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**Andrii Shymanskyi**
Vinnytsia Mykhailo Kotsiubinskyi State Pedagogical University
Ph.D student at the Department of psychology and social work (Ukraine)
Dr.shymanskyi@gmail.com
https://orcid.org/0009-0001-7320-1191

# THE PROFESSIONAL PRACTICE OF HEALTHCARE WORKERS: TODAY'S PSYCHOLOGICAL CHALLENGES

**Анотація.** Професійне вигорання медичного персоналу в умовах війни, пандемій і системних реформ охорони здоров'я набуло ознак хронічного стану, що глибоко вкорінюється у клінічну практику, когнітивні процеси та моральну свідомість лікаря. Йдеться не лише про емоційне виснаження, а про комплексне порушення внутрішнього функціонального балансу, коли змінюється мотиваційна структура, редукується здатність до емпатії, а толерантність до невизначеності стрімко знижується. В умовах повномасштабної війни в Україні ці симптоми набули нової інтенсивності: лікарі працюють у постійній загрозі для життя, при мінімальних ресурсах, часто без адекватного відновлення чи підтримки. Це формує системну загрозу не лише для психічного здоров'я працівників, а й для стабільності медичної допомоги в цілому.

Метою статті є дослідження змін у структурі професійного вигорання медичного персоналу в умовах війни, пандемій і трансформацій медичної системи, з акцентом на зрушення в мотиваційному, емоційному та когнітивному компонентах, а також на потребу в нових підходах до психологічної підтримки.

У статті представлено комплексний аналіз механізмів професійного вигорання через призму надзвичайних умов: бойових дій, епідеміологічних викликів, реформ управлінських структур. Описано трансформацію класичної моделі вигорання в нову, контекстуально-обумовлену форму, де ключовими стають десенсибілізація, фрустраційна втрата професійного сенсу та зниження когнітивної гнучкості. Розглянуто дані клінічних спостережень, опитувань і статистики МОЗ, що демонструють масштаб проблеми. Виокремлено моделі психологічної підтримки, які довели свою ефективність: телемедичні консультації, мобільні бригади кризових психологів, супервізійні групи для медичних команд. Наголошено на потребі переосмислення не лише методик інтервенції, а й організаційної філософії закладів охорони здоров'я, де профілактика емоційного виснаження має бути вбудована в щоденну практику.

Отримані результати мають прикладне значення для формування нової парадигми підтримки медичного персоналу в умовах тривалих криз, що забезпечить збереження їхньої функціональної спроможності та стійкості до професійних деформацій.

**Ключові слова:** професійне вигорання, медичний персонал, війна в Україні, психологічна підтримка, емоційне виснаження, ПТСР

Burnout among healthcare staff, in the context of war, pandemics and systemic healthcare reforms, has taken on the characteristics of a chronic condition that is becoming deeply ingrained in clinical practice, cognitive processes and the moral consciousness of healthcare professionals. This is not merely a matter of emotional exhaustion, but a complex disruption of internal functional balance, where the motivational structure shifts, the capacity for empathy diminishes, and tolerance for uncertainty rapidly declines. In the context of full-scale war in Ukraine, these symptoms have taken on a new intensity: doctors work under constant threat to their lives, with minimal resources, often without adequate rest or support. This poses a systemic threat not only to the mental health of staff but also to the stability of healthcare provision as a whole.

The aim of this article is to investigate changes in the structure of professional burnout among medical staff in the context of war, pandemics and transformations of the healthcare system, with a focus on shifts in the motivational, emotional and cognitive components, as well as on the need for new approaches to psychological support.

The article presents a comprehensive analysis of the mechanisms of professional burnout through the prism of extraordinary conditions: combat operations, epidemiological challenges and reforms of management structures. It describes the transformation of the classical burnout model into a new, context-

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dependent form, where desensitisation, frustration-induced loss of professional meaning, and reduced cognitive flexibility become key factors. Data from clinical observations, surveys and Ministry of Health statistics are examined, demonstrating the scale of the problem. Models of psychological support that have proven their effectiveness are highlighted: telemedicine consultations, mobile teams of crisis psychologists, and supervision groups for medical teams. The need to rethink not only intervention methods but also the organisational philosophy of healthcare institutions is emphasised, where the prevention of emotional exhaustion must be embedded in daily practice.

The findings have practical implications for the development of a new paradigm for supporting medical staff during prolonged crises, which will ensure the preservation of their functional capacity and resilience to occupational burnout.

**Key words**: professional burnout, medical personnel, war in Ukraine, psychological support, emotional exhaustion, PTSD

**Formulation of the problem** In the current climate of a multi-faceted crisis caused by full-scale war, pandemics and reforms, the psychological strain on healthcare workers has reached unprecedented levels. From interns and general practitioners to surgeons working in frontline conditions, everyone faces multi-faceted pressure – emotional, operational and moral. Traditional training does not always take these challenges into account, which is why there is a rise in burnout, anxiety disorders and PTSD. Professional burnout is no longer limited to isolated cases – it is becoming systemic. This is precisely why a detailed study of the structure of professional burnout in emergency situations must form the basis for developing modern support mechanisms that are adapted to the new reality of clinical practice in Ukraine.

**The purpose of this article** is to analyze the transformation of professional burnout among healthcare workers during war, pandemics, and systemic healthcare reforms, with a focus on motivational decline, reduced tolerance for uncertainty, and the urgent need for sustainable psychological support mechanisms.

**Outline of the main material** The professional activities of healthcare workers in the modern healthcare system are increasingly accompanied by multi-layered psycho-emotional stresses, which are chronic in nature and linked to constant interaction with patients experiencing physical and mental stress. A characteristic feature is the cumulative effect of emotional burnout, which develops against a backdrop of high responsibility, conflicting expectations between patients and staff, and the need to make decisions in situations of high uncertainty. Working under strict regulations, limited resources and time constraints, healthcare professionals are forced to constantly adapt their responses and adjust their communication behaviour, transforming individual patterns to comply with the requirements of professional etiquette and medical protocols. This creates the basis for persistent neuropsychological stress, in which cognitive fatigue, sensory overload, emotional exhaustion and a state of constant readiness for emergencies converge. At the heart of daily practice lies the confrontation with complex diagnoses, incurable diseases and palliative care, which inevitably leads to traumatic experiences, including the phenomenon of secondary traumatisation. This is compounded by frequent changes to the regulatory framework, the ongoing digitisation of processes, and an increasing administrative burden, which distances the doctor from direct contact with the patient, shifting the focus towards bureaucratic functionality. Faced with a constant lack of time and the need to balance a multitude of roles, healthcare professionals experience psycho-emotional pressure that manifests as sleep disturbances, psychovegetative disorders, anxiety, and symptoms of depression. As noted by Zhdan V. M., in collaboration with Rudenko Yu. O. and Kolisnyk A. A., modern medical education must take these dynamic stresses into account, developing the individual's internal resources as early as the training stage [2].

Chronic emotional stress in the medical environment is not an exceptional individual phenomenon, but a structural characteristic of professional activity, which is actively encoded in neuropsychological structures through the constant activation of the sympathetic-adrenal system. Emotional stress accumulates due to the inability to complete the stress response – doctors are often forced to suppress natural emotional expression due to social prohibitions and the ethical imperatives of the profession. The result is a delayed psychological reaction, manifesting as increased irritability, somatic symptoms and affective instability, which over time creates the conditions for professional burnout. The absence of appropriate mental hygiene mechanisms leads to frustration and tension escalating into chronic demotivation and an apathetic attitude towards patients. Y. V. Gorbokon emphasises that effective professional training must include modules on developing psycho-emotional self-regulation skills, enabling future doctors to adapt to the high emotional turbulence of the working environment [1]. The ability to withstand repeated psychological blows – from the loss of a patient to moral dilemmas – is becoming no less a significant competence than clinical

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reasoning or mastery of modern treatment protocols. At the same time, the development of resilience to destabilising factors depends to a large extent not only on an individual's psychological constitution, but also on the level of support from the team, the presence of a clear hierarchy, and conditions for continuous professional development.

Constant exposure to serious diagnoses triggers psychological defence mechanisms that are not always adaptive. The clinical setting is dominated by cases that go beyond routine practice: complex operations, terminal conditions, and therapeutic helplessness in the face of progressive cancer or chronic renal failure. The psyche internalises a recurring pattern of helplessness, triggering syndromes of loss of professional identity and causing crises of meaning in one's work. In a series of publications, Lazurenko O. emphasises that a healthcare professional's professional development must integrate experience of extreme situations as a fundamental training model with reflective reinforcement [3][4][5]. Processing such experiences emotionally without proper preparation leads to a loss of cognitive flexibility, a reduction in empathic mechanisms, and a tendency to formalise relationships with patients. The sense of a living ethical interaction disappears, replaced by the functional performance of duties without emotional involvement, which in turn creates an internal conflict between ethical vocation and professional reality. This confirms the need to introduce a psychotherapeutic element into training programmes – not merely as an optional module, but as a compulsory component for developing the skills to deal with difficult topics such as death, loss, hopelessness, and the limits of medical care.

Time constraints in medical practice become a constant background stressor which, combined with an excessive workload, triggers a state of multi-tasking overload. The essence of this phenomenon lies in the fact that the doctor simultaneously performs diagnostic, therapeutic, administrative and communicative functions, without sufficient time for cognitive recovery. This leads to impaired ability to concentrate deeply, errors in record-keeping, and emotional breakdowns in high-pressure situations. At the same time, multitasking has become the norm, a situation not addressed by organisational policy. Smila N. V. and Lazurenko O. highlight that the training of future doctors must incorporate not only clinical but also organisational competence, teaching future specialists to independently structure their working hours and avoid psychological overload [4]. The lack of distinction between work and private time, particularly in the context of night shifts, on-call duties and emergency calls, leads to disruption of circadian rhythms, reduced cognitive performance and a chronic decrease in dopamine levels. This has consequences not only in physiological terms but also in terms of moral motivation, as the doctor begins to lose a sense of productivity, which translates into a feeling of professional helplessness.

Limited resources, particularly shortages of medicines, equipment or support staff, lead to a disconnect between professional ideals and actual practice. Although aware of the optimal course of action, doctors are often unable to implement it due to a lack of basic conditions. This creates a state of cognitive dissonance, which is extremely psychologically draining. Faced daily with compromises between what is right and what is possible, the doctor gradually loses a sense of effectiveness, and responsibility begins to weigh heavily, a burden not offset by any external rewards. As Lazurenko O. emphasises, to bridge this gap, elements of psychological support, reflective analysis and the development of internal self-regulation skills are essential [6]. It is self-regulation in the face of stressors that allows one to maintain a balance between the humanistic values of the profession and the realities of clinical practice. An increase in the level of professional self-awareness occurs not through abstract ideals, but through the ability to bridge the gap between normative expectations and actual resource capabilities without undermining one's personal structure.

Modern medical practice operates within a constantly changing social and operational environment, in which professional burnout is not a temporary condition but takes on the characteristics of a chronic syndrome with distinct dynamics and phases. Pandemics, large-scale military conflicts and cyclical healthcare reforms create multi-structural stress-inducing systems, where external threats, institutional transformations and internal cognitive-emotional dichotomies are simultaneously activated. In such conditions, healthcare workers lose their footing in familiar models of professional fulfilment: the stability of routine protocols disappears, the structures of interaction between colleagues change, and the boundary between personal and professional life becomes blurred. The motivational foundation, previously built on humanistic ideals of care, gradually shifts towards survival, resource conservation and the avoidance of overload, leading to a reduction in professional identity. Tolerance for uncertainty, which was previously a relatively stable competence, diminishes in emergency situations due to constant cognitive conflicts caused by a lack of clear information, contradictory instructions and the absence of a definitive prognosis. Within the pandemic regime, healthcare professionals are forced to operate in a state of constant mobilisation: changing protocols, temporary patient routes, restricted access to protective equipment, and a shortage of

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specialists – all of this creates a high level of emotional strain, which over time leads to professional burnout. Depersonalisation syndrome is particularly acute when a doctor, in an attempt to conserve their remaining energy, automatises their interaction with the patient, reduces their empathetic engagement and projects detachment as a self-defence mechanism [6].

With the onset of full-scale military operations, the burden on the healthcare system—as the organisational and functional framework for the population's survival—increases. In such conditions, burnout takes on a mixed character – it involves both the classic symptoms described in clinical classifications and new phenomena associated with combat trauma, rapid decision-making in an unstable environment, and constant exposure to life-threatening situations. Doctors working in frontline hospitals or mobile teams face a total lack of time, resources and even the right to a full psycho-emotional response. Such conditions lead to the development of persistent forms of desensitisation, where the psyche cuts off access to emotions, leaving only cognitive function. This is useful for survival, but catastrophically dangerous in the long term: the lack of emotional processing of loss, aggression and helplessness accumulates and turns into a background psychological pressure that cannot be relieved. In the context of the medical front line, the very concept of motivation changes: instead of a desire to help, an internal imperative arises to function despite pain, fatigue and a loss of meaning. This transformation of the motivational core creates a risk of professional involution, where the healthcare worker performs actions without engagement in the process, feeling neither gratitude, nor a sense of achievement, nor a need for further fulfilment.

One of the most paradoxical consequences of systemic transformations is that internal reforms in healthcare, designed to optimise processes, in many cases merely complicate staff adaptation. Changes in management structure, digitalisation, deregulation or increased control are often not accompanied by appropriate psychological support. As a result, doctors are forced to spend a significant amount of energy mastering new administrative functions, rather than concentrating on the clinical process. A decline in tolerance for uncertainty under such conditions becomes a widespread phenomenon, as the system fails to provide answers to basic questions regarding stability, roles and the rules of the game. Uncertainty about how long a particular funding policy will remain in place, what regulatory changes are in the pipeline, and what the workflow and scope of responsibilities will be tomorrow – erodes inner confidence, which is a key stabilising factor in a high-stress profession. Strategic thinking is lost, there is a shift towards short-term tasks, and the motivational structure is dominated by the avoidance of negativity rather than the pursuit of positivity. This fundamentally alters behavioural patterns: instead of initiative, we see increased reactivity; instead of openness to change, we see defensive avoidance of new formats [3].

The growing need for new mechanisms of psychological support is a logical consequence of the intensification of crisis factors. Traditional approaches to psychological support, focused on individual counselling or training sessions, no longer meet the scale of demand, as the need extends beyond emotional stabilisation to include organisational, motivational and existential support. A multi-tiered system is required: ranging from daily self-regulation protocols embedded in the workflow to integrated programmes of psychosocial recovery involving the entire clinical team. Such an approach demands a shift in the very paradigm of human resources management within healthcare institutions – from a focus on control to a priority on support. Mechanisms for emotional relief must become a standard part of medical routine, rather than an exception or a privilege. It is advisable to create spaces for psychological reframing, where staff can discuss their experiences, process events, and reframe their own reactions without fear of judgement or administrative punishment. In this context, it is not clinical psychotherapy that comes to the fore, but preventive psychology, which focuses on maintaining work capacity, fostering resilience and supporting self-identity within stressful systems.

New forms of support must take institutional dynamics into account: if the environment is unstable, support must be mobile, adaptable and accessible in various formats – from online consultations to group supervision. It is advisable to establish multidisciplinary mental health support teams that collaborate with management to identify areas of psychological risk and implement recovery-oriented practices. This could involve both the introduction of daily mindfulness micro-practices and the development of internal support protocols for crisis situations – protocols where healthcare professionals are not left to cope with trauma alone, but have guaranteed support from colleagues, mentors and qualified specialists. Thus, the transformation of psychological support mechanisms must take place not only at the level of individual programmes, but also through a systemic rethinking of the role of psychological well-being in healthcare management policy. Without this, no reform, no equipment, and no protocols will be able to ensure the full functioning of a system that relies on human resources – vulnerable, yet capable of regeneration, provided they are not ignored [10].

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Since 24 February 2022, the psychological landscape of the Ukrainian healthcare system has become extremely complex. Medical staff, particularly in frontline areas, are working in a state of constant operational mobilisation, where clinical care is intertwined with military logistics, life-threatening risks and unpredictability. Amid regular shelling, evacuations, unstable energy supplies and periodic shortages of medicines, doctors are forced to work with maximum concentration and minimal rest. The pattern of professional burnout, which until 2022 was largely driven by overwork, has now been compounded by a shift in the motivational framework. In the first months of the full-scale invasion, a phase of hyperactive altruism was observed: medical staff often volunteered for extra shifts, set up mobile clinics, and voluntarily accompanied the evacuation of patients. However, by early 2023, many were already showing signs of accumulated emotional exhaustion: according to the Centre for Public Health, 60% of healthcare workers are showing signs of chronic burnout, 25% require specialist psychological support, and over 30% have symptoms comparable to PTSD. The prevalence of sleep disorders among healthcare workers exceeded 80%, depressive symptoms 60%, and anxiety and concentration disorders over 50%. These findings were confirmed by studies conducted as part of a programme by the Ministry of Health in collaboration with international partners (WHO, 2023), which revealed a clear link between the duration of shifts in high-risk areas and an increase in symptom severity.

In the clinical structure of burnout in wartime conditions, a transformation can be observed not only at the motivational level but also at the cognitive level. Whereas until 2022 the main stressor was multitasking, it is now unpredictability and the lack of reflective stabilisation. The doctor is unable to conduct a post-event analysis of the clinical situation, as they immediately switch to a new source of risk. After treating injured civilians or military personnel, the medic is forced to switch to attending to families in a bomb shelter or the urgent evacuation of a premature infant without an incubator available. Such operational overload triggers the phenomenon of professional decongruence, where consciousness ceases to recognise the integrity of the professional mission, focusing solely on tactical responses. This deepens depersonalisation – the doctor loses contact not only with patients but also with themselves as a practitioner of a humanistic profession. Instead of satisfaction from helping, a neutral reaction or even alienation sets in, which is the mind's natural response to chronic danger. This phenomenon is exacerbated by the lack of access to qualified psychological support. As of mid-2024, according to data from the Mister-Blister platform, there are around 120 specialised centres for psycho-emotional support officially operating in Ukraine; however, the actual need is three times this number.

The number of requests for psychological help in Ukraine's healthcare sector rose from 8,000 in 2020 to over 40,000 in 2024, indicating an unprecedented increase in psychological strain. In particular, there has been a rise in requests for short-term crisis intervention, as most workers are unable to undergo full-scale psychotherapy due to their irregular schedules. In frontline regions, such as the Kharkiv, Donetsk and Zaporizhzhia regions, a telemedicine support model is in use, allowing consultations to be conducted online. However, with limited access to a stable internet connection, this model loses its effectiveness. That is why, from 2023, mobile teams of psychologists have been actively introduced, working on a rota basis alongside medical facilities, particularly in military hospitals and rehabilitation centres. These teams consist of a psychotherapist, a crisis psychologist and a support coordinator, enabling the rapid identification of PTSD symptoms and the implementation of stabilisation techniques even before clinical decompensation occurs. The brief-focus CBT method, adapted to the conditions of combat medicine and time constraints, has been found to be particularly effective. According to estimates by the PZMOZ clinical group, its effectiveness when working with medical personnel reaches 80% in the first three weeks following the traumatic event [11].

In the context of contemporary social and civilizational challenges, the issue of the successful professional integration of future medical professionals has become particularly relevant, as it is directly determined by the level of their psychological resilience. This resilience emerges as a complex, multi-component construct that integrates the emotional, volitional, motivational, and cognitive aspects of an individual's life. As substantiated in the study by O. Palamarchuk and I. Gaba , it is precisely this integral resource that ensures an individual's effective adaptation to conditions of high uncertainty, allowing them to maintain internal homeostasis, high performance, and constructive communication in a professional environment [12]. Through the lens of the conceptual model proposed by these authors, psychological resilience transforms into a powerful tool for professional development through a series of interrelated mechanisms. In particular, emotional stability serves as a fundamental factor in counteracting destructive psychological reactions, minimizing the risks of developing professional burnout syndrome or panic states in crisis clinical and organizational situations. At the same time, volitional tension ensures the ability to consciously maintain the chosen course of action and fulfill professional duties under the intense moral and

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psychological pressure inherent in medical practice. The motivational component, based on an internal orientation toward the profession's social mission, continuous self-improvement, and individual responsibility, supports long-term work capacity in a stressful environment. Finally, cognitive flexibility and analytical thinking determine the ability to quickly solve complex clinical problems and make informed decisions in the face of a lack of or conflicting relevant information.

Within the framework of higher medical education, this resilience functions not merely as a static safety margin, but rather as a dynamic platform for the development of a future physician's professional identity. During the learning process, students with a high level of psychological resilience find it significantly easier to manage distress during simulation sessions, clinical rotations, and direct interaction with patients; they demonstrate greater self-confidence, the ability for deep self-analysis, and constructive reflection. This, in turn, determines their integration as agents who proactively respond to environmental challenges rather than merely reacting to them. According to the research by O. Palamarchuk and I. Gaba (2024), the development of psychological resilience is closely correlated with the development of agency (subjectivity)—a conscious internal stance through which a professional does not merely reproduce a prescribed social role, but autonomously and meaningfully constructs their own professional mission and development trajectory [12]. In this way, resilience transforms from a purely individual psychological resource into a fundamental basis for self-determination in the professional sphere, upholding deontological norms, collegiality, and maintaining stable, long-term motivation.

From a practical standpoint, the empirical and theoretical findings obtained justify the need to modernize current educational and professional programs at medical higher education institutions. The emphasis must shift from the purely academic development of clinical competencies (hard skills) to the targeted development of students' psychological resilience and resistance. Effective implementation of this approach is possible through the systematic integration into the educational process of training in emotional self-regulation, psychological supervision practices, and reflective analysis, as well as through the incorporation of controlled, high-intensity stressors into simulation-based training. The implementation of this strategy will not only optimize graduates' readiness for initial adaptation in the workplace but also lay a solid foundation for their long-term personal and professional viability in a changing sociocultural context.

Given the scale of the traumatic stress, the duration of the war and the strain on the healthcare system's resources, we should expect to see symptoms becoming chronic among medical staff in the coming years. This requires not only an expansion of emergency care but also the strategic implementation of a policy of long-term psychological recovery, focused on preserving the specialist's core sense of self. Integrated support models that simultaneously take into account emotional, ethical, motivational and organisational components – with an emphasis on autonomy, flexibility and institutional accountability – could provide a solution. Without such solutions, even the most dedicated professionals face the threat of emotional breakdown, whilst the system itself faces the risk of losing human resources, the recovery of which will take not months, but years.

**Conclusions** Thus, the full range of contemporary challenges faced by medical staff – from pandemic-related overload to the existential strain of martial law – forms a new picture of psychological strain, in which the boundaries between clinical, moral and cognitive fatigue are blurring. Burnout is no longer a reaction to overload, but rather an integrated symptom complex of systemic destabilisation. Profound shifts are occurring within the professional structure: tolerance for uncertainty is declining, empathic engagement is diminishing, and motivation is shifting from a sense of vocation to the mechanical performance of duties. The psyche of healthcare professionals, constantly immersed in multifactorial stress, loses its ability to regenerate without external support. As evidenced by survey data and clinical monitoring, over 60% of Ukrainian healthcare professionals exhibit symptoms of chronic exhaustion, with one in four requiring specialised psychotherapeutic assistance. These circumstances necessitate a rethinking of organisational models towards the introduction of comprehensive psychological support systems – ones that are adaptive, mobile and integrated into daily routines. Without such a strategic shift, it will be impossible to maintain either the quality of care or the human resources upon which the entire healthcare system relies.

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