization of the school, the basic principles of which are: balance, adaptability, and prevention; stages and continuity; complexity; and the concept of psychosocial rehabilitation of veterans of the war in Afghanistan, including three stages, is described: allocation of the main streams of combatants; conducting the main rehabilitation course (using special assistance centers); and supporting medical, psychological, and social methods [20].

Development of the organization of necessary assistance to combatants should be based on a multi-professional, integrated approach with brigade methods and involvement of psychiatrists, psychotherapists, clinical psychologists, and drug addicts (in connection with the epidemic of drug use in the world

and in Russia in particular). The most significant strategic miscalculation of the rehabilitation service creation is that the foundation on which the service is built is not defined [18].

Many experts in the field of mental health noted that the rehabilitation and therapy of veterans of combat operations are not sufficient; in this regard, they have the most pronounced risk of BMD and deviant behavior, which leads to a decrease in professional reliability and social functioning in general [11, 19].

S. Litvintsev notes that the treatment of persons with PTSD is advisable to produce in specialized departments and centers; the system of which in our country has not yet been established [9].

The sequence and complexity of rehabilitation treatment are dictated by the need to resocialize combatants to reduce the negative psychosocial consequences in the modern society [7, 13].

When treating and rehabilitating combatants with PTSD, it is important to balance clinical and social approaches and motivate patients to recover quickly.

In literature there are conflicting data on the evaluation of the effectiveness of therapy and rehabilitation of participants in hostilities. The analysis of the long-term results of rehabilitation measures conducted by O. Yurkovsky [20] showed that 88.5% of patients were successfully adapted and the effectiveness of treatment remained during the year. The effectiveness of therapy and rehabilitation depends on the timeliness of treatment, favorable premorbid, social support, and the absence of concomitant somatic diseases [8].

Rehabilitation of persons with combat PTSD is a complex problem requiring improvement of organizational approaches and development of programs with the participation of various specialists involved in mental health.

The use of psychopharmacotherapy in the treatment of BMD in combatants allows to stop psychopathological symptoms in the early stages, to increase the effectiveness of crisis psychotherapy, to reduce anxiety and aggression, to neutralize negative emotional reactions, and to improve interpersonal communication and social interaction.

The choice of methods of medical treatment of BMD in combatants is based on clinical symptoms and is prescribed taking into account the main psychopathological syndromes and clinical forms in accordance with the standards of psychiatric care.

With the predominance of depressive symptoms in the picture of BMD, it is advisable to use antidepressants (selective serotonin reuptake inhibitors and tricyclic antidepressants).

In the case of the presence of PTSD and AD structure of alarming symptoms with sleep disorders, short course of explosive prescribe benzodiazepine tranquilizers and/or small neuroleptics.

In conversion disorders, behavior correctors are mainly used. Antidepressants are not used due to the fact that they increase the dissociative symptoms.

In the case of an explosive version of PTSD and AD, behavioral disorders are corrected with drugs with predominantly sedative effect; in some cases, a good effect is observed when taking lithium drugs due to stabilization of the emotional state.

In the treatment of short-term depressive reactions caused by AD and PTSD with symptoms of anxiety and depression, selective serotonin reuptake inhibitors are most often used.

A good effect in the treatment of PPR, in the structure of which is dominated by anxiety and hypochondriac symptoms, as well as insomnia is noted when using benzodiazepine tranquilizers in the course 2–3 weeks, with gradual abolition.

In combatants due to the negative impact of stresses of official activity after the execution of operational tasks in special conditions, often there are situational-due

affective reactions, which are accompanied by anxiety and anxiety-phobic symptoms, which require the use of drugs with anxiolytic action. Their advantage is the absence of addiction and withdrawal syndrome, as well as a minimum number of side effects.

In addition to drug therapy, combatants with BMD are provided with psychotherapy to respond to negative feelings and change attitudes to traumatic events. The main difficulty is the establishment of trusting contact, which is associated with the characteristics of patients that expressed distrust of the environment.

When conducting psychotherapy at the initial stage of medical rehabilitation, the presence of “combatant accentuation,” in the structure of which there is a formed distrust, unwillingness to seek help, skepticism, difficulties in interpersonal communication, and increased irritability and temper. These features often lead to conflicts with medical staff and psychologists. In combatants with PTSD, preference is given to individual forms of psychotherapy, especially at the stationary stage, since collective and group psychotherapy in the stage of acute clinical symptoms causes protest reactions in some people with BMD in the form of explosive outbreaks and dissociative symptoms.

The establishment of empathic, trusting relationships between the patient and the psychotherapist is a critical therapeutic factor necessary for the effectiveness of therapy. When building communication in the process of psychotherapeutic treatment, it is necessary to take into account the personal characteristics of patients [3].

Psychotherapy with combatants is aimed at:

- * Formation of motivation for treatment and overcoming of the stigmatized attitude to the treatment process.
- * Combatant study of their psychological and personal characteristics.
 - Correction of response patterns in civilian life.
- * Formation of adaptive behavior skills in the service and at home.
 - Training in the techniques of psychical self-regulation and increase of their psychological capabilities for gaining control of emotional reactions.

At the initial stage of rehabilitation, it is advisable to conduct individual rational psychotherapy with all combatants—for the interpretation of the nature and causes of traumatic stress through logical re-persuasion, the formation of motivation for psychotherapeutic treatment, and overcoming the stigmatized attitude to psychotherapeutic assistance. The means of psychological influence are persuasion, explanation, and distraction. The main purpose of this psychotherapeutic method is to study the patient’s personality, evaluation, and correction of inadequate emotional and behavioral stereotypes of the patient, which determine the violation of his psychological and social functioning.

The use of art therapy contributes to the additional diagnosis of personal problems, affective disorders, further de-actualization of traumatic events, the expansion of adaptive reserves, self-esteem, and mood correction. The plot should be connected with the peculiarities of the combatants’ attitude, feelings, and experiences reflecting the stressful effects. The therapy is conducted individually and effective combatants as with adjustment disorder, and PTSD. Painting and drawing techniques are used with various materials (gouache, pencil, oil, watercolor, artistic coal). Depending on the material chosen by the combatant, the duration of the session is from 30 minutes to 1.5 hours, and the number of sessions per course of therapy is from 3 to 10 times.

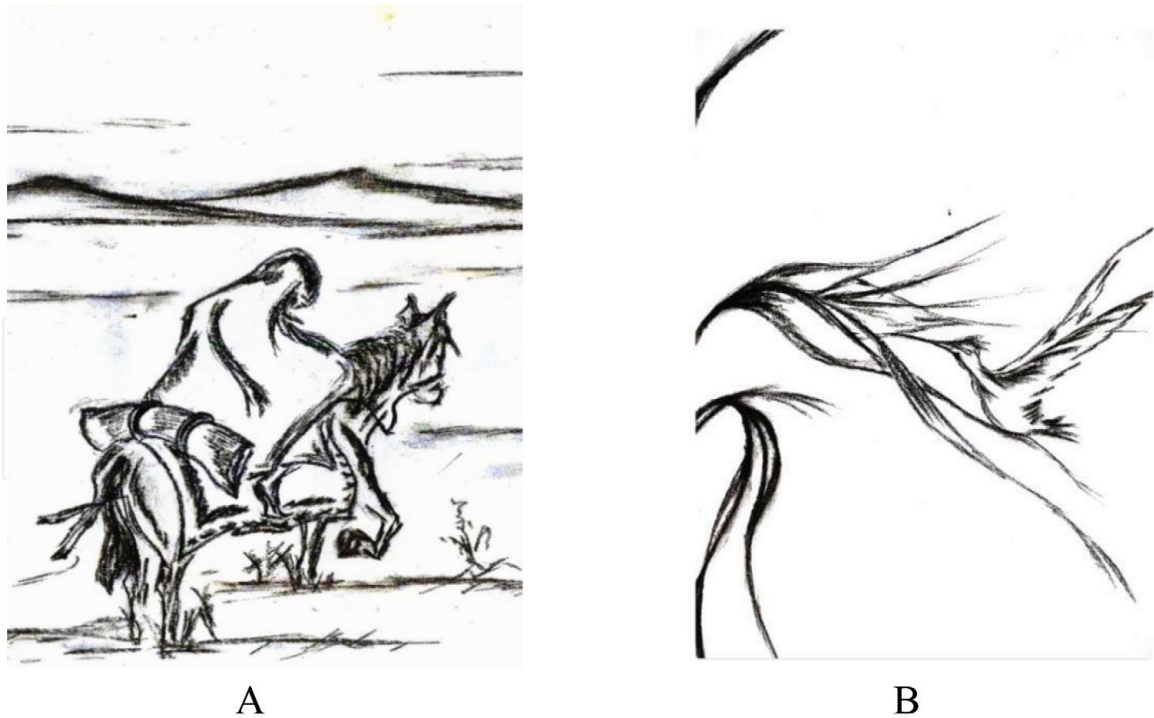


Figure 1.
(A) Combatant K—Before treatment. Diagnosis: PTSD, dysphoric type. (B) Combatant K—In a month of therapy.

As an example, illustrating the theoretical material, we present the work of two combatants diagnosed with PTSD. A work of art is made with charcoal.

In the examination of combatant K, 27 years old, after returning from the NCR, he was found to have pronounced explosive and dysphoric symptoms, the violation of communicative processes, social isolation, pessimism, and a diagnosis of PTSD, dysphoric type (a plot—“a lone rider,” **Figure 1A**).

After the medical and psychological rehabilitation, improvement of the emotional background and reduction of the main psychopathological manifestations were noted (a plot —“nest,” **Figure 1B**).

During the examination of combatant M. after returning from the NCR (a plot—“warrior,” **Figure 2A**), there was a pronounced aggressive-dysphoric mood, violation of interpersonal communication skills, negativity, and “defensive position.” After the medical and psychological rehabilitation, the stability of the emotional background, balance, and reducing anxiety and aggression were noted (a plot—“sea, calm,” **Figure 2B**).

In the works of the combatant K, 27 years old, diagnosed with PTSD, an alarming type, there was also a positive dynamics of mental state. A work of art is made with charcoal. After returning from the NCR (a plot—“a wolf howls at the moon”), expressed anxiety and depression symptoms, a violation of communication processes, social isolation, and pessimism were noted (**Figure 3A**). After the medical and psychological rehabilitation (a plot—“winter landscape”), the stability of the emotional background, balance, and lack of anxiety and depression on the background of introversion were noted (**Figure 3B**).

The leading method in working with combatants is family psychotherapy, aimed at restoring family values and interpersonal relations in the family. The attention of the immediate environment is focused on the need to provide psychological assistance and family support to the combatants; it is explained that the return to peaceful life may be accompanied by difficulties. Family members are given a description of the combatant’s behavior, the problems that have arisen after combat stress are reported to be of a nonpermanent nature, and the family can help to deal with them.



Figure 2.
(A) Combatant M—Before treatment. Diagnosis: PTSD. (B) Combatant M—in a month of therapy.

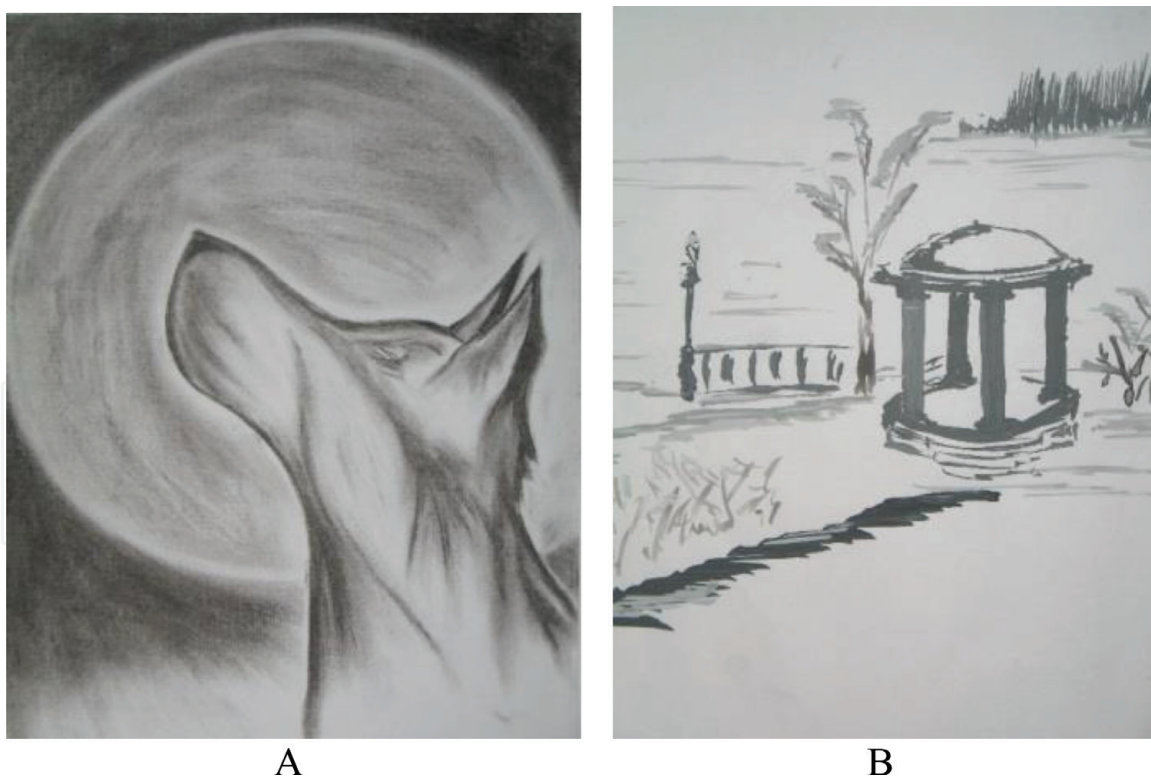


Figure 3.
(A) Combatant K—Before treatment. Diagnosis: PTSD. (B) Combatant K—in a month of therapy.

Our data in the study of mental morbidity among combatants significantly differ from the studies of O. Shevtsova and V. Kokhanova, who revealed that the background of the increase in the number of BMD, dismissal among the military who underwent BND, is 61.4% due to clinical resistance to therapy and the presence of psychosocial consequences [19]. Similar data are noted in the works of

D. Svechnikov and co-authors, who show that neurotic disorders in military personnel are the leading pathology for defense agencies, leading to early dismissal and extremely negative impact on the combat effectiveness of the army [11].

According to our data, the timely provision of professional assistance to combatants with the BMD not only does not lead to dismissal but also is not an obstacle to professional growth. In the process of rehabilitation of combatants with BMD, there is a positive trend: a month after the start of therapy in persons with RA is 83.3% and PTSD in 67.4% of cases; during the year 93.1 and 89.9% and in 4 years 98.9 and 96.6%, respectively. V. Shamrey noted that the identified violations in the combatants rarely led to a serious violation of social adaptation but felt sick as hindering the possibility of adequate realization of their personal potential; they did not associate them with the disease, regarded them as “growing up” [17].

Thus, early detection of BMD and pre-pain conditions in combatants with appropriate poly-professional therapy leads to positive results, contributing not only to the preservation of mental health but also to further career growth.

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