

ROUTE OF OPPORTUNITIES

Roadmap for Comprehensive Support of Veterans
and Other People with Vision and/or Hearing Loss
and Related Combat Injuries

A practical roadmap for families, professionals, NGOs and public institutions



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Introduction to the Roadmap

The war has caused an unprecedented rise in the number of people with sensory impairments resulting from combat injuries. Loss of sight and/or hearing, particularly when combined with other combat injuries, is among the most disorienting and difficult-to-recover-from injuries, as it requires long-term, comprehensive rehabilitation covering medical, psychological, educational, vocational and social aspects.

For the individual, a sensory injury is not merely a functional limitation. It often triggers an identity crisis, reduces motivation, intensifies feelings of worthlessness and creates a high risk of social isolation. The recovery process affects not only the person undergoing rehabilitation but the whole family: in the first few months, confusion, fear, a sense of helplessness and the constant question «what is the right thing to do and how can we avoid causing harm?» become the norm.

Expert discussions and an analysis of practice have shown that in the first days and weeks following a trauma, people most commonly experience disorientation, a loss of autonomy and control, emotional instability, avoidance of social interaction, and a fear of movement or activity (kinesiophobia); amongst military personnel, apathy and a sense of meaninglessness are also frequently observed.

At the same time, there are systemic barriers to the provision of support: the absence of a single standardised approach to support at all stages; fragmentation between services (medical, psychological, social and educational-vocational components operate without a shared logic); unclear criteria for transition between stages; loss of information when a person moves between institutions; insufficient preparation of the family and adaptation of the home environment; scattered data and the inability to see a complete picture of progress. A separate gap is the lack of tools and practices for assessing the educational and vocational potential and skills necessary for a return to productive activity.

The consequences of such a «disconnected» system are very practical and painful: regression (loss of acquired skills), prolonged rehabilitation periods due to chaotic and duplicated interventions, inefficient use of resources, secondary traumatising and social isolation, as well as a low rate of return to productive activity despite the individual's potential.

The key challenge is the lack of a common language among all those involved in the process. When everyone describes a person's condition and needs «in their own language» (using different terms, criteria and priorities), decisions become out of sync, important information is lost during transitions between institutions, and the family receives conflicting signals and is left alone to decide on the next steps.

This is precisely why the proposed approach centres on the Roadmap «Route of Opportunities» as a common language for coordination, which:

- establishes a consistent framework for the stages from injury to the restoration of quality of life, autonomy and return to activity;
- establishes agreed criteria for transitions between stages to minimise subjectivity in decision-making and «gaps» in support;

- standardises basic definitions of conditions and indicators of change so that specialists, families and managers share a common understanding of progress and risks;
- defines a minimum set of information to be shared between institutions and teams (via a «Patient Rehabilitation Profile»), reducing data loss and duplication of interventions;
- helps to align the roles and responsibilities of those involved in the process – from the family to inter-agency coordination at the community and state levels.

The Roadmap is implemented through three interlinked components: the individual rehabilitation pathway, the Patient Rehabilitation Profile (to record the starting point, changes and key indicators), and Recommendations for professionals and families, which ensure a shared understanding of the appropriate actions at each stage. The approach is based on international practices in the rehabilitation and support of veterans and is aligned with national priorities for the development of the rehabilitation system and veteran services.

In this sense, the guide serves as a practical vehicle for the Roadmap's common language: it helps to utilize the stages, transition criteria and «Patient Rehabilitation Profile» to coordinate decisions within the team, the family and the support system.

The materials in the Guide are the result of the «Route of Opportunities» online laboratory held in December 2025 and a preliminary expert survey. The survey involved 31 experts, including 5 combatants with relevant injuries; typical psycho-emotional states at different stages, indicators of positive change, criteria for increased autonomy, risks of regression and methods for recognising them were recorded.

The online laboratory took the form of structured work by expert groups, conducted via online meetings with the outcomes recorded in real time.

The Roadmap is a common language for everyone involved in the rehabilitation of people with sensory impairments resulting from combat injuries. It is not intended to replace professional methodologies, but rather to harmonise the logic of interaction, make the transitions between stages visible, and minimise information loss at critical points along the route.

The key participants in this process are:

- the person with trauma and their family – to help navigate the process, understand the stages, risks and appropriate support measures without taking on the role of professionals;
- specialists from the multidisciplinary team – to agree on objectives, shared indicators of change and transition criteria, as well as to prevent regression;
- civil society organisations and partner initiatives – to integrate support programmes into the pathway, provide accompaniment and advocacy, and establish sustainable mechanisms for accessing services within the community;
- civil servants and local government officials – for inter-agency coordination, planning of services and resources, and evaluating effectiveness at the community/regional level.

All these groups view recovery from different perspectives, but the Roadmap enables them to act in a coordinated manner – through shared definitions, criteria and a sequence of decisions.

The common language of the Roadmap enables:

- agreement on the stages and objectives of the support process, so that everyone understands «where we are now» and «what the next step is»;
- standardise the criteria for transitions between stages, reducing the risk of erroneous «too early/too late» decisions;
- maintain continuity of support when changing institutions and teams thanks to a minimal handover package;
- identify risks of regression in a timely manner and respond before a «setback» in skills or emotional state occurs;
- enhance individual autonomy and reduce dependence on the environment through predictable support logic;
- support management and planning: link needs at each stage to services, resources and performance indicators.

Individual rehabilitation route: concept and structure

An **individualised route** is a standardised logic for a rehabilitatee to go through key stages, from acute trauma to restoring quality of life, linked to the five components of the person-centred model.

1. General logic (framework)

Each person goes through different stages, but standards provide a unified system of guidelines that helps avoid chaos.

The route consists of six basic stages:

1. Acute stage: stabilisation and safety
2. Initial adaptation: reducing shock and anxiety
3. Formation of autonomy and basic skills
4. Psychological and identity recovery
5. Educational and professional rehabilitation
6. Long-term integration and quality of life

This is a **universal standard**, and within it there are individual trajectories.

2. Details of the stages (duration is approximate)

Stage 1. Stabilisation and safety (0–14 days)

Objectives:

- physical and psychological safety
- control of shock, anxiety, disorientation
- risk minimisation

Criteria for moving on:

- basic orientation
- reduction of acute anxiety
- capacity for minimal interaction

Stage 2. Initial adaptation (2–6 weeks)

Goals:

- stabilisation of functional status
- basic mobility and self-care skills
- building trust in the team
- reducing dependence on external assistance

Criteria for moving on:

- reducing fear of movement
- ability to follow simple instructions
- stability of emotional reactions

Stage 3. Basic autonomy (6–12 weeks)

Goals:

- development of mobility
- orientation in the environment
- development of independence in daily activities
- stabilisation of rhythms (sleep, activity)

Criteria for moving on:

- ability to move independently in familiar surroundings
- performance of everyday activities
- readiness for cognitive load

Stage 4. Identity and psychological recovery (2–6 months)

Goals:

- forming a new identity after trauma
- restoring motivation and initiative
- working with frustration, loss, and role changes

Criteria for moving on:

- ability to set personal/everyday goals
- emotional regulation
- interest in learning or activities

Stage 5. Educational and professional stage (3–12 months)

Goals:

- return to education/retraining
- professional assessment and planning
- environmental adaptations (tactile, auditory, digital)

Criteria for moving on:

- stable independent mobility skills
- sufficient psychological stability
- willingness to take responsibility

Stage 6. Long-term integration (from 12 months)

Goals:

- social inclusion
- stable life activities
- professional independence
- quality of life (subjective and objective)

Transition (completion of the route):

- independence in key areas of life
- stable social roles
- sustainable adaptation mechanisms

3. Linking the route to the Status Passport

At each stage, the following are recorded:

- functional status according to 5 components
- risks and signs of regression
- micro-goals for 2–6 weeks
level of autonomy
- recommendations for the team and family

The passport becomes a tool for navigating the route.

4. Standardised «transition points» between stages

For systematic work, it is important to define standardised transition criteria:

Psychological: stabilisation of emotional reactions, ability to make contact

Functional: minimum set of self-care skills

Sensory: ability to navigate a safe space

Communicative: accessibility of communication channels

Motivational: initiative, readiness to act

This allows for the **unification of support team decisions** and avoids subjectivity.

5. IF-THEN model (for making decisions about continuing along the route)

The route can operate according to the following logic:

IF	the level of anxiety is high	→	THEN	return to stabilisation interventions
IF	autonomy increases	→	THEN	focus on orientation and mobility
IF	initiative appears	→	THEN	inclusion in educational and professional routes
IF	social interaction is limited	→	THEN	work with accessible communication

This ensures **adaptability** and **predictability**.

Why do the system and experts need this route?

- It ensures standardised operating logic.
- It allows for the integration of different institutions.
- It provides common criteria for all teams.
- It unifies performance evaluation.
- It ensures transparency and predictability for the rehabilitant.
- It forms the basis for the **Roadmap and Rehabilitation Profile**.

DETAILED MODEL OF THE TOOL «Patient Rehabilitation Profile»



1. Logic and rationale behind the composition of parameters

The «Patient Rehabilitation Profile» tool is based on the logic of a holistic, **person-centred model of recovery**, which identifies five components:

1. Basic psychological stability and sense of security
2. Autonomy and functional mobility
3. Self-awareness, identity and motivation
4. Social interaction and social integration
5. Quality of life and long-term resilience

This composition is based on three key arguments:

Argument 1. Functional recovery model (WHO ICF)

International Classification of Functioning, Disability and Health (ICF, WHO):

- proposes viewing a person through bodily functions, activity, participation in life, personal factors, and environmental conditions;
- emphasises the need for a meaningful assessment of changes, not just medical parameters;
- supports a comprehensive approach to disability and rehabilitation.

Our 5 components integrate the key domains of the ICF:



Argument 2. The logic of the rehabilitation path (dynamic model)

The path to recovery for people with vision loss, hearing loss, combined sensory impairments (deafblindness), and related combat injuries is not linear, but rather a dynamic process that passes through the same substantive areas of change:

1. First, the person must regain a sense of security and orientation.
2. Next, they must regain control over their body and actions.
3. Then, they must achieve self-awareness and see their prospects.
4. Next, they must become involved in society.
5. And finally, they must find stability and quality of life.

These changes are not strictly tied to the stages of the route – they can occur in parallel, in waves, with regressions and breakthroughs.

Therefore, it is logical to group the parameters according to the content of the person's condition, rather than according to the stages of the route.

Argument 3. Psychological mechanisms of adaptation after trauma

Psychological science describes adaptation after loss of function (sensory or physical) as going through:

1. Shock – disorientation
2. Search for control – functional adaptation
3. Reinterpretation of oneself – formation of a new identity
4. Restoration of social roles
5. Stabilisation, integration, new level of quality of life

This **fully corresponds to the 5 components of the tool**, with the difference that we make them measurable.

Component 1. Basic Psychological Stability and Sense of Security

What we measure:

- level of anxiety/panic
- internal sense of physical and psychological security
- orientation in one's condition
- ability to perceive information
- primary sense of control

Example statements:

I feel safe here and now.

I understand what is happening to me.

I can perceive and remember information.

My anxiety prevents me from acting. (reverse code)

I feel that I can cope with my situation.

No	Indicator	Description / Statement	Starting score (0–4)	Post-stage assessment	Post-stage assessment
1.1.	Sense of security	«I feel safe here and now»			
1.2.	Orientation in the state	«I understand what is happening to me»			
1.3.	Ability to perceive information	«I can listen, understand and remember»			
1.4.	Level of anxiety	«My anxiety prevents me from acting» (reverse statement)			
1.5.	Basic control	«I feel at least a little bit like I can handle this»			

Why is this important? Because without it, it is impossible to orient oneself in information or develop autonomy. This is a fundamental condition for any subsequent action.

What we measure: anxiety, orientation and basic sense of control.

Interpretation: low values → the person is not ready for active rehabilitation.

Positive dynamics: the first sign that the person is «coming back to themselves».

Component 2. Autonomy and functional mobility

What we measure:

- fear of movement
- self-care skills
- ability to move around (with a cane, with support, independently)
- body awareness
- basic control over actions and situations

Example statements:

I am afraid to move independently. (reverse code)

I can perform daily activities independently.

I move confidently in familiar spaces.

I understand my body in new conditions.

I can plan my movements and actions.

No	Indicator	Description / Statement	Starting score (0–4)	Post-stage assessment	Post-stage assessment
2.1.	Fear of movement	«I am afraid to move on my own» (reverse statement)			
2.2.	Self-care skills	«I can perform basic daily activities independently»			
2.3.	Mobility	«I move confidently in familiar spaces»			
2.4.	Body image	«I understand my body in new conditions»			
2.5.	Control of movements and actions	«I can plan my movements and actions»			

Why is this important? Autonomy is a key indicator of functional rehabilitation. Without it, there can be no return to normal life.

What we measure: fear of movement, self-care skills, mobility, body awareness.

Interpretation: an increase in points indicates real progress along the route.

This is a central block for people with vision/hearing loss.

Component 3. Self-awareness, identity, motivation

What we measure:

- self-image in a new situation
- professional vision
- self-efficacy
- intrinsic motivation to act
- reduction of feelings of hopelessness

Example statements:

I see opportunities for my professional future.

I feel that I have valuable skills.

I want to learn or try new activities.

The future seems hopeless to me. (reverse code)

I feel my value and ability to develop.

No	Indicator	Description / Statement	Starting score (0–4)	Post-stage assessment	Post-stage assessment
3.1.	The image of a professional future	«I have at least a rough idea of what I could do»			
3.2.	Self-efficacy	«I feel that I have valuable skills»			
3.3.	Motivation for action	«I want to learn/try new things»			
3.4.	Fear of the future	«The future scares me» (reverse statement)			
3.5.	Self-esteem and self-worth	«I feel my importance and ability to develop»			

Why is this important? After trauma, a new identity is formed – without this, it is impossible to have a purpose in life.

What we measure: vision of the future, motivation, self-belief.

Interpretation: stable growth in this block allows for transition to professional rehabilitation.

Component 4. Social interaction and integration

What we measure:

- social confidence
- interaction with people
- ability to fulfill social roles
- social connectivity and participation
- readiness for team/community integration

Example statements:

I feel comfortable interacting with other people.

I have people with whom I communicate regularly.

I feel like part of a community/family/group.

I can handle some social affairs on my own.

I am ready to participate in community life.

No	Indicator	Description / Statement	Starting score (0–4)	Post-stage assessment	Post-stage assessment
4.1.	Social confidence	«I feel more comfortable engaging with others than I did before»			
4.2.	Membership / participation	«I feel like I'm part of a group/ community»			
4.3.	Social contacts	«I have people with whom I communicate regularly»			
4.4.	Independence in social actions	«I can handle some social affairs on my own»			
4.5.	Collaborative readiness	«I am ready to be part of a team or group»			

Why is this important? Because recovery without social inclusion is only half the route.

What we measure: connectivity, participation, social agency and confidence.

Interpretation: this component is critically important in the transition period to employment.

Component 5. Quality of life, resilience and long-term adaptation

What we measure:

- subjective assessment of quality of life
- ability to overcome difficulties
- ability to plan
- participation in family or community life
- emotional stability

Example statements:

Overall, I am satisfied with my life right now.

I know how to cope with difficult situations

I can plan for the future.

My emotional state is stable throughout the day/week.

I am active in the life of my family or community.

No	Indicator	Description / Statement	Starting score (0–4)	Post-stage assessment	Post-stage assessment
5.1.	Subjective quality of life	«Overall, I am satisfied with my life right now»			
5.2.	Strategies for overcoming	«I have ways of coping with difficulties»			
5.3.	Planning for the future	«I can plan ahead and set goals»			
5.4.	Emotional stability	«My emotional state has been relatively stable throughout the week»			
5.5.	Emotional stability	«I participate in the life of my family or community»			

Why is this important?

This is the resulting component that allows us to understand whether a person has truly «returned to life» or is simply «functioning»

What we measure: life satisfaction, resilience, planning and participation.

Interpretation: high values = successful rehabilitation;
low values = need for further support.

Final block of assessment

Component	Starting score	Score after stage 1	Score after stage 2	Score after stage 3	Score after stage 4
1. Stability and security					
2. Autonomy and mobility					
3. Identity and motivation					
4. Social interaction					
5. Quality of life					

3. Interpreting the Results: How to Read and Understand Them?

Two models are available – basic and advanced.

■ Simplified interpretation (for practitioners)

Component scores:

- 0–1: critical level → the individual is not ready for the next stages
- 2: low level → intensive work is required
- 3: medium level → transition to the next stage is possible
- 4: high level → good progress, readiness to move forward

This is easy to explain to both the individual and the team.

■ Extended interpretation (for specialists, analysts, roadmaps)

1. BASELINE SCORES: form the initial state profile.

For example: high scores in autonomy, low scores in stability = risk of emotional breakdown.

2. DYNAMICS: the main criterion for success.

Positive dynamics in 3 out of 5 components = successful stage.

3. GAPS (Discrepancies): if one component is «lagging behind», the route needs to be adjusted.

For example: a person is autonomous but lacks social confidence → high risk of failure in employment.

4. PROFILES FOR DIFFERENT TYPES OF TRAUMA

the tool allows you to see:

- deafblind profile
- profile heavy PTSD
- profile with cognitive impairment
- amputee + sensory loss

This enables the customization of the roadmap to fit the specific type of rehabilitee.

Regulatory and methodological basis for the structure of the tool «Patient Rehabilitation Profile»

(international standards, protocols, recommendations)

1. International documents defining rehabilitation standards



1.1. International Classification of Functioning, Disability and Health (ICF) World Health Organization (WHO), 2001

- Defines domains of functioning: **psychological functions, activity, participation, personal factors, environment.**
- The proposed structure of indicators («5 components») is an integration of key ICF domains.
- It allows us to form **a comprehensive profile of a person's functioning, which is the goal of our tool.**

***Justification:** The components «psychological stability», «autonomy», «social interaction», and «quality of life» directly reflect the areas of functioning that, according to the ICF, determine a person's level of functioning after trauma.*



1.2. «WHO Rehabilitation 2030: A Call for Action» (World Health Organisation, 2017)

Key provisions:

- rehabilitation should be person-centred,
- assessment should include functional, psychological and social parameters,
- dynamic assessment (not one-off) is mandatory,
- rehabilitation should include medical, psychosocial and vocational interventions.

***Justification:** our tool includes precisely these parameters: from emotional stability to autonomy, participation and quality of life; and provides for regular reassessment, which fully complies with WHO requirements.*



1.3. «Guidelines on the Provision of Assistive Products» (WHO, 2022)

Indicates the need to:

- assess functional capabilities,
- determine the level of autonomy,
- take into account the personal goals of the rehabilitant,
- assess the context of the social environment.

Justification: components 2 (autonomy) and 4 (social integration) fully comply with these recommendations.



1.4. Rehabilitation Interventions Package (WHO, 2020)

Develops standardised intervention models, including:

- psychological,
- sensory,
- mobility,
- social.

Justification: RIP is based on the principle of assessing abilities and barriers, not just the disease. Our tool works on the same logic.

2. European standards and institutional recommendations



2.1. The European Disability Rights Strategy 2021–2030

- emphasises the importance of independence,
- participation in public life,
- access to education and employment.

Justification: components 2, 3, 4 and 5 directly correspond to the requirements of this strategy.



2.2. European Quality Framework for Social Services (2010)

- the key quality parameters are: participation, self-determination, safety, effectiveness of support,
- emphasising the need to assess personal development.

Justification: this directly corresponds to components 1 (safety), 4 (social interaction) and 5 (resilience and quality of life).



2.3. Nordic Welfare Centre standards for deafblind people (2015–2019)

- recommendations for working with people with dual sensory impairments,
- including requirements for assessment of communication, mobility, social participation and psychological state.

Justification: our five components cover all domains required by these standards.

3. Recommendations and protocols for the rehabilitation of military personnel and individuals with combat injuries



3.1. NATO Centre of Excellence for Military Medicine – Rehabilitation Guidelines (2018–2022)

- Systematic assessment
- Psychophysiological stability
- Autonomy and mobility
- Social adaptation of veterans
- Quality of life as the ultimate criterion

Justification: our tool is fully consistent with military rehabilitation models.



3.2. VA Polytrauma System of Care (US Department of Veterans Affairs)

Model for individuals with:

- explosive injuries,
- combined sensory impairments,
- cognitive impairments.

The main assessment parameters include:

- emotional functions,
- independence,
- communication,
- social participation,
- quality of life.

Justification: our system of indicators corresponds to this model almost completely.

4. Psychological and clinical models of adaptation after loss of function



4.1. Lindemann's model – major recovery after crisis

Describes the sequence of transition from shock → to adaptation → to constructive living.



4.2. Moos-Shaeffer model of post-traumatic adaptation

Includes:

- emotional state,
- coping strategies,
- social resources,
- confidence and motivation.



International concepts of grief & loss in sensory impairment (Kübler-Ross model + modern adaptations for sensory loss)

Justification: components 1–5 reflect all key psychological mechanisms of adaptation.

5. Summary of regulatory justification

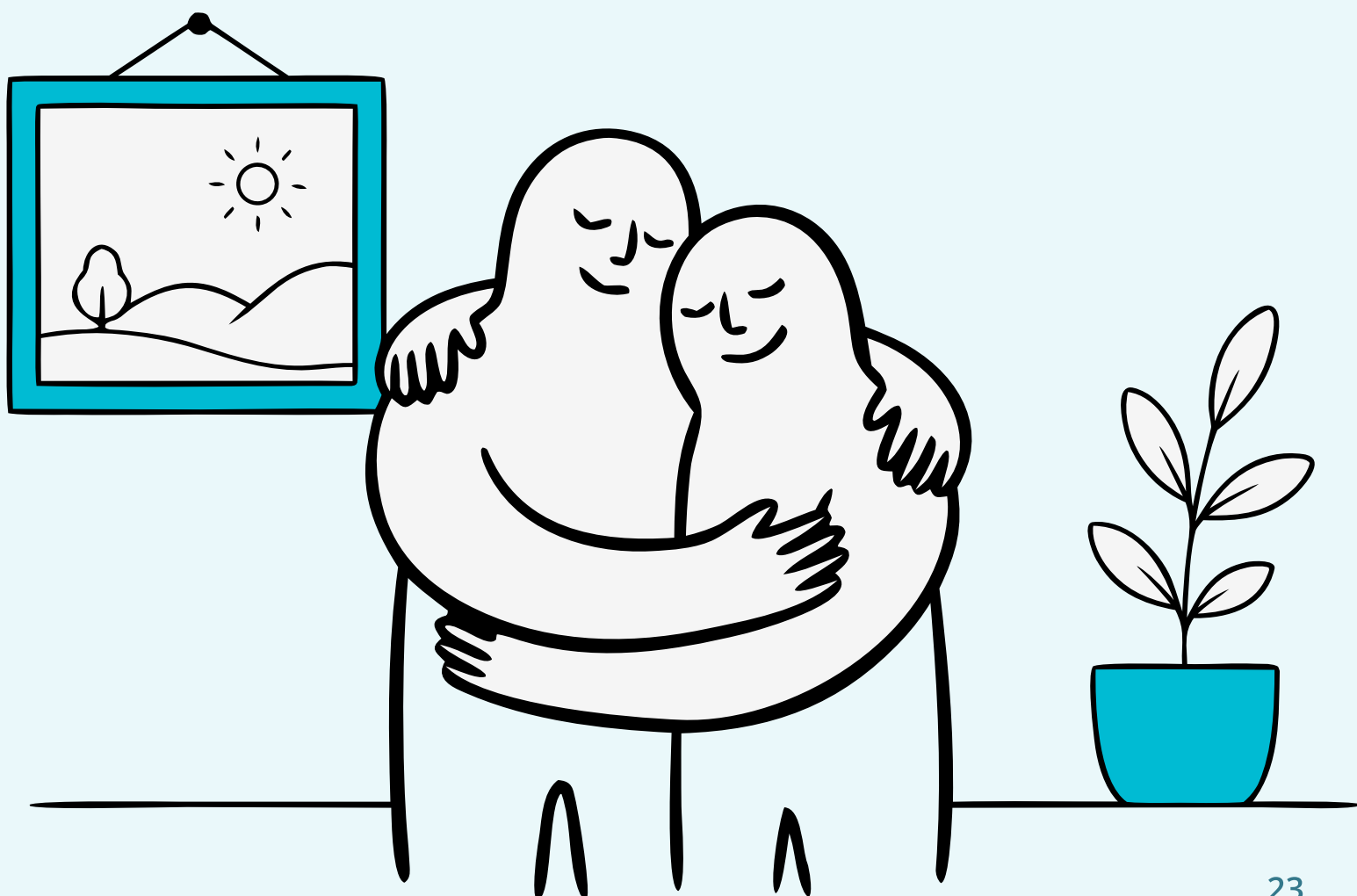
The proposed structure of indicators in the «Patient Rehabilitation Profile»

- is confirmed by WHO, ICF, and Rehabilitation 2030 standards,
- corresponds to European approaches to independence, participation, and integration,
- is fully consistent with recommendations for the rehabilitation of military personnel and individuals with sensory impairments,
- reflects psychological models of adaptation after loss of function,
- provides a universal, interdisciplinary and inter-stage assessment format,
- allows the formation of a dynamic profile of an individual's recovery, as required by modern international approaches.

Thus, the structure of the tool is methodologically sound, evidence-based, internationally valid and adapted to the Ukrainian context.

GUIDE FOR FAMILY MEMBERS

support at every step



Introductory remarks – a message to families

When someone close to you returns from war with severe trauma, the whole family's life changes. It is a journey full of challenges, often dominated by confusion, fear and feelings of helplessness. This is normal. You are not alone in your feelings.

This guide is designed specifically for you – wives, husbands, parents, children and loved ones of veterans who have suffered sensory trauma. It is your personal navigator in the complex world of rehabilitation. It is designed for family members of veterans with sensory combat injuries (loss of sight, hearing, combined injuries). It is based on the results of the online laboratory «Route of Opportunities» and international experience in the rehabilitation of veterans.

The path to recovery for someone close to you is a Roadmap consisting of stages. But you, as a family, have your own route – a route of support, patience, love and, most importantly, a Route of Opportunities. Opportunities to understand, help, find new ways to be together and find your own footholds.

The purpose of this guide is to provide practical recommendations and resources to help you:

- Understand what happens at each stage of rehabilitation
- Know how to support your loved one without harming yourself
- Get help when you need it
- Take care of your own well-being

Important!

You are not a therapist or a medical professional. Your role is to be a supportive partner who understands the process and knows when to seek professional help.

Terminology

This guide uses the term «person in rehabilitation» to refer to a person undergoing rehabilitation following sensory combat trauma (loss of sight, hearing, or a combination thereof).

• Why «person in rehabilitation»?

It emphasises the active role of the person in their own recovery.

- It is not «patient» (passive recipient of services) or «client» (consumer).
- It recognises subjectivity – the ability of a person to make choices, set goals, and influence their own development.

Here you will find practical advice: what to do (and what not to do) at each stage, how to respond to crises, where to go for help, and how to take care of yourself. Because in order to be a reliable support for others, you need to stand firmly on your own two feet.

**Remember! You are not observers, you are key participants in this journey.
Welcome to your «Route of Opportunities!»**

CHAPTER 1.

What happens inside: the invisible side of sensory trauma

Sensory combat trauma is not just about «they cannot see» or «they cannot hear». It is about the familiar way of being in the world being destroyed in an instant.

To understand the behaviour of someone close to you – aggression, withdrawal, silence, tears – it is important to know what is happening inside them after the loss of sight, hearing or both (often accompanied by amputations, pain and chronic fatigue). This chapter is about the invisible side of trauma.

1.1. Loss of basic security: «The world has become hostile»

Before the trauma, a person relied on their senses without even thinking about it. The eyes, ears and body constantly sent signals: «Everything is under control» or «There is danger».

After sensory trauma:

- **The world becomes unpredictable.** A hole, a kerb, unfamiliar stairs, a voice behind you that you cannot see or hear.
- **The body is constantly waiting for a blow.** It could be a fall, a collision, a sharp sound, a touch from behind.

Therefore:

- A person is afraid to leave the room, clings to the walls or your hand.
- They flinch at touch if you approach quietly.
- They become tense, irritable, distrustful.

This is not a «bad temper». It is the brain trying to survive in a new reality where basic safety has disappeared.

1.2. Sensory deprivation: the brain in «silence» and «darkness»

The brain is accustomed to receiving millions of signals every second. When sight or hearing vanishes abruptly, sensory deprivation sets in.

What can happen:

- **Overload of remaining senses.** For a person with vision loss, hearing and touch begin to work «at full capacity». Ordinary sounds become too loud, touches too sharp or jarring.
- **Phantom sensations.** Flashes of light, figures in the darkness, «voices» or noises that are not there may appear. This is the brain's reaction to a lack of incoming information.
- **Rapid fatigue.** A simple task – like walking from the room to the kitchen – requires tremendous concentration, and afterwards the person may be exhausted.

What it looks like:

- The person tires quickly of sounds, voices, conversations or asks to turn off the TV or music.
- They become silent and retreat to their room.
- They have trouble sleeping: it is difficult to fall asleep, and they may wake up during the night.

This is not «laziness» or «unwillingness to communicate» It is the brain working at its absolute limit, adapting to a new reality.

1.3. Loss of subjectivity: «I am now a burden, not a person»

Especially for a military professional who is used to defending, commanding and making decisions, the most painful realization is the feeling of becoming:

- «An object of care»
- «A problem»
- «A burden on the family»

When everything is decided, done and controlled for a person, they get the feeling that:

- «I am no longer in control of my life».
- «Others decide where to take me and what to do with me».
- «Without you, I am nobody».

The result:

- Aggressive refusal of help. «Don't touch me! I can do it myself!» – even if they cannot cope on their own.
- Or, conversely, complete apathy. «Do what you want, I don't care».

Neither of these is about being «grateful/ungrateful». It is a painful struggle for dignity and the right to remain a human being, rather than an object of care.

1.4. Social isolation in a crowd: «I am among people, but it's like being behind glass».

This is especially difficult for people with hearing loss (complete or partial).

Imagine the situation:

- Everyone is laughing, talking, and joking.
- You can see their lips moving and their facial expressions, but you cannot understand their words.

You constantly have to:

- ask them to repeat themselves;
- guess from the context;
- pretend that you understand everything.

How does a person feel:

- **Embarrassment.** «I'm in the way, I'm annoying everyone with my "what?"»

- **Suspicion.** «Are they talking about me, laughing at me?»
- **Exhaustion.** Listening with your «eyes» (reading lips, catching gestures) is very energy-consuming.

Result:

- The person begins to avoid company, celebrations, even family gatherings.
- They choose to sit in another room, «because it's easier that way».

From the outside, this may look like «distancing themselves from the family» or «indifference». In reality, it is often an attempt to protect themselves from the constant painful reminder of loss.

1.5. Anger at one's own body: «My body has betrayed me»

When the body was an instrument of strength (running, jumping, weapons, body armour), and now:

- it does not obey;
- it hurts;
- «holds me back» (prosthetics, phantom pain, limitations),

a person may experience intense anger towards their own body.

This manifests itself as:

- Refusal to maintain hygiene, exercise or seek treatment: «I'm not going to do anything».
- Self-destructive behaviour: alcohol, risky actions.
- Insulting statements about oneself: «I'm a cripple», «Nobody needs me».

It is vital to understand: this is not a request for you to agree with these self-assessments. It is an attempt to somehow express the pain and shame of a body no longer matching the internal image of the self.

1.6. Grieving for the «former life»

Sensory trauma is not only about «an injury to the body». It is also about the loss of a former life:

- profession;
- hobbies;
- usual way of communicating with loved ones;
- roles (protector, breadwinner, commander, specialist).

Psychologically, it is similar to the grieving process:

1. Shock and denial: «This is temporary», «I will regain my sight/hearing, medicine can do anything».
2. Anger: At oneself, at doctors, at the state, at the command, at God.
3. Bargaining: «I'll try if...», «If I get through rehabilitation, everything will be as it was before».
4. Despair, depression: «Nothing will ever be the same», «I am ruined».
5. Gradual acceptance: «Life will be different. Not the same, but it can still be life».

These stages may come in waves rather than in a straight line.

1.7. Why is this important for families to know?

When you understand this invisible side, it becomes easier to:

- blame yourself less («I'm doing something wrong»);
- blame the recovering person less («He's become lazy/bitter»);
- recognize the fear, pain and loss that lie behind the shouting, silence or refusal to cooperate.

This does not mean you must tolerate any behaviour. But it helps to respond not out of resentment, but out of understanding.

The rest of this Guide will discuss:

- how to support a person at different stages of rehabilitation;
- how to notice regression and what to do about it;
- how not to «lose yourself» and burn out in the process.

This first chapter is about making sure you are not «in the dark» in this journey. You have the right to know what is really going on inside your loved one.



CHAPTER 2.

Recommendations for families at each stage of the Rehabilitation Route

Stage 1: Medical and initial psychological phase

What happens to the rehabilitee:

shock, disorientation, fear, feeling of loss of control. The rehabilitee may be emotionally unstable, withdrawn or, conversely, anxious and agitated. They are not yet aware of the scale of the changes in their life.

Key task for the family:

Be there for them, create a sense of security, do not pressure them.

Recommendations:

What to do?	What to avoid?
Simply be present – physically and emotionally	Do not demand to «keep it together» or «be strong»
Announce your presence with your voice or a touch (if appropriate)	Do not do for the rehabilitee what they can do for themselves
Allow time for silence, do not fill in the pauses	Do not discuss their condition in front of them as if they were not in the room.
Ask: «What can I do for you right now?»	Do not make decisions on behalf of the rehabilitee without their involvement.
Keep a diary of events and contacts (the rehabilitee may not remember)	Do not hide medical information «to avoid upsetting them»
Take care of yourself: eat, sleep, ask for help	Do not ignore your own feelings and needs

Signs to watch out for (possible regression or crisis):

- Complete refusal to communicate for more than 2–3 days
- Pronounced aggression or increasing apathy
- Expressions of hopelessness, a lack of desire to live

Stage 2: Comprehensive rehabilitation/habilitation

What happens to the rehabilitee:

They begin to master basic skills: orientation, self-care, use of assistive devices. May experience fear of movement, shame, disappointment with slow progress.

Key task for the family:

Support independence rather than doing things for the rehabilitee.

Recommendations:

What to do?	What to avoid?
Encourage attempts, even unsuccessful ones: «You tried – that's already a step forward»	Do not grab their hand or «rescue» them at the slightest pause.
Ask: «What is the most comfortable way for you?», «Where do you need help?»	Do not say: «Let me do it myself, it'll be quicker»
Adapt the home environment together with the person	Do not move things without warning
Learn new skills together with the person (e.g., how to describe space)	Do not show excessive pity or exaggerated admiration for simple actions.
Celebrate small victories	Do not compare the current situation with «how it used to be»
Support participation in rehabilitation classes	Do not skip sessions «because you're in a bad mood today»

Signs of regression:

- Refusal to leave the room/apartment
- Return to complete dependence on assistance in activities that had already been mastered
- Statements such as, «What's the point? I won't be able to do it anyway.»

Stage 3: Educational and professional rehabilitation

What happens to the rehabilitee:

they seek answers to the questions «Who am I now?» and «What can I do?» They may experience an identity crisis, fear of the future and uncertainty about their value.

Key task for the family:

Support the search for new meaning without imposing their own vision.

Recommendations:

What to do?	What to avoid?
Show genuine interest in their plans, dreams, ideas – without judging	Do not say: «That won't work for you» or «That's unrealistic»
Assist in searching for information about education, courses and job vacancies	Do not decide for them what career path they should take
Keep in touch with former colleagues and friends	Do not isolate from society «until they recover»
Discuss a person's strengths and previous experience	Do not focus solely on limitations
Being prepared for changes in plans is normal.	Do not pressure them: «You said you wanted to...»

Що робити?	Чого уникати?
Provide financial support without creating total dependence	Do not turn them into a «dependent»

Signs of regression:

- Complete refusal to discuss the future
- Loss of interest in things that were previously enjoyable
- Statements such as: «Nobody needs me», «I'm a burden»

Stage 4: Social integration and participation in community life

What happens to the rehabilitated person:

they enter a wider society: community, new acquaintances and potentially employment. They face social stigma, the awkwardness of other people and environmental barriers.

Key task for the family:

To be a «bridge» to the community, but not a mediator in every interaction.

Recommendations::

What should I do?	What to avoid?
Encourage participation in social events, groups, meetings	Do not decline invitations «on the person's behalf »
Help build up contacts, but do not «take over» the communication entirely	Do not answer questions addressed to a person
Plan outings together: discuss the route, needs, expectations	Do not avoid public places because of «embarrassment»
Discuss experiences after social situations: what went well, what was difficult	Do not stay silent about incidents – discussing them reduces anxiety
Support participation in veterans' mutual aid groups	Do not say: «Why do you need these meetings? You have me.»
Work on your own attitude towards disability	Do not project shame or a desire to «hide» the situation

Signs of regression:

- Refusal to leave the house, avoidance of people
- Conflicts with loved ones, irritability after contact
- Return to isolation after a period of activity

Stage 5: Long-term support and prevention of regression

What happens to the rehabilitee:

they have achieved a certain level of stability but need support to maintain it. Crises may arise due to life events, health or fatigue.

Key task for the family:

Be attentive to signals, maintain routine, do not «close the case» on their recovery.

Recommendations:

What to do?	What to avoid?
Maintain regularity of support contacts (doctor, psychologist, group)	Do not assume that «everything is fine now, so you can relax»
Know the individual triggers of regression for this person	Do not ignore early signs of deterioration
Have a plan of action in case of a crisis (who to contact, what to do)	Do not panic at the first signs of trouble
Discuss changes in mood, energy, behaviour	Do not make the topic taboo: «Let's not talk about anything negative»
Maintain a healthy lifestyle: sleep, exercise, nutrition	Do not create «greenhouse» conditions that stifle activity
Take care of your own resources – your family gets tired too	Do not sacrifice yourself completely; this is a path to burnout.

Signs of regression:

- Sleep or appetite disturbances lasting more than 2 weeks
- Refusal to engage in activities that were previously enjoyable
- Return of symptoms that had already been overcome

Stage 6: Development and self-realisation

What happens to the rehabilitee:

they go beyond mere «adaptation» to active participation: volunteering, mentoring, community involvement, professional fulfilment. The experience of trauma is reinterpreted as a resource.

Key task for the family:

Support ambitions, respect autonomy, be partners.

Recommendations:

What to do?	What to avoid?
Celebrate achievements, openly share pride	Do not downplay success: «Well, it's not like it's a real job»
Support civic activity, even if it «takes time away from the family»	Do not compete for attention
Accept their new identity (activist, mentor, expert)	Do not hold on to the image of the «sick/injured» person
Discuss workload balance to prevent burnout	Do not issue ultimatums: «It's either me or your work»
Be prepared for a person to dedicate time to helping others	Do not be jealous of new contacts and roles

Що робити?	Чого уникати?
Reevaluate your own role: from guardian to partner	Do not keep a person in dependence

Signs of regression:

- Signs of burnout: exhaustion, cynicism, loss of meaning
- Neglecting health for the sake of work
- Conflicts in the family due to «excessive busyness»

General principles for families at all stages



The person undergoing rehabilitation is not an object of care, but the subject of their own life. Even if they need help, the decisions must remain theirs



Regression is not failure. Temporary setbacks are a normal part of the process. It is important not to panic, but to respond.



The family also needs support. Family groups, psychological counselling, and time for oneself are not luxuries, but necessities.



Know your resources. Keep contacts handy: crisis hotline, psychologist, rehabilitation centre, support group.



Communication is key. Talk about what is happening. Silence creates distance.

CHAPTER 3.

How to respond to regression? What is regression and why does it occur?

Regression is a temporary deterioration in the condition of a person undergoing rehabilitation: the return of symptoms that had already been overcome, loss of acquired skills, emotional setback.

It is important to understand that regression is a normal part of the rehabilitation process, not a failure.

Typical triggers of regression:

- Physical illness, pain, fatigue
- Stressful life events (conflicts, losses, financial difficulties)
- Anniversaries of traumatic events, holidays
- Bureaucratic delays (documents, payments, queues)
- Change of environment or team of specialists
- Break in the rehabilitation process
- Failures in education or professional life
- News about the war, loss of comrades

First steps when identifying regression

Step 1: Stay calm

What to do	What to avoid
Take a deep breath. Your calmness is an anchor for the rehabilitee.	Do not panic or overreact.
Remind yourself: this is temporary, it has been overcome before.	Do not blame yourself or the rehabilitation specialist
Focus on the present moment rather than fears about the future.	Do not say: «Here we go again» or «So much effort – and all for nothing»

Step 2: Observe and note

What to keep an eye on?	How do you do that?
What exactly has changed? (sleep, appetite, mood, activity, skills)	Make short notes in a diary or in your phone
When did it start? (after what event, date)	Try to identify a possible trigger
How severe is it? (mild deterioration or sharp decline)	Compare with previous episodes, if any
How long does it last?	Record your progress day by day

These records will be useful when consulting a specialist.

Step 3: Ensure basic safety

Priority	Actions
Physical safety	Ensure that the person undergoing rehabilitation is not a threat to themselves. If they make suicidal statements, immediately contact the crisis hotline.
Basic needs	Gently maintain a routine: sleep, food, hygiene. Do not demand, but suggest.
Reduce stimuli	If the rehabilitee is overloaded, temporarily reduce the number of contacts, events, and demands.

Step 4: Make contact

What to say	What to avoid
«I can see that you are having a difficult time right now. I am here for you»	«What's wrong with you again?»
«You don't have to explain. Just know that I'm here»	«Pull yourself together»
«This is a difficult period, but we will get through it. It has happened before, and you coped»	«Think about others, they have it even worse »
«What can I do for you now?»	«You have to be strong»
«We can just sit in silence together, if you want»	«After everything we've done for you...»
«I love you. That hasn't changed»	«You've ruined everything again»

Step 5: Don't do it for them, but be there for them

Situation	What to do
The rehabilitee refuses to perform activities that he has already mastered	Do not insist forcefully. Suggest doing it together or reducing the amount.
The rehabilitee displays aggression or irritability	Do not engage in conflict. Give them space. Return to the conversation later.
The rehabilitee is isolating themselves	Remain available, but do not intrude. Briefly announce your presence.
The rehabilitee expresses hopelessness	Listen without arguing. Don't try to convince them that «everything will be fine» Just be there for them.

Step 6: Seek help

When a specialist is mandatory:

Immediately (crisis hotline)	As soon as possible (psychologist/doctor)
Statements about not wanting to live, suicidal thoughts	The regression has been going on for more than two weeks without improvement.
Self-harm or threat of self-harm	Complete refusal to perform basic activities (eating, hygiene)

Негайно (кризова лінія)	Найближчим часом (психолог/лікар)
Severe aggression towards oneself or others	Return of symptoms that had been stabilised (panic, flashbacks)
Psychotic symptoms (hallucinations, delusions)	Significant deterioration in functionality

Emergency contacts:

Lifeline Ukraine:

☎ 7333 ⌚ 24/7

Ukrainian Veterans Foundation Hotline:

☎ 0 800 33 20 29 ⌚ 24/7

Emergency Psychological Assistance:

☎ 103

Quick reference: 5 steps in regression

Step	Action
1	Calm down. Your calmness is a source of strength for the rehabilitee.
2	Observe. What has changed? When? How much?
3	Be present. Do not «fix» things – just be there.
4	Seek help. If necessary, consult a specialist.
5	Take care of yourself. You need resources too.

Phrases that can help

«I can see that things are hard right now. I'm not going anywhere»

«You don't have to be strong around me»

«This will pass. We've been through this before.»

«I love you not for your achievements, but simply for who you are»

«Let's just be together. We don't have to do anything»

«You're not a burden. You're my family»

CHAPTER 4.

Time as an ally: how not to lose faith on a long journey

Rehabilitation after sensory combat trauma is not a sprint; it's a marathon. It rarely lasts weeks, more often months and years, with progress coming in waves rather than a straight line. This is exhausting for both the rehabilitee and their family, especially when expectations («soon everything will be as it was before») clash with reality.

To make this journey easier, it is important to «befriend time» – to change the way you look at the duration of recovery and stop perceiving slowness as failure.

**Time is not your enemy,
but your ally.**

Slow progress is still progress. Every day you spend together is a step forward, even if it is not visible at first glance.



Metaphor 1. «Healing an invisible wound»

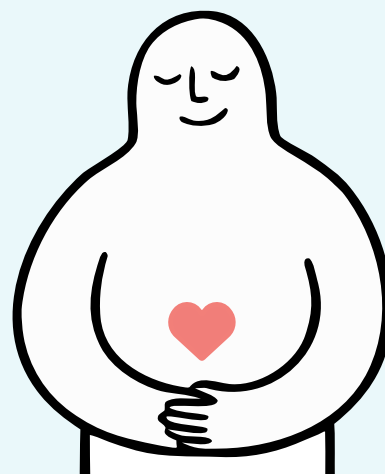
When a person breaks their leg, everyone understands that it takes weeks for the bone to heal and then months to regain muscle strength. No one expects them to run a marathon a week after the cast is removed.

Losing your sight or hearing is a «break» in the way you perceive the world. The brain has to physically rebuild its connections to learn to live in a new reality. This is called **neuroplasticity**: the nervous system changes its structure and functions in response to new experiences, training, and sensory stimulation. This process cannot be accelerated by willpower, just as you cannot force a bone to heal overnight.

Your patience is not a weakness, but a strength.
The ability to wait, support, and believe when the results are not visible is true courage.

How this helps the family:

- It reduces feelings of «guilt» (as if someone is not trying hard enough).
- It shifts the focus from «timing» to «quality of steps».



Metaphor 2. «Learning a new language»

Adapting to sensory loss is like moving to a country with a completely new language. At first, a person learns to survive: to understand basic signals, to find the «exit» and «entrance». Then individual «words» appear – the first skills. Only with time does «fluency» come – when you can joke, plan, work.

The same is true here: at first, the rehabilitee learns basic things (how to get to the bathroom, recognise a voice), and this takes months. What seems like a «small thing» from the outside is an enormous task for the brain.

Practical advice for families:

- Praise them for their «first words» (small steps) rather than expecting «novels» (complete independence) right away.
- Compare the patient with themselves «yesterday», not to who they were «before the injury».

Metaphor 3. «Seasons of recovery»

Rehabilitation can be imagined as a change of seasons.



Winter (acute period): the main thing is to preserve life and minimal stability. There is a lot of darkness and little strength. This is not a time for «achievements»; it is a time for survival.



Spring (beginning of rehabilitation): mud, puddles, instability. There are the first shoots – individual skills, attempts, hope. It is very important not to trample them with impatience.



Summer (active phase): the pace of growth is higher, there is more confidence, the scope of action expands. But this is also a period of heavy workload, and fatigue is normal.



Autumn (integration): harvesting the «crop» – consolidating skills, transitioning to new roles, work, study. At the same time, it is preparation for new cycles – there will be new «winters» and new «springs».

Why it matters:

- You can't jump straight into «summer» if you're still in «winter».
- If it's «winter» now, the family's job is not to demand «blooming», but to provide warmth and protection.

Approximate time frame (very approximate)

Each case is unique, and it is impossible to predict exact dates. But it is useful to have at least approximate guidelines:

Adaptation stage	Approximate duration
Acute adaptation (shock, primary acceptance)	from a few weeks to 3–6 months
Learning basic self-sufficiency skills	several months of intensive rehabilitation
Social and psychological adaptation to the new reality	from a few months to 1–2 years and longer

Important: These are not «norms», but rather guidelines that show that what you are experiencing is normal.

What to do when it seems that «nothing is changing»

1. Change the scale of comparison

Instead of: «A year has passed, and we still don't live as we used to»

Try: «A month ago, they didn't leave their room at all. Today, they walked to the kitchen by themselves and made tea»

The brain tends to devalue small things and notice only the «big» ones. **A diary of small changes** (1-2 lines per day) helps you literally «see» progress.

Accept periods of plateau

Periods when «nothing seems to be happening» often mean that the brain is integrating what has already been learned. It's like after an intense workout: muscles grow not when you lift weights, but when you rest.

Important: plateau ≠ regression. The family's task is not to be afraid of «stagnation» but to carefully maintain the routine.

Distinguish regression from fatigue

- If the rehabilitee temporarily «cannot handle» the session after a period of activity, but recovers in a few days, it is fatigue.
- If stable skills are lost, the signals described in the previous sections appear, and this continues for weeks, it is regression, and it is worth talking to a specialist.

How to talk about this with a rehabilitee

Helpful phrases:

«We don't have to be fast. We have to be alive»

«You are doing what you can in these circumstances. That's already a lot»

«We will not look at how things were “before”, but at how they are becoming “better than yesterday”»

«We are learning a new life. It is not a failure of the old, it is a different life»

How to reduce the pressure of expectations in the family

1. **Set a realistic timeline.** Not «everything will be sorted out in a month», but «it will take months and years, but every step counts»
2. **Agree on a «small steps rule» within the family.**
For example: «We don't measure how far we are from the finish line; we measure how many small steps we took this week.»
3. **Normalise repetition.** The fact that the rehabilitee is learning the same thing «again» is not a failure, but reinforcement.
4. **Regularly remind yourself:** «Slow does not mean “useless”. Slow means “real”»

You are growing a life.

You are not restoring the old,
but creating something new.
And that takes time.



Practical tool: «Rule of LPP»

When it seems that everything is at a standstill, use this simple algorithm:

Step	Action
L – Look back	Do not compare yourself to an ideal version, but to yourself a month ago. «A month ago, I couldn't walk to the kitchen. Today, I made tea. That's progress»
P – Plan for today	Focus on just one small step. «Today, learn how to fasten a button. That's it. I'll think about tomorrow»
P – Pause	Permission to stop. «I'm tired. I have the right to do nothing for two days. This is not regression, it's a pit stop»

Life situations: practising the right response

Theory is useful, but emotions often take over in real life. Here are 6 typical situations that may happen (or have already happened) and options for turning them from conflict into a step towards recovery.

Case 1. «It's all useless» (Despair due to failure)

What happened: A rehabilitation patient (for example, with vision loss) has been learning to pour tea for three weeks, but today he spilled boiling water again. He throws the cup and shouts: «I'm useless! I'll never be able to live normally! All this rehabilitation is useless!»



Wrong reaction

(attempt to «speed up time»):

«Calm down, it's nothing serious»
(Devaluation of emotions).

«Let me pour it myself, you're just tired»
(Return to dependence, confirmation of helplessness).

«You have to try harder!»
(Pressure).



Correct reaction

(Alliance with time):

Action: Calmly clean up the mess (wipe up the water) without drawing attention to it. Let the emotions out.

Words: «You're angry right now, and that's okay. It's frustrating when things don't work out. But remember: a month ago, you didn't even pick up the kettle. Today you spilled water, but you picked up the kettle yourself. That's progress, it's just a bad day today. We'll try again tomorrow when you're ready»

Why it works: You validate the emotion (anger), but refocus on the «big picture» (progress over a month, not a minute).

Case 2. «Plateau effect» (The Lull)

What happened: The wife notices that her husband has been attending orientation classes for a month, but he still sits in his room at home and does not go outside on his own. It seems that rehabilitation has stalled.



Wrong reaction

(Impatience):

«So what did you learn there? Why are we still sitting at home?»

«Come on, go to the shop, you need to practise!»



Correct reaction

(Understanding «winter/spring»):

Action: Understand that this «plateau» is a build-up of strength. Suggest a small, safe action.

Words: «I see that you are putting a lot of effort into your classes right now. Perhaps it is still

difficult to apply this here, in our neighbourhood. How about we just go out to the entrance together on Sunday and stand there for 5 minutes? Just to the entrance. You can tell me what sounds you recognize»

Why it works: You are not pushing them into «summer» (activity), but offering a «spring» step – a small, safe experiment without pressure.

Case 3. «Seesaw» (One step forward, two steps back)

What happened: Last week, my son (a veteran with hearing loss and concussion) was active, joking and playing with the children. This week, he is lying face to the wall, hardly eating and refusing to talk.



Wrong reaction

(Fear of wasting time):

«Here we go again! We've only just started living normally!»

«Get up right now, you can't mope around like that!»



Right reaction

(Accepting cyclicity):

Action: Don't panic. Check basic needs (if nothing hurts). Give them peace and quiet for an agreed period of time.

Words: «It looks like your battery is running low. That's normal after an active week. Rest. I'll be nearby in the next room. If you want to eat, give me a signal. We'll give you two days of complete "silence mode", and on Wednesday we'll try to have coffee together»

Why it works: You name the condition (fatigue, not disaster), give permission for a break (legalize it), but set a gentle «beacon» for the future (Wednesday) so that the break does not turn into isolation.

Case 4. «Double barrier» (Loss of vision + Arm amputation)

What happened: A veteran tries to fasten his jacket or cut food with one hand, unable to see what he is doing. He fails, throws things down, and cries out in frustration: «I'm crippled! I can't even put on my trousers!»

**Wrong reaction**

(Pity):

Silently rush to do it for him.

«Oh, poor thing, let me do it quickly, don't worry»

*«Don't say that, you're a hero!»
(In a moment of helplessness, this sounds like mockery).*

**Correct reaction**

(Partnership and patience):

Action: Do not grab things from his hands. Wait until the first flash of anger passes. Offer an adaptive method.

Words: *«It's really damn hard. You have to learn to do it not only blindly, but also with one hand. It's double the work. Let's try again, but we'll use the button hook. I'm here, I'm in no rush. We have all the time in the world»*

Why it works: You acknowledge the objective difficulty (not «you're weak», but «the task is extremely difficult»). You offer a tool, not pity.

Case 5. «Fear of the invisible» (Loss of vision + Partial hearing + Amputation)

What happened: It's time for a doctor's appointment. The veteran refuses to leave and becomes aggressive. His main fear is vulnerability: «I can't hear anything on that side, I can't see potholes, and I won't even be able to put my hands out if I fall»

**Wrong reaction**

(Disregarding fear):

But I'll be right there, what are you afraid of?»

«Don't be silly, the road is flat»

**Correct reaction**

(Creating safety):

Action: Physically demonstrate the reliability of contact. Agree on a system of signals.

Words: (Clearly, towards the healthy ear)
«I understand your fear. It's scary not to be in control of your surroundings. Let's agree: you hold my shoulder with your healthy arm. I will be your eyes and your balance. We will walk very slowly. If you want to stop or turn back, we will do so immediately. We are not going for a walk, we are going to practise our interaction.»

Why it works: You do not deny the danger. You offer a clear safety algorithm and restore a sense of control.

Case 6. «Cargo in the dark» (Loss of vision + Amputation of legs)

What happened: The veteran is lying in bed. You want to take him outside, pick up the chair and start transferring him without warning. He resists and shouts: «Don't touch me! I don't want to be a bag of potatoes!»



Wrong reaction (Overprotection and ignoring his will):

«Don't make it up, you need to go to the sun»

Silently, forcefully transferring him while thinking: «I know» better.



Correct reaction
(Return control):

Action: Stop. Sit next to each other. Do not move him without a command.

Words: *«I'm sorry I started this without your permission. I understand that it is a terrible feeling – when you are being moved around in the dark. Let's make an agreement like this: you are the captain, I am the engine. I won't budge until you say "go". I will describe each threshold. You are not a cargo. You decide where we go. If you want to stay, that's your right»*

Why it works: You return subjectivity («You control»). The promise to describe actions removes the fear of the unknown.

«The main secret of all these scenarios is simple: we fight not against a loved one, but alongside them – against their fear and powerlessness».

CHAPTER 5.

A little guide to key words (Simple explanations for complex things)

In this guide (and in the doctors' offices) you can hear words that sound incomprehensible or frightening. We translated them from «scientific» into plain human language.

On the state and processes

Habilitation – Learning completely new skills that a person did not have before.

Example: If rehabilitation is restoring the ability to walk, then habilitation – is to learn to read with your fingers (braille) or focus on your hearing. This is not «fixing the old», but creating a new one.

Deprivation – A state of deprivation of something vital.

In simple words: When the brain lacks something as much as the body lacks food.

Cognitive functions – The brain's ability to work: remembering, being attentive, planning actions, making decisions. Why it is important: After an injury, a person can become forgetful or distracted. This is not a «bad character», it is a temporary disruption of cognitive functions.

Neuroplasticity is the superpower of our brain to change. When one area is damaged (for example, vision), the brain makes new «routes» and learns to use other senses (hearing, touch) much better. This is what gives us hope.

Plateau – A quiet period . A time when it seems that there is no progress and everything has stopped. In fact: This is the time when the brain «tampes» new knowledge. This is not a stop, this is a consolidation of the result before a new rush.

Sensory trauma – Damage to the senses – vision or hearing. It's an injury to the channels through which we perceive the world.

Sensory hunger (sensory deprivation) – A situation where the brain stops receiving the usual signals from the eyes or ears. Why it is important to know: When there is «silence» or «darkness», the brain can start panicking or inventing signals (noises, flashes) to fill the void. This is not madness, it is the brain trying to «feed» itself with information.

Trigger – anything (sound, smell, word, situation) that instantly causes a strong emotional surge, fear or memory of trauma. Example: The sound of a firecracker can be a trigger that instantly returns to a state of combat stress.

On Attitudes and Society

Validation

Recognition of a person's right to their feelings. Example: Instead of «Don't be sad, everything will be fine», we say «I see that you are sad, and it is normal in your situation». We do not try to «correct» the emotion, we give it the right to exist.

Inclusion

Creating conditions where the veteran feels like they belong, not «special» or «sick». This is when the world adapts to a person, and does not force him to overcome barriers.

Stigma

Offensive «label» or stereotype. When a person is seen first of all as their disability, not their personality. Our task: Fight the stigma, remembering that before us is primarily a Hero, a father, a specialist, and not just a «disabled person».

Subjectivity

Ability to be the «author» of one's life. In simple words: Rehabilitée – is not a suitcase that we carry home from the hospital. They are the captain of the ship. Even if they need the help of a team, they set the course themselves.

CHAPTER 6.

Useful literature and resources for families

Books about communication and understanding of a veteran

1. **«Love in the Line of Fire» (Frank Bury, Susan Johnson).**
What is it about?: How to keep an emotional connection in a couple when one of the partners has experienced a traumatic war experience. Practical advice to restore trust and intimacy.
2. **«The body keeps the score» (Bessel van der Kolk).**
What is it about?: A world bestseller on how trauma affects the body and brain, and how to live with it. Helps to understand the physiological causes of changes in the behavior of a loved one.
3. **«How are you, beloved?» (Free Guide from Veteran Hub).**
What is it about?: Simple answers to difficult questions: how to speak, how to be silent, how to have sex, how to quarrel and reconcile after returning from the war. Where to find: On the website veteranhub.com.ua
4. **«Trauma and Recovery: The Aftermath of Violence – from Domestic Abuse to Political Terror» (Judith Herman).**
What is it about?: A classic book about the stages of recovery after traumatic events. Helps to understand what is happening to the psyche of your loved one.

Practical guides and brochures

1. **«Interaction without barriers» (Handbook).**
What it is about: Specialized guide on the ethics of communication and accompaniment of people with sensory impairments (particularly people with loss of vision). Where to find: On the site «Barrier-free directory» (bf.in.ua).
2. **«We survived: recovery techniques for families»**
What it is about: A collection of practical exercises for self-regulation, stress relief and resource recovery for the whole family.
3. **«How are you bro? /How are you, sunshine?» (Psychological Support Project)**
What it is about: A series of illustrated guides on how to talk to military personnel and how to support yourself. Very simple and accessible language. Where to find: yakty.com.ua

Online courses and platforms

1. **«Poruch» (Online platform)** What it is: Psychological support groups, lectures and webinars for military families. Website: poruch.me
2. **«Brain and War» (Video Lectures on YouTube)**
What it is: Short videos from neuroscientists and psychologists on how war changes the brain and how to return it to «peaceful regime».

3. Application «Baza» (Mobile application)

What it is: A tool for psychological self-help for veterans and loved ones. Contains exercises for reassurance, a crisis aid button, contacts of specialists. Download: App Store /Google Play.

Books for children about war and trauma

1. «My dad became a star» (Halyna Kyrpa) – to talk about loss (if relevant) or change.
2. «The war that changed Rondo» (Romana Romanyshyn, Andrii Lesiv) – on how trauma changes, but does not break.

CHAPTER 7.

List of support sources

Crisis support hotlines (24/7 or in extended mode)

Name of the organization	Phone number	Work schedule	Services
Ukrainian Veterans Foundation Hotline	0 800 33 20 29	24/7	Psychological Crisis Support, Legal Consultations Mon–Fri 9:00 AM – 6:00 PM
Single Veterans Line (Ministry of Veterans Affairs)	0 800 505 217	Daily 8:00 AM – 8:00 PM	Comprehensive support for veterans and their families
Government Hotline (Veterans' Issues)	1545 (press 9)	Working hours	Information on Benefits, Services, and Documents
Lifeline Ukraine (Suicide Prevention)	7333	24/7	Crisis support for suicidal ideation and emotional crises
National Psychological Association (NPA)	0 800 100 102	Daily 10:00 AM – 8:00 PM	Psychological assistance for war victims

Support lines specifically for families

Name	Phone number	Work schedule	Services	Format
Veteran Hub – Family & Relatives Support Line	+38 (067) 348 28 68	Daily 9:00 AM – 9:00 PM	Psychological, Legal, and Social Support for Veteran Families	Phone Support and Individual Sessions
Psychosocial Support Service for Families (NGO «Woman Force»)	0 800 332 720 Telegram: @pidtrymka	Daily 10:00 AM – 8:00 PM	Support groups for wives and mothers, individual consultations	Online and offline
Ministry of Veterans Affairs – Psychological Support	063 230 23 25	Working hours	Coordination of free psychological assistance for families	Counseling

Support groups for families (online and offline, you can join through the website)

Organization	Format	Contact/Links	For
Ukrainian Veterans Foundation (UVF)	Weekly support groups (online Zoom sessions)	veteranfund.com.ua/projects/hot_line/hrupy-pidtrymky	Veterans and their families

Veteran Hub	Support groups	veteranhub.com.ua/services/bezoplatni-grupy-pidtrymky	Families of the deceased, wounded, and captives
«Varto Zhyty» (Worth Living)	Support groups	vartozhyty.com.ua/projects/grupy-pidtrymky	Military personnel and their families
«Blakytyni Ptakh» (Blue Bird)	Support groups	hostage.org.ua	Families of prisoners of war and missing persons
«Sociotherapy» Crisis Center	Group psycho-, art-, and film therapy	sociotherapy.org.ua	Veterans and families

Individual psychological assistance for families

Organization	Phone number	Features	Session restrictions	For
CETA Program (Common Elements Treatment Approach)	066-147-43-17; 068-283-20-98	Individual therapy	Up to 12+ sessions	Veterans and families
BO Vesta	Viber/WhatsApp/ Telegram: 097-595-33-50	Family consultations	Up to 8 consultations (renewable every 3 months)	Up to 8 consultations (renewable every 3 months)
«Mindy» Foundation	050-136-97-73 / Web-based form	Individual sessions, group therapy, and prosthetics support	No limits, depends on the program	Veterans and families
YARMIZ Center (Veteran Health and Rehabilitation Center)	Facebook: yarmizkyiv / +38 (073) 891 14 50	Mental health counseling	Depends on the situation	Veterans and families
Register of Psychologists Ministry of Veterans Affairs	Ministry of Veterans Affairs Portal	Verified specialists, government-funded	Varies by program	Combat participants

Resources for families of people with vision loss

Organization	Contact	Services	Regions	Note
Ukrainian Society of the Blind (UTOS)	cputos.org.ua	Rehabilitation center, consultations, libraries for the blind, and support groups	Nationwide support network	Lead organization
Rehabilitation Center of the Ukrainian Society of the Blind	cputos.org.ua/orhanizatsiji-utos/reabilitatsijnyj-tsentr-utos	Activities of Daily Living (ADL) rehabilitation, orientation and mobility, Braille, and computer technologies.	By location	Free classes

Organization	Contact	Services	Regions	Note
Kyiv City Organization of the UTOS	kmoutos.org.ua	Local support chapters, cultural events, and advocacy.	Kyiv and Kyiv Region	Local contacts

Resources for families of people with hearing loss

Services	Contact	Coverage	For	Cost
Free hearing aids for veterans	mva.gov.ua nssu.gov.ua	43 Medical centers	Veterans without official disability status	Free
«Betterton» Hearing Rehabilitation Center	bettertone.com.ua Київ: (096) 634-48-48	Branches in several cities	Open to everyone in need	Paid (grant opportunities available)

Comprehensive support (legal, social, psychological)

Organization	Contact	Services	Format	Regions
Veteran Hub (Kyiv, Vinnytsia)	veteranhub.com.ua 067-348-28-68	Legal consultations, psychological support, career counseling, and home visits.	Online, in-person, and on-site	Kyiv, Vinnytsia and mobile offices
«Kyiv Military Hub»	0 800 300 633 Mon–Thu 9:00 AM – 5:30 PM, Fri 9:00AM – 4:00PM	Comprehensive support for combatants and families of the fallen	Telephone support and consultations	Kyiv and partner regions
«Space of Opportunities» Mobile Teams (Prostir Mozhlyvostei)	pm.in.ua	Mobile consultations (lawyer, psychologist, case manager)	Mobile and Online	Remote communities

Support for children and adolescents in veterans' families

Організація	Контакт	Послуги	Вік / Цільова аудиторія	Мови
«La Strada-Ukraine» NGO (National Child Hotline)	116 111 0 800 500 225	Psychological, legal, and information consultations for children	Children and adolescents	Ukrainian, Russian
«PORUCH» Project (By Your Side)	poruch.me/teenagers	Online support groups for adolescents	Adolescents 12+	Ukrainian

Afterword

If you have read this guide to the end, you have already taken the first and most vital step – you have chosen to understand.

Understand what is happening to your loved one. Understand why they changed. Understand that it's not their fault, it's not your fault, it's a reality that we are all learning to live together.

You don't need to be perfect. You can make mistakes. You can get angry, disappointed, tired. You may not know the correct answer. And that's perfectly normal.

This guide is not about following all the recommendations perfectly. It's about having a compass – something to look back on when you're lost in a fog of uncertainty.

Your role is not to be a «superhero». You don't have to fix the person in rehabilitation. You don't have to save them. You don't have to understand everything the first time.

Your role is to be the person who says: «I'm here. I will try to understand. I'll make mistakes but I'm not leaving. We'll solve it together»

That's enough. In fact, it is more than enough.

About time. This guide says a lot about time. And this is not accidental.

Rehabilitation– is a marathon, not a sprint. Some days will be dark. Some will be bright. Most will be ordinary – neither good nor bad, just days when you go forward together. And these ordinary days are the most important.

These are days when no one is a hero, but everything works. Days when the veteran made tea without your help. Days when you both just laughed. Days when nothing happened and it was okay. Accumulate these days. They will build a new life – not what happened before, but what will come next. Points to remember!

When you're struggling, go back to these simple truths:

Regression is not a failure. This is a signal that a pause or help is needed.
You have already overcome it before – you will overcome it now.

Your fatigue is serious. If you burn out, you can't help anyone. Help yourself first.
This is not selfishness, this is the logic of physics.

You can't control everything. You can only control your attitude, words and actions.
The rest is the work of the rehabilitee, time and process.

Small steps count. If today the rehabilitee just got out of bed, it is already an achievement.
If they smiled, it's a victory. If you listened to them without arguing, you performed a miracle.

You are not alone. Thousands of families have gone through many of the things described in this guide. You can call the crisis lines. Join the groups. You can talk to psychologists. You do not have to carry this by yourself.

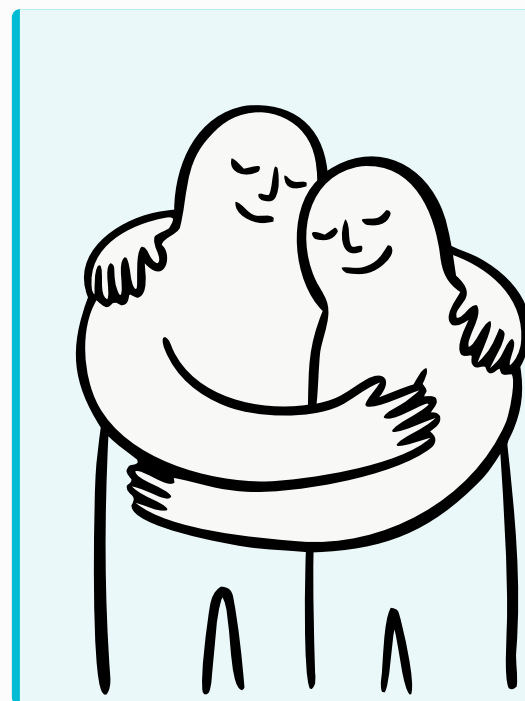
What makes us stronger.

Australian writer Tim Winton wrote: «Trauma finds us all. The difficulty is not in avoiding it, but in passing through it and remaining human.»

A person close to you went through an incredible injury. And here they are, with you, trying to build a new life. You are going through it together.

It won't connect you in the usual way. It can break both of you.

But if you choose – over and over – to stay together, talk, try, make mistakes, and move on, then you'll both build something stronger than what was there before.



How to use this guide going forward?

- Read it again. Every time you feel scared or unclear, open it again. Something new will always «click».
- Give it to others. To your children's classmates, friends, parents. Share the understanding
- Critique it. If something doesn't work for you, say so. This guide was written for you, not against you. It is meant to evolve.
- Add to it. Write down in the margins what helps you. Records from doctors, phones from psychologists, quotes that motivate. Let it become yours.
- Ignore it when you're fine. When things are relatively easy, you can forget about the manual. And that's okay. When it's hard, it will be here.

In conclusion

You are given the hardest task – to be the human being standing beside another human being who survived something that shattered their world.

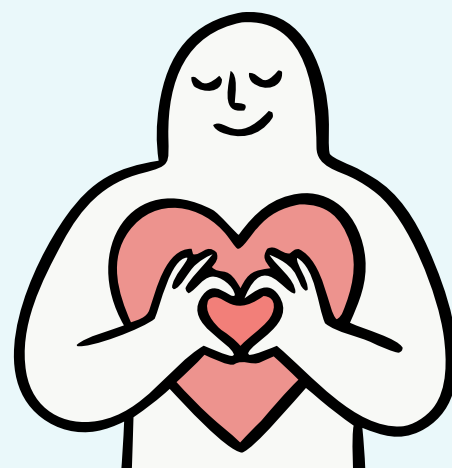
You may not know all the answers. You may make mistakes. You may stay awake at night from anxiety. But you chose to stay.

And here's what it means: you are strong. You are important. You are the hero in this story, not a secondary character.

Thank you for being here.

With hope,

*The Team of the "Route of Possibilities"
Online Laboratory*



P.S. If you come across words or phrases in this guide that raise questions, go back to the «Dictionary» section. If there is no answer, write to us. This guide is a living document and we try to make it understandable for everyone.

A note for quick access

EMERGENCY CONTACTS (suicide, violence, psychosis):

7333 (Lifeline Ukraine)

103 (emergency psychological assistance)

0 800 33 20 29 (Veteran Fund)

PSYCHOLOGICAL CARE:

0 800 100 102 (National Psychological Association)

0 800 332 720 (Sexosocial Support Service)

+38 (067) 348 28 68 (Veteran Hub)

INFORMATION FOR VETERANS:

0 800 505 217 (Unified Veteran Line)

1545 (Government hotline)

GUIDE FOR MEDICAL STAFF

supporting patients
with sensory combat injuries



Foreword

Dear colleagues!

This Guide was not created in the offices of theorists. It was the result of the work of dozens of practitioners – doctors, rehabilitators, psychologists, veterans and their family members who united as part of the online laboratory «Route of Opportunities».

We asked veterans with vision and hearing loss: «What did medical staff do that helped you most, and what hurt you?».

We asked families: «What was missing in your communication with the doctors?».

We asked you, the healthcare professionals: «What is the hardest part of working with these patients?».

This document is the quintessence of these answers. It is an attempt to build a bridge of understanding where a chasm of silence or conflict often exists.

We, the project team, understand the extremely difficult conditions you are working in today.

We do not want to add unnecessary instructions or bureaucracy to you. Our goal is to give you a tool that will save you energy, protect you from emotional burnout and help your patients find their way to recovery faster.

You are the first line of hope for those learning to live in darkness or silence. We hope that this Guide will become a reliable assistant for you on that front line.

With respect and gratitude,

The «Route of Opportunities» Online Laboratory Development Team

Why this Guide is important

More and more servicemen are returning from the front with sensory combat injuries – loss of vision, hearing or their combination, often along with amputations and chronic pain. For the medical system, this means not only an increase in workload, but also the emergence of patients with a completely different reality of daily life, different demands and vulnerabilities.

In such a situation, the healthcare professional becomes not only a specialist who treats the body, but also one of the key figures on the long path of rehabilitation.

This Guide is designed as a practical tool to help you:

- Navigate the specifics of sensory trauma
- Understand what is happening to the patient «from the inside»
- Build effective communication
- Recognize regression in time
- Work collaboratively with the family
- Take care of your own professional resource

CHAPTER 1.

What you need to know about sensory combat injuries

Sensory injury is more than a physical injury.

Sensory combat injuries are not only about anatomical damage to the sense organs. They represent the destruction of the basic way of interacting with the world.

Types of injuries in question:

Vision loss:

total or partial.

A person loses orientation, does not see faces, depends on voice and touch.

Hearing loss:

acoustic injuries, contusions. A person feels isolated, does not hear danger, may seem «indifferent» or «aggressive» due to lack of language understanding.

Combined injuries:

Vision + Hearing or Sensory + Amputations – the most complex cases requiring a multidisciplinary approach.

Psychological consequences (Invisible side)

Understanding what is happening in the patient's head:

Loss of basic security: The world is becoming hostile. Every step, every touch without warning is stressful. A person does not know where they are, who is approaching or what happens next.

Sensory hunger: The brain, accustomed to receiving a constant stream of sensory information, suddenly finds itself in a void. It panics. This can trigger hallucinations, uncontrolled anxiety and disorientation. This is not psychosis! This is a healthy brain response to abnormal conditions.

Loss of agency (subjectivity): «I am a cargo now. I depend on everyone. I'm manipulated». This causes either rebellious aggression («I'll do it myself!») or complete apathy («I don't care anymore»).

Anger toward the body: «It betrayed me. It is now an enemy». Refusal of hygiene, exercise or treatment is often a manifestation of this anger directed at oneself.

Grief and loss: A person experiences multiple losses at the same time: loss of health, loss of profession, loss of independence, loss of the previous self. This is not one depression, but layer upon layer of profound grief.

CHAPTER 2.

The role of the healthcare professional at each stage of the rehabilitation route

Your role varies depending on which stage of the rehabilitation route the patient is on.

Stage 1: Medical (Hospital, ICU)

You are the primary contact and guarantor of the patient's survival.

Stage objective: stabilization, wound healing, pain control.

Your role: first voice, first touching hand, first instruction.

What to do: give your name, position (doctor, nurse, etc.), explain where they are, what will happen next, how to call for help.

Stage 2: Comprehensive rehabilitation

You are a therapist companion and the monitor of the «response to stress».

Stage objective: training of new skills, physical recovery, psychological adaptation.

Your role: observing how the patient reacts to exercise, pain, fatigue.

What to do: stimulation to movement, control of regression, coordination with multidisciplinary team (MDT).

Stage 3: Vocational/Social rehabilitation

You are a consultant and practical skills coordinator.

Stage objective: return to work, development of new competences, integration into society.

Your role: environment adaptation, equipment recommendations, opportunity counselling.

What to do: stimulation to new challenges, involvement of social workers.

Stage 4: Long-term support

You are a monitor and assistant in maintaining the quality of life.

Stage objective: prevention of relapses, tracking of accompanying consequences (hearing degradation, mental disorders).

Your role: regular consultations, early diagnosis of problems.

What to do: support sessions, referral to specialists if necessary.

CHAPTER 3.

How to communicate with a rehabilitee (Tools and techniques)

3.1. Golden rules of communication (Universal for all patients)

- **Introduce yourself verbally when entering the ward.** State your name, role and what you are doing.
- **Warn them about touch BEFORE touching.** Sudden touch is frightening. Always establish contact via voice first, then touch with a prior warning.
- **Talk to the patient directly,** not about them, even if their family, consultant doctor or other staff are nearby.
- **Acknowledge the patient's complex emotions;** do not correct them. Do not say, «Don't be sad»; say, «I can see that this is difficult for you. That's okay».
- **Listen out loud.** If the patient is silent, it does not mean that they cannot hear or understand. Sometimes it means that they are afraid and waiting for a sign.
- **Explain where they are and what surrounds them.** The patient is disoriented in space. The phrase «Your bed is by the window, the door to the ward is on the left» gives them a sense of control.

3.2. Communicating with patients with vision loss

- **Descriptive technique (typhlo-commenting):**
Instead of: «Look, a window» → Say: *«It's raining outside, you can hear the raindrops, and there's a scent of moisture in the air»*
- **Orientation in space:**
 - Use the clock method: *«The plate is at 12 o'clock, the cup is at 3 o'clock, the fork is at 9 o'clock».*
 - Describe the route: *«Five steps straight ahead from the bed, then right to the door».*
- **Physical contact:**
 - Offer your elbow, do not pull them by the hand.
 - Allow them to hold on to you, do not control their movements.

- **Addressing:**

- Say their name before starting a conversation
- If there are several people in the room, clarify: «Ivan, I am talking to you».

3.3. Communicating with patients with hearing loss

- **Alternative communication:**

- Stand facing the light (so that your facial expressions are visible).
- Speak clearly, but do not shout (shouting distorts facial expressions, which are vital for those with hearing loss or deafness).
- Use writing on paper, a tablet or a smartphone.
- Gestures and facial expressions are a very important part of communication.

- **Communication apps:**

- Install the «Sign Language Translator» app or a similar app that converts spoken language into text on your work phone.
- Offer to let the rehabilitee use your smartphone for written communication.

- **Addressing:**

- Get their attention with a gesture or a light touch before starting a conversation.
- Make sure they are looking at you.

3.4. Communication with patients with combined loss (deaf-blind)

This is the most vulnerable category. These individuals are deprived of two main channels of contact with the world. Methods of contact:

- **Palming** – writing letters with a finger on the patient's palm.
- **Tactile sign language** – adapted sign language where gestures are performed on the patient's hands.
- **Simple touch** – as a signal of emotion (stroking – reassurance, steady hand – presence).

Psychological feature: A deaf-blind person often fears total isolation above all else. Your constant presence and consistent communication are their lifeline to the world.

3.5. Complex conversations

Do not say:	Say:
When a patient asks, «Will I be able to see? Will I be able to hear?»	
«Yes, you will get 100% back» (this is not true).	«It's hard to predict right now. We will do everything we can. You have already noticed some changes in [mention something specific: "hearing perception", "spatial orientation"]. Let's observe together»
«No, it's too late» (this kills hope).	
When a patient displays aggression or becomes discouraged:	
«Why are you like that? We're helping you!»	«I understand that this is difficult for you. Tell me what is bothering you. Perhaps I can change something»
When a patient says, «I wish I were dead»:	
«Don't talk like that!»	«I see that you are in a lot of pain. This is a sign that you need help. Let's invite a psychologist to help you»
	And immediately call a psychologist or refer the person for counselling.

3.6. Encouragement/motivation without manipulation

Do not say:	Say:
«Do exercises for marriage»	«Every exercise gives you back a little bit of control over your body. That's your victory»
«Be patient to get back to work»	

Celebrate small victories: «Today you walked down the stairs without help! That's a big achievement»

CHAPTER 4.

How to recognise regression and what to do (Safety Algorithms)

4.1. What is regression in rehabilitation

Regression is not just a deterioration in physical condition. It is a temporary loss of acquired skills, a return to patterns of hopelessness or isolation, often under the influence of stress, pain, fatigue or psychological crisis.

Medical professionals often perceive regression as their own failure («I am not treating the patient well enough»). In reality, it is a **signal that the patient's resources are depleted and they need to recharge**.

4.2. Warning signs (red flags)



Physical signs:

- Insomnia for 3+ consecutive days or, conversely, unmotivated hypersomnia.
- Complete or partial refusal to eat (more than 24 hours without food).
- Phantom pains that cannot be relieved by conventional medication.
- Sudden change in reaction to temperature, light, sound (hypersensitivity).



Behavioural signals:

- **Isolation:** The patient covers their head, does not want to communicate, refuses to exercise or attend therapy sessions.
- **Regression of skills:** A person who has learned to orient themselves independently suddenly asks for help with every little thing.
- **Aggression:** Unprovoked irritability, shouting, sometimes physical outbursts.
- **Refusal to maintain hygiene:** The patient does not want to wash, change clothes or use the toilet.



Psychological signals:

- **Apathy:** The patient stands or sits motionless, does not respond to communication.
- **Suicidal statements:** «There is no point», «I'd rather die», «Give me any injection».
- **Sudden panic:** Fear for no apparent reason.

Algorithm of actions: WATCH – ASK – ACT

Step 1: WATCH

Note the facts (not interpretations):

- «Has been lying down for 3 days with no signs of activity».
- «Did not eat yesterday evening or today».
- «The sound of a half-closed door causes panic».

Step 2: ASK

Address the patient directly:

- «I see that something has changed since yesterday. How are you feeling?».
- «You are not eating. Is it pain or something else?».
- «You look worried. What's bothering you?».

Step 3: ACT

Mild regression

(one or two signals, patient responds to contact):

- Reduce workload for 1-2 days.
- Postpone PT/OT sessions.
- Spend more time nearby (just being present).
- Emphasise/remind the patient of what they have already achieved.

Moderate regression

(3-4 signals, patient has withdrawn):

- Call the psychologist immediately.
- Inform the head of the department.
- Exclude violent procedures (only those that are vital).
- Prepare folders for communication (if the patient does not want to talk).

Severe regression (suicidal statements, aggression towards oneself/ others, acute psychotic symptoms):

- Call a psychiatrist and psychologist immediately.
- Remove dangerous objects from the room.
- Place the patient under constant supervision.
- Inform the family.
- Record all statements in the medical record.

CHAPTER 5.

Working with families: from «visitors» to partners

5.1. Why the family is your key partner

You see the patient for 3-4 hours a day (during rounds or procedures). The family will be with them 24/7 – during meals, hygiene, nights, when they are alone with themselves and their anger.

How the family helps the doctor:

- **Translators:** They often understand the vague language, gestures or reactions of their loved one better than the staff.
- **Motivators:** For many patients, their spouse or children are the only reason to endure pain and do exercises.
- **Change detectors:** Family members are the first to notice small changes in behaviour (the onset of regression) that may escape the physician's notice on rounds.
- **Асистенти:** Навчена родина може взяти на себе частину побутового догляду (годування, гігієна), розвантажуючи молодший медперсонал.

Your interest:

Invest 15 minutes in educating the family now to save hours of time solving problems later.

5.2. What to explain to the family (Medical literacy)

The family is often in a state of confusion or panic. They need not just «information» but instructions.

A. «It's not forever, but it's for a long time» (Reality)

Problem: The family waits for a «miracle» in a week. When the miracle does not happen, they blame the doctors or fall into despair.

What to say: «Recovery from sensory trauma is a marathon, not a sprint. There will be some good days and some bad days. That's normal. Your task is not to wait for a quick finish, but to celebrate every little step (sitting up on their own, eating on their own, smiling)».

B. «Don't do it FOR them, do it WITH them» (Subjectivity)

Problem: Overprotection. The family tries to feed someone who can eat on their own with a spoon «so that they don't get tired». This kills rehabilitation.

What to say: «I understand you want to help. But if you do for them what they can do for themselves, you take away their victory. Want to help? Put the spoon in their hand and support their elbow. Let them control the process. It's their recovery, not yours.»

C. «Tears and anger are a part of the healing process» (Emotions)

Problem: The family is frightened by the patient's aggression or depression and asks for «something to calm them down».

What to say: «They are currently processing a profound loss. Anger and tears are a healthy response to abnormal circumstances. Do not forbid them from crying. Just be there for them. If they stop talking, stop responding and start refusing food, that's an alarm signal. Then we take action».

5.3. How to support the family (Burnout prevention)

An exhausted family = a troubled family (conflicts, complaints, outbursts at the patient). Supporting them is in your best interest.

1. Legalise fatigue

Tell them: «*You are also doing a tremendous job. It is normal to get tired. You don't have to be made of iron.*».

Relatives often feel guilty for wanting to sleep or eat while their loved one is suffering. Give them «medical permission» to rest.

2. The «oxygen mask» rule

Reminisce: «*First yourself, then the patient. If you collapse, who will help them? Go home, get some sleep, we'll take care of them.*».

3. Agree on a time for questions:

«I can answer your questions every day at 2 p.m. Please write them down in a notebook so you don't forget». This structures their anxiety and frees you from chaotic questions in the hallway.

4. Refer them further

If you see that the family is struggling emotionally, don't try to be their psychologist. Give them contact details: *«Here is the number for the family helpline. They have specialists who know how to help you. Call them, it's free».*

CHAPTER 6.

Documentation and coordination

6.1. Patient Rehabilitation Profile: what it is and your role

A **Patient Rehabilitation Profile** is a single document that travels with the patient from one institution to another.

What you should include in it (apart from diagnoses):

1. Functional status (What they CAN do):

NOT just: «S.O.S. (no particular features)». BUT SPECIFICALLY:

- ☒ «Sits independently for 15 minutes»,
- ☒ «Holds a spoon with an adapted grip»,
- ☒ «Navigates within the ward with prompts», etc.

2. Sensory characteristics (How to communicate with them):

- ☒ «Responds to voice only on the right side».
- ☒ «Bright light causes headaches – needs semi-darkness».
- ☒ «Does not recognise faces, navigates by voice».

3. Triggers for regression (What to avoid):

- ☒ «Categorically refuses help from women with hygiene».
- ☒ «Panic attack when hearing a siren».

Rule: Write as if you were writing instructions for a colleague who will be seeing this patient for the first time tomorrow.

6.2. How to transfer information (The «Relay Baton»)

Transferring a patient (to another shift, another department, another institution) is the moment of highest risk for information loss.

Algorithm for effective transfer
(SBAR for rehabilitation):

S B A R

S**S (Situation):**

«Patient Ivanenko, after a mine-blast injury, loss of vision, partial loss of hearing».

B**B (Background):** «Three days ago, there was an episode of aggression, now stable. Taking [medication]. Family is active, wife is learning assistance techniques».**A****A (Assessment) – Assessment of current condition:** «Physically stable. Psychologically – in denial. Needs help walking, but eats on his own».**R****R (Recommendation):** «Attention! Always announce your presence before entering. Do not change the arrangement of items on the bedside table – this causes panic».

6.3. Who to coordinate with

You are not alone in this. You are part of a multidisciplinary team (MDT).

Psychologist:

When to call: Suicidal thoughts, refusal to eat/take medication, insomnia, uncontrolled aggression.

What to say: «Please note that he has asked for painkillers three times today, even though he is not in any pain. Check for risk of addiction».

Social worker/case manager:

When to call: Problems with documents (no passport, no ID), no relatives, no one to pick them up after discharge.

What to report: «Preparing for discharge in 3 days. Is the accommodation ready? Have crutches/wheelchairs been arranged?».

Physical therapist/Occupational therapist:

When to call: Pain after exercise, changes in blood pressure/pulse, new skills.

What to convey: «He has a temperature of 37.2 today, reduce the physical load».

6.4. Red lines in documentation

What NOT to ignore in your notes:

- **Signs of physical injury of unknown origin:** could be self-harm or violence.
- **Refusal to sign informed consent:** be sure to record the reason and the fact that it was explained.
- **Facts of alcohol/drug use in the ward:** this is legal protection for staff and a signal for a narcologist.

CHAPTER 7.

Self-support for medical personnel

7.1. Secondary traumatization: an enemy you must know by sight

When you see the consequences of war every day – mangled bodies, ruined lives – your psyche is also traumatised. This is called compassion fatigue.

Signs that you are burning out:

Cynicism: Using inappropriate “dark humor” or referring to patients with derogatory nicknames (“that blind guy from Room 5”).

Irritability: Patients, colleagues and family annoy you. Any request makes you angry.

Freezing: You stop feeling any emotions at work. You do everything mechanically, like a robot.

Problems at home: You snap at your children or spouse. You can't relax at home.

Physical symptoms: Headaches, insomnia, constant fatigue that does not go away after the weekend.

Important: If you recognise yourself in this description, it does not mean that you are a «bad healthcare worker». It means that you are a living person who has taken on too much pain. You need to reboot.

7.2. Quick self-regulation techniques (on shift)

You don't have an hour to meditate while on duty. But you do have 3 minutes.

Technique 1: «Grounding» (when emotions overwhelm you)

When a patient is screaming or you have just seen something horrific:

1. Stop.
2. Feel your feet on the floor (stomp your feet).
3. Find 5 blue objects with your eyes.
4. Find 4 objects you can touch (table, gown, pen).
5. Hear 3 sounds (buzzing of a lamp, footsteps, breathing).

This switches the brain from emotional «panic» to the reality of «here and now».

Technique 2: «Square breathing» (stress relief)

Before entering a difficult ward or after talking to an aggressive relative:

- *Inhale (4 seconds)*
- *Pause (4 seconds)*
- *Exhale (4 seconds)*
- *Pause (4 seconds)*

Repeat 3-4 times.

Technique 3: «Robe removal ritual» (end of work)

When you change clothes after your shift, imagine that along with your robe, you are removing someone else's pain, responsibility and patient stories.

- Say to yourself: *«I did everything I could today. My shift is over. Now I am just [Name]».*
- Wash your hands with cold water up to your elbows – this is a physical marker of «cleansing».

7.3. Where to seek support

Medical professionals are often reluctant to ask for help («I am a doctor/nurse myself, I should be able to cope»). This is a mistake.

1. Supervision/Balint groups:

If your institution has a psychologist, initiate discussion groups for complex cases. The goal is not to complain to colleagues, but to understand: «Why did this patient affect me so much?».

2. Psychological support hotlines (for everyone):

Lifeline Ukraine: 7333 (24/7, anonymous).

Ministry of Health (MOH) Hotline: 0-800-60-20-19.

3. Colleagues (the «Alarm» buddy system):

Agree with a colleague you trust: if one of you sees that the other is «losing it» (aggression, tears), they have the right to say a stop word (for example, «Coffee»). This is a signal: «You need to step out for 5 minutes, I'll cover for you».

7.4. Reminder «The rights of medical staff in the context of emotional stress»

What is this reminder about and where does it come from?

This memo is not a legal document, but a psychological tool for self-regulation. It is based on the principles of professional ethics and mental health protection for medical staff, as formulated by international organisations (WHO, ICN – International Council of Nurses).

The purpose of the reminder:

- To legitimize feelings and limitations that medical professionals are often ashamed to admit.
- To prevent burnout syndrome due to unrealistic expectations of oneself.
- To give oneself permission to take care of one's own resources without feeling guilty.

REMINDER

Rights of medical staff during emotional stress

- 1** I have the right **not to know** the answers to all questions immediately.
- 2** I have the right **to feel helpless/sad/grief** when I cannot save someone.
- 3** I have the right to **a break, food, water, sleep and basic safety** (so as not to make mistakes due to exhaustion).
- 4** I have the right to demand **respect and proper communication**.
- 5** I have the right **to set boundaries** and stop the conversation if there is abuse/pressure (and return after a while).
- 6** I have the right to **ask for backup/replacement/help** (from a colleague, senior, security, administration) – this is not a weakness.
- 7** I have the right to **delegate** and «not carry it all myself».
- 8** I have the right to **psychological support/supervision** (without shame).
- 9** I have the right to say, «I need time to clarify/check/agree».
- 10** I have the right to be **a person, not a function**.

How to use it?

This is not a declaration that you need to memorise. It is a checklist for moments when you feel that «something is wrong».

Examples of use:

Situation 1: A relative aggressively demands: «Why haven't you diagnosed him yet?! You're the doctors!»



**Inner voice
(without reminder):**

I am a bad doctor; I should know everything»



Response with a reminder:

Remember: «I have the right not to know the answers to all questions»

Say aloud: «We have conducted all available tests. We are now awaiting the results of a consultation with a neurologist. I understand your concern, but some questions take time»

Situation 2: The patient died even though you did everything you could. You feel guilty.



**Inner voice
(without reminder):**

I should have done something else, I let him down»



Response with a reminder:

Remember: «I have the right to feel helpless when I cannot save someone»

Give yourself permission to grieve: «It's not my fault. I did everything I could. Death is a part of the reality of medicine that I can't always fight» If necessary, talk to a colleague or psychologist to discuss the case.

Situation 3: You have been working for 12 hours straight without a break. A colleague says, «One more discharge, quickly!»



**Inner voice
(without a reminder):**

«I must, I'm a medic, I have to endure»



Response with a reminder:

Remember: «I have the right to rest, food and safety»

Say: «I am only writing prescriptions for emergencies right now. I will do the rest after a 15-minute break, because I am on the verge of making a mistake due to fatigue»

Situation 4: A relative of a patient insults you: «You're all scum here, you don't care!»



**Inner voice
(without reminder):**

*I must endure because
they are suffering»*



Response with a reminder:

Remember: «*I have the right to demand respect»*

Say calmly but clearly: «*I understand your pain and am ready to help. But I will not work in an environment where I am insulted. If you need help, please communicate politely. If you cannot do so now, let's return to this conversation in 10 minutes»*

If the aggression continues, involve the administration/ security (this is not a sign of weakness, but of protecting your boundaries).

Legal basis (for those who doubt)

Although the reminder is a psychological tool, it is based on real norms:

1. Constitution of Ukraine (Article 43): «Everyone has the right to proper, safe and healthy working conditions».
2. Law of Ukraine «On Labour Protection»: The employer is obliged to ensure safe conditions, including psychological stress.
3. Code of Ethics for Medical Professionals: You are not obliged to sacrifice your health for the sake of a patient – this is not heroism, but a path to burnout.

How to implement the reminder in the department's work?

Option 1: Individual use

- Print it out and stick it in your locker or office.
- Reread it after difficult shifts.

Option 2: Team discussion (10 minutes at a meeting)

- The head/senior nurse reads the reminder aloud.
- Asks: «Is there anyone who feels that these rights are being violated in relation to themselves?».
- Discuss how the team can help each other (e.g., agree on mandatory breaks).

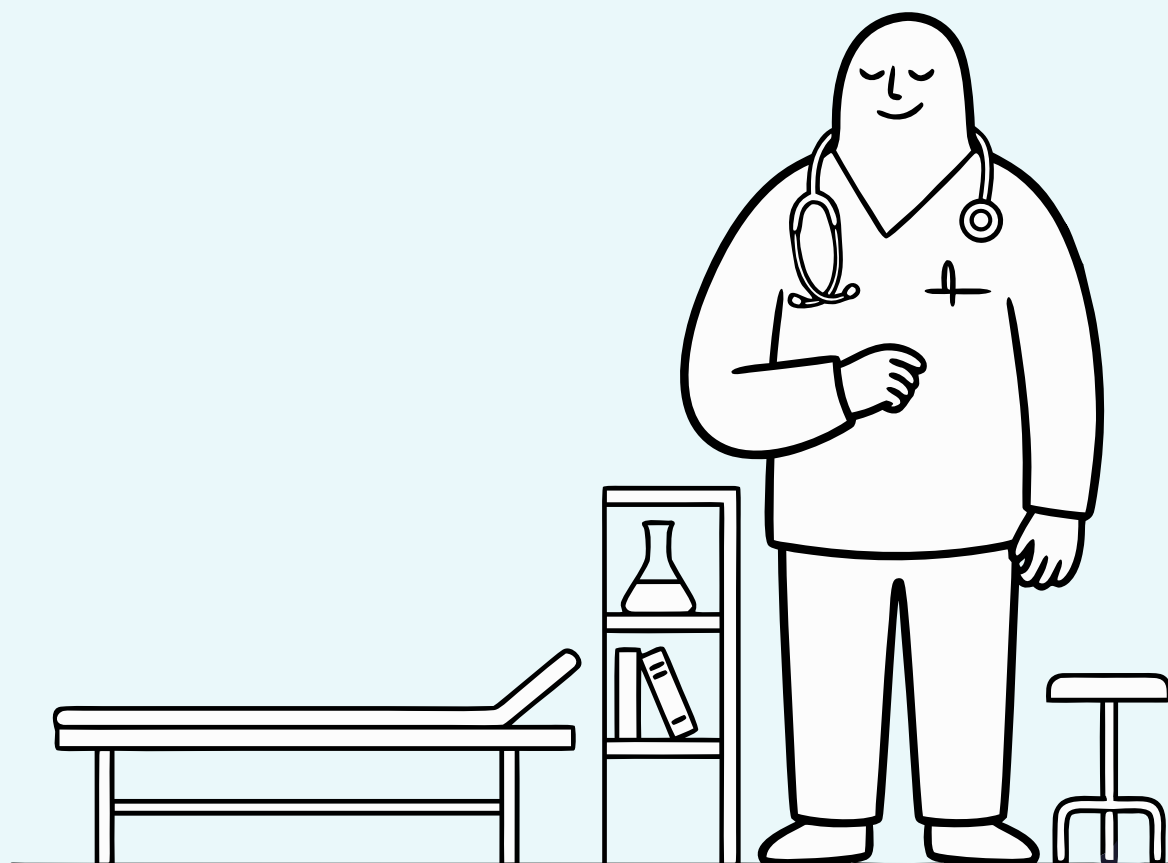
Option 3: Supervision of difficult cases

- If there is a psychologist, use the reminder as a basis for analysis: «Which of these rights did you neglect in that situation?».

You cannot pour from an empty cup.

Taking care of yourself is not selfish. It is a professional necessity that makes you a capable healthcare worker for many years to come, rather than a short burst followed by burnout.

These rights are not about «excuses» but about resilience. A healthcare professional who knows their limits and protects them is a professional who will be able to be there for their patients for years, not months.



APPENDICES

Appendix 1. Quick checklists

Appendix 1. Quick checklists

«First contact with a patient after sensory trauma»

- ☒ Introduced myself verbally (name and role)
- ☒ Warned the patient about touching before the procedure
- ☒ Described where the patient is (ward, floor)
- ☒ Explained what will happen next (simple steps)
- ☒ Asked if there is any pain
- ☒ Left a way to call for help (button/bell within reach)

Checklist:

«Preparing to discharge a patient with sensory trauma»

- ☒ Discharge contains clear recommendations (not «observation», but «where and when»)
- ☒ Family trained in basic care skills
- ☒ Contact details for emergencies provided
- ☒ Referrals for rehabilitation completed (if necessary)
- ☒ Patient rehabilitation completed and submitted

Checklist:

«Signs of regression – what to check»

- ☒ Sleep (disturbances 3+ consecutive nights?)
- ☒ Appetite (refusal to eat 2+ days?)
- ☒ Communication (silence, isolation?)
- ☒ Hygiene (refusal to take care of oneself?)
- ☒ Verbal signals («I'd rather die», «there's no point»)?
- ☒ Aggression (towards oneself, staff, family?)

If 3+ points – follow the regression algorithm

Appendix 2. Emergency Contacts Table

The problem	Telephone number	Work hours
Suicide crisis	Lifeline Ukraine: 7333	24/7
Mental health crisis	Ukrainian Veterans Foundation Support Line: 0 800 33 20 29	24/7
Emergency psychiatric care	103	24/7
Medical advisory (Ministry of Health)	0 800 60 20 19	Daily 8:00 AM – 8:00 PM
Documents and Combat Participant Status (CPS)	Мінвeterанів: 0 800 505 217	Daily 8:00 AM – 8:00 PM
Legal aid for veterans	Veteran Hub: 067-348-28-68	Daily 8:00 AM – 9:00 PM
Family Support Services	NGO "Woman Force": 0 800 332 720	Daily 8:00 AM – 8:00 PM

Appendix 3. Sample phrases for communication (Quick Reference)

Situation	What should not be said?	What needs to be said
The patient is crying	«Calm down, everything will be fine»	<i>«I see that this is difficult for you. I am here for you»</i>
The patient is aggressive	«Why are you yelling? I'm helping!»	<i>«Tell me what annoys you, and I'll fix it»</i>
The patient is silent	«Say something!»	<i>«If you don't want to talk, I'll just sit next to you»</i>
The patient refuses the procedures	«You must!»	<i>«Let me explain why this is necessary. It's up to you to decide»</i>
The patient asks about the prognosis	«You'll find out soon enough»	<i>«It's difficult to predict right now. We'll watch together»</i>
Regression, apathy	«What results were you expecting?»	<i>«Your body needs a break. That's normal»</i>

Appendix 4. Glossary of key terms and concepts

Acoustic trauma – damage to the inner ear caused by exposure to extremely loud noise (explosion, gunshot). Often combined with barotrauma.

Alternative and augmentative communication (AAC) – methods of communication without the use of spoken language (gestures, cards, writing on the palm, smartphone apps).

Audio description – a concise verbal description of visual information (objects, space, actions) for a blind person with visual loss. A skill required by medical staff to explain procedures.

Habilitation – the process of developing new skills that a person did not previously have (e.g., reading Braille, navigating with a cane), as opposed to rehabilitation (restoring what has been lost). For veterans with complete vision loss, habilitation is particularly relevant.

Multidisciplinary team (MDT) – a group of specialists (doctor, physical therapist, occupational therapist, psychologist, social worker) who jointly plan and implement the patient's treatment plan.

Patient agency – the ability and right of a patient to be an active participant in the treatment process, to make decisions and take responsibility, even in conditions of limited physical abilities.

Phantom sensory sensations – visual (flashes, images) or auditory (voices, music) phenomena that arise in the brain in response to the loss of real signals from the eyes/ears. This is not a mental disorder! (Charles Bonnet syndrome).

Plain Language – a style of communication where information is presented as simply as possible, in short sentences, without complex terms. Critically important in cases of concussion and cognitive impairment.

Regression (in rehabilitation) – temporary deterioration of condition, loss of acquired skills or return to previous behavior patterns (isolation, helplessness) under the influence of stress, pain or fatigue.

Secondary traumatising (compassion fatigue) – emotional exhaustion of a specialist due to constant contact with the traumatic experiences of patients.

Sensory combat trauma – damage to the sensory organs (vision, hearing) or corresponding areas of the brain as a result of combat operations, leading to a persistent impairment of information perception.

Sensory deprivation – a condition in which the body is deprived of its usual amount of external stimuli (sounds, visual images). In veterans, it can cause hallucinations, anxiety and disorientation.

Appendix 5. Useful resources for healthcare professionals and rehabilitation specialists

1. Training and professional development (for medical professionals). Courses, webinars, and materials to improve skills in working with sensory trauma.

- **Public Health Center of the Ministry of Health of Ukraine (PHC)**
Topic: Psychological Assistance Courses, Working with PTSD.
Access: academy.phc.org.ua (Distance Learning Platform)
- **Prometheus Platform: «How to Communicate with People with Disabilities»**
Topic: Communication Ethics, Accessibility (Barrier-free environment), Correct Terminology.
Access: prometheus.org.ua (Free online course)
- **EdEra: «Working with People with Traumatic Experiences»**
Topic: Specifics of Communication with Veterans.
Access: ed-era.com

2. Resources for patients with visual impairment Where to refer patients and families for skills training (orientation, Braille, gadgets).

- **UTOS Educational and Information Computer Center**
Key Benefits: Training on smartphone/PC use with Screen Reader (voice-over), typhlotechnic consultations (assistive technology for the blind).
Website: utos.org.ua
- **«Barrier-Free Ukraine» Resource Center**
Key Benefits: Collections of audiobooks, software for the blind, and information on spatial accessibility.
Website: bezbariarnist.gov.ua

■ **Be My Eyes app**

What it is: A mobile app where volunteers use video calls to help blind people (read expiry dates, find items).

Recommendation: Help the patient install it on their smartphone.

3. Resources for patients with hearing impairment

Communication tools.

■ **«Vidchuy» NGO (Feel NGO)**

Key Benefits: Free online hearing diagnostics, consultations, and sign language courses.

Website: vidchui.ua

■ **Connect by BeWarned app**

What it is: An app that converts spoken language into text on the screen (and vice versa) for communicating with people with hearing impairments.

Recommendation: Install on a work tablet/phone in the department.

4. Legal and social support (for reference)

Where to go for advice.

■ **«E-Veteran» Platform (Ministry of Veterans Affairs)**

Key Benefits: Comprehensive information on Combatant Status (UBD), benefits, and health resort treatment.

Website: eveteran.gov.ua

■ **«Legal Hundred» (Yurydychna Sotnya)**

Key Benefits: Free legal consultations for military personnel and their families (MSEC/disability commissions, payments/allowances).

Website: legal100.org.ua

5. Psychological support (online)

■ **«Baza» Mobile App**

Description: A self-help app for veterans featuring tools to manage anxiety, panic attacks, and flashbacks.

Recommendation: Recommended for patient use (available on Google Play and the App Store).

Afterword

Instead of conclusions

Rehabilitation after sensory trauma is not about repairing a broken mechanism.

It is about the birth of a new person in an old body. And you are the ones who deliver this «birth».

The patient may not remember the names of the drugs you administered. They may forget your name.

But they will never forget the moment when you put your hand on their shoulder and said, «I'm here. You are not alone».

Or when you first made them feel that they were not a helpless patient, but a person with dignity.

Your work is measured not only by healed wounds, but also by saved souls.

Every time you explain to a blind person where their cup is, instead of silently handing it to them, you are giving them back a piece of their life.

Every time you take an extra minute to write a question to a patient with hearing loss, you are building a bridge across the chasm of isolation.

It is hard work.

Take care of yourself so that you have the strength to continue.

