преподавателей и инструкторов предмета «Первая помощь» не может быть навязано организации, осуществляющей образовательную деятельность по дополнительному образованию, извне.

4. Подготовка преподавателей и инструкторов предмета «Первая помощь» должна быть практикоориетированной с полноценным симуляционным компонентом.

5. Подготовка преподавателей и инструкторов предмета «Первая помощь» является важным звеном системы безопасности, позволяет обеспечивать качественное обучение населения приёмам оказания первой помощи, а значит, и качественное оказание первой помощи пострадавшим и остро заболевшим людям до прибытия СМП.

Литература:

1. Авдеева в. Г. Организационно-функциональная модель типовой образовательно-методической системы службы медицины катастроф регионального уровня. 05.26.02. Безопасность в ЧС (медицина катастроф). М.: 2006. С. 325-329.

2. Авдеева В. Г. Опыт использования учебно-тренировочного оборудования при подготовке специалистов, работающих в условиях догоспитального периода, в Пермском крае / Первая Всероссийская конференция по симуляционному обучению в медицине критических состояний с международным участием 01.11.2012, Москва, НИИ СП им. Склифосовского Н. В. Сборник тезисов. М.: 2012. С. 3-7.

3. Авдеева В. Г. Технологии измерения уровня профессиональной готовности специалистов, работающих в системе СМК и СМП / Всероссийская научно-практическая конференция «Готовность Всероссийской СМК к реагированию и действиям при ЧС – важнейший фактор повышения качества и доступности медицинской помощи пострадавшим при авариях, катастрофах и стихийных бедствиях», Москва, 03.10.-04.10.2017. Материалы конференции. М.: ВЦМК «Защита», 2017. С. 12-16.

4. Авдеева В. Г. Исторические записки о первой помощи (факты, хронология, мнения, зарисовки, гипотезы). Пермь: Издательский дом «Ника», 2018. 238 с.

5. Авдеева В. Г. Симуляционные технологии измерения уровня профессиональных компетенций специалистов, работающих в системе службы медицины катастроф и скорой медицинской помощи. / Сборник материалов VII Международной научно-практической конференции «Наука как решение и антикризисная сила», Киев, 30.09.2020. – Киев: Центр научных публикаций «ВЕЛЕС», 2020. С. 155-157.

6. Нечаев Э. А., Фаршатов М. Н. Военная медицина и катастрофы мирного времени. М.: НИО «Квартет», 1994. 320 с.

7. Bloom, B. S., Engelhart, M., D., Furst, E.J, Hill, W. and Krathwohl, D. (1956) Taxonomy of educational objec tives. Volume I: The cognitive domain. New York: McKay. Электронный ресурс. – [Режим доступа]. http://www.sciepub.com/reference.

UDC 159.923

MODIFIED DETAILED INFANTILISM TEST – DIT-M

Israel (Vladimir Modestovich) Datskovsky, Ph.D
Cabinet of Clinical Psychology and Pathopsychology,
Beit Shemesh, Israel

Abstract. The introduction (the first part of the article) raises the general issue, the second part of the article presents brief data on the types of infantilism, the third part deals with the issues of general (nonspecific) signs of infantilism, the fourth part contains a DIT-M test (Modified Detailed Infantilism Test), the fifth part of the article sets out the mathematical apparatus for processing test results, the sixth part of the article is devoted to the use of the test and the diagnosis of the degrees of infantilism introduced in the article on the basis of the test results, the seventh part summarizes the results of the [insufficient number of] trial tests.

Keywords: infantilism, diagnostics, testing, degrees of infantilism, validity, reliability.

1. Introduction

In society, the number of infantile young and not very young people with behavior that does not correspond to their biological age is growing like an avalanche. They cannot live normally in a normal society, because they cannot (sometimes do not want) to take responsibility for themselves, and even more for others, even for the people closest to them, they cannot (or do not want) to make responsible decisions, cannot (or do not want to) be responsible for their actions, for their behavior. Acting a little emotionally, we can say that the tendency for the growth of a layer of such infantile people begins to threaten society, to destroy its social fabric. In such conditions, the relevance of timely diagnosis of the state of infantilism increases significantly, and such diagnostics will allow both to assess the scale of the problem and outline general, primarily social, public and educational ways of solving it in society, and in more detail than it is defined today, to provide individual assistance in solving, alleviating, sometimes treating this condition in specific people.

2. Types of infantilism

Let us start with the definitions. The term "infantilism" comes from the word "infant". From Wikipedia: Infant (Spanish: infante, Portuguese:

infanta) is the title and rank given to the sons and daughters of the king in Spain and Portugal. From the same source: Infantilism (Latin: infantilis) is an obsolete term for various disorders of human development, which consist of retention of the physical and/or psychological characteristics of early developmental stages into a relatively advanced age.

Usually, when assessing infantile thinking, infantile behavior, there are very few and general definitions of this mental phenomenon natural for a child, this mental state that ceases to be natural for older children, and even more for adolescents, young people and adults.

Sometimes scientists add about "childish behavior", about the naivety and passivity (however, passivity in children has been often very selective), about avoiding responsibility.

The importance of the problem is emphasized by Kirill Eliseev [K. Eliseev, 2013]: “The minds of millions of inhabitants (especially in the Western world) turned out to be conserved in the adolescent-child state, with adolescent-child interests, with outlooks on life and understanding (more precisely, misunderstanding) their place in the world.

In the United States, for example, the so-called kidults (abbreviated from English: kid and adult) have become a common phenomenon. Kidult is an adult with interests traditionally seen as suitable for children. The term "kidult" was first appeared in 1985 in The New York Times to describe men of 30 years and older who are passionate about cartoons, fantasy, computer games and useless, but nice and often expensive gadgets. In psychology, the term "Peter Pan Syndrome" is used to refer to this type of personality. Psychologists explain "The Peter Pan Syndrome" as a relatively mild, superficial form of escapism – the desire to escape from reality into a world of illusion".

Another assessment of infantilism is introduced (within the limits of their theory) by the followers of Sigmund Freud [Freud S., 2014], describing the infantilism of adults either as being stuck, fixed at a certain stage of development, overcoming the corresponding conflict in childhood, or as a type of individual defense called regression. Although sometimes this type of behavior is applied to an adult as normally developed and mentally healthy person in order to avoid responsibility.

Carl Gustav Jung [Jung C., 1997] disagrees with the first part of Freud's opinion, pointing out that such behavior in adulthood may indicate the consequences of effeminacy, negligence, passivity, greed, anger and other types of selfishness. But he also points to the possible dependence of a person with elements of infantilism in thinking and behavior.

But if such thinking and the corresponding behavior is natural for a child, the relatively constant preservation of these properties and/or their frequent use at older ages and, especially, in adulthood is a noticeable mental deviation, indicating an insufficient development of mental properties.

Although infantilism always manifests itself in the psychic sphere, its etiology, upon close examination, turns out to be much more complex. The root causes of infantilism may be not only mental disorders or CNS trauma. Emil Kraepelin [Kraepelin E., 2009] and a number of other psychiatrists (Mikhail Osipovich Gurevich [Gurevich M.O., 1932], Vasily Alekseevich Gilyarovsky [Gilyarovsky V.A., 1954], etc.) considered some variants of infantilism as an atypical form oligophrenia. Possible causes of infantilism in the literature are also called hereditary causes (drug addiction, alcoholism), causes acquired due to their own deviant behavior and problems of physical and somatic disorders (endocrine disorders, underdevelopment of certain organs and systems of the body, including organic brain disorders, etc.).

It can be assumed that the infantilism of thinking and behavior in the mental form of infantilism, although in some cases it may indicate a latent form of oligophrenia (mental retardation – the terms are close to each other, but are not complete synonyms) in its high part of the measured IQ (IQ 60-69), but more often it may indicate Minimal brain dysfunction (MBD) with an IQ of 70-85.

Actually, a number of ICD-10 headings correspond to infantilism: F89; F60.8; F07.8. A long series of works is devoted to the diagnosis and treatment of infantilism ([Makushkin E.V. et al., 2015] and other works).

3. Common signs of infantilism

Here are the most common signs of infantilism, which may lead us to the idea of the need for a deeper and more accurate diagnosis of this state. As a rule, children's infantilism is clearly noticeable as a clear lag in development and behavior behind the age norm. It is much more difficult to identify infantilism in adults, although many aspects of behavior raise questions about the discrepancy between natural expectations and presented behavior. Let us single out a number of common, often nonspecific features of "adult" infantilism based on the article ["What is infantilism", 2018]:

- ✓ egocentrism – everything should revolve around the infantile person, without efforts on his or her part;
- ✓ parasitic smugness – social position;
- ✓ performing actions without thinking about the consequences, but only focusing on his or her own needs;
- ✓ no purpose in life, except for his or her own comfort;
- ✓ no adequate self-awareness;
- ✓ no desire for self-knowledge and self-development;
- ✓ cannot solve problems, waiting for someone to solve for him or her, fear of responsibility;
- ✓ getting stuck in childhood experiences and resentments;
- ✓ the tendency to blame the whole world for his or her failures;
- ✓ no desire for development and new knowledge;
- ✓ inability to set goals and implement them;
- ✓ it is difficult to perceive someone's refusal to do something, infantiles believe that everyone owes them, and they owe nobody;

- ✓ strong affection for parents;
- ✓ in their work they tend to shift their responsibilities to others.

Childhood infantilism looks very different. For a typical characterization of an infantile child, we will use the characteristics of this state, drawn from the article ["Infantile child at school", 2018]. Here is a typical characteristic of an infantile child. The child's infantilism is manifested in the following features:

- ✓ the child's weak ability to subordinate his/her behavior to the requirements of the situation;
- ✓ inability to restrain his/her desires and emotions;
- ✓ childish spontaneity;
- ✓ the predominance of playing interests at school age;
- ✓ carelessness;
- ✓ elevated mood;
- ✓ underdeveloped sense of duty;
- ✓ inability to volitional tension and overcoming difficulties;
- ✓ increased imitation and suggestibility;
- ✓ relative weakness of abstract and logical thinking, verbal and semantic memory;
- ✓ lack of cognitive activity during learning;
- ✓ lack of school interests, lack of formation of the "role of the pupil", rapid satiety in any activity that requires active attention and intellectual tension;
- ✓ the desire to be in the company of young children or those who patronize them;
- ✓ insufficient differentiation of interpersonal relations;
- ✓ slower assimilation of the skills and knowledge about the surrounding world.

Nonetheless, it should be noted that the cited both adult and childhood signs of infantilism describe the picture of social and educational infantilism to a greater extent and correspond much weaker to the picture of mental infantilism that is much more difficult to diagnose and correct.

As an important source on the diagnosis and treatment of child mental infantilism, let us note the work of the group of psychiatrists of The Serbsky State Scientific Center for Social and Forensic Psychiatry [Makushkin E.V. et al., 2015], however, the use of the recommendations of this work requires a sufficiently high level of special (professional) knowledge of a psychiatrist or pathopsychologist.

4. The proposed DIT-M (Modified Detailed Infantilism Test)

To identify infantile behavior, first of all, of adolescents, we tried to identify and list a much larger number of symptoms of such behavior than mentioned in various sources, but we gave preference to those of them that are easier to detect by external long-term observation. To assess infantilism, we propose a test, consisting of 69 questions, divided into four scales unequal in the number of questions and in importance:

A. scale of thinking – 31 questions; scale weight – 1.3;

B. scale of information gathering, planning and decision making – 19 questions; scale weight – 1.0;

C. scale of activity – 12 questions; scale weight – 0.8;

D. auxiliary scale of symptoms of psychasthenia – 7 questions; scale weight – 0,6.

A. Scale of thinking

No.	Description of the symptom	The symptom characterizes a person – 4 points	The symptom is noticeably expressed – 3 points	The symptom is moderately expressed – 2 points	The symptom is poorly expressed – 1 point	The symptom is absent – 0 points
A-1	Marked egocentrism (typically attributed to early childhood stages of mental development)					
A-2	Personal responsibility for decision-making, for the results of their own actions or for actions dictated by others is not perceived or reduced					
A-3	A noticeable hope for "this time, perhaps, the danger will over"					
A-4	Even with minor problems (for example, medical), they require increased and unremitting attention from others and immediate attention to this problem					
A-5	Frequent change of opinion about phenomena and events under the influence of mood at the moment or under the influence of factors and events not related to the discussed phenomena and events.					
A-6	Unpredictable decisions and behavior					

A-7	No distinction is made between objective cognition of reality and subjective ideas, or the perception and awareness of such differences is weakened.					
A-8	During discussions, they try passively and uncritically to adhere to the emerging majority or to the opinion of the leaders					
A-9	The absence of questions to clarify initially incomprehensible things and to plan the necessary actions to achieve the set goals. Lack of awareness that a number of things remained unclear					
A-10	Weakened curiosity in general and even to the questions that are important for the inevitable or planned future (both near and more distant)					
A-11	They do not check the consistency of instructions that must be followed, does not try to understand the meaning behind their compilation, does not think about the mathematical apparatus or physical principles behind computer programs or devices that must be used					
A-12	Fear of delving into issues and topics that, at least potentially, may require a significant investment of time or effort to clarify them					
A-13	Overestimated self-esteem in their ability to solve a particular problem, in real planning, in their ability to implement the planned					
A-14	Overestimated self-esteem of the correctness of their understanding of events and phenomena, hence the lack of the need to deepen their knowledge in these areas, to consult with someone and disregard for incoming other views or advice.					
A-15	Low self-criticism and low objectivity in assessing their behavior and decisions					
A-16	Underestimating the real properties of partners and other people around them					
A-17	Uncritical trust in information, advice and guidance received, primarily, from adults					
A-18	Interests that do not correspond to biological age (corresponding to younger ages)					
A-19	Maintaining interest in games (computer, gambling, monotonous) at an age outside irresponsible periods of life					
A-20	Little sympathy for other people, relative indifference to others,					

	especially to those who are not part of the first close social circle with general sympathy for "the whole world."					
A-21	There are few fantasies (or they are primitively simple, often vulgar) and complex mental constructions, arbitrary analogies. Lack of original ideas. The presence of situational role-playing fantasies, an idea of themselves, achieving brilliant success in the future.					
A-22	Experiencing real events is often replaced by confabulations (made up memories).					
A-23	The difficulty of finding the common properties of fairly distant objects and phenomena.					
A-24	The difficulty of making analogies					
A-25	Difficulties in generalizing					
A-26	General learning difficulties, difficulties and slowness of perception of new information and difficulties of its use					
A-27	Difficulties in solving non-standard tasks and orientation in a non-standard setting or situation					
A-28	They prefer stories and books that do not imply the complexity of feelings and difficult moral experiences.					
A-29	When others try to direct such a person to the necessary actions or at least to collect information, they respond with a dysphoric reaction ("... a combination of affective disorders of the hyposthenic (melancholy, anxiety, fear) and hypersthenic (anger, wrath) poles... A paroxysmal course is characteristic" – [Pervyy V.S. et al. 2013, p. 214, article "Dysphoria"].					
A-30	Emphasized individualism and independence even when loved ones offer disinterested help, which often masked with the lack of development of the correct responses to help and because of the fear (unwillingness) to take on moral obligations in connection with receiving help.					
A-31	Ease of falling into depression during life failures					
The amount of points on columns						
Total Scale A						

B. Scale of information gathering, planning and decision-making

No.	Description of the symptom	The symptom is pronounced –	The symptom is noticeably	The symptom is poorly	The symptom is absent – 0 points

		3 points	expressed – 2 points	expressed – 1 point	
B-1	Initial ideas, emotions and momentary desires have a great influence on decisions and plans.				
B-2	Not all factors affecting the situation are taken into account in the analysis of the situation.				
B-3	In the analysis of the interaction of factors already taken into account, not all connections and interactions between factors are considered.				
B-4	A simplified and abbreviated analysis of factors already adopted for the analysis and their interrelationships is used.				
B-5	Those factors and their connections that correspond to the initial setting or momentary emotional state acquire an unjustifiably overestimated influence on the final decision or conclusions, and factors and their connections that contradict the initial setting or momentary emotional state receive an unjustifiably underestimated influence on the final decision or conclusions.				
B-6	Weak and incomplete consideration of previous experience, both of their own and that of others				
B-7	Disdainful attitude to advice on the principle "we ourselves know everything better than you" even in situations of lack of experience and knowledge in the issue under consideration. Inability to choose what is useful for themselves from advices of others				
B-8	Planning for the future is represented by fantasies and vague plans without regard for reality				
B-9	Incompatible links are combined both in planning and in assessing the situation				
B-10	Arbitrary rejection of factors and arguments that can lead to conclusions that do not correspond or even contradict the initial attitude or momentary emotional state				
B-11	Incomplete plans, an abundance of omissions in planning				
B-12	Significant errors in planning the time required to perform certain actions				
B-13	Errors in the necessary sequence and interdependence of the elements of the plan				
B-14	Constant or frequent attempts not to make decisions, to postpone decisions, "I decided not to decide yet"				
B-15	Uncertainty in their abilities, difficulties in initiating new, especially long-term actions, fear of "crossing the Rubicon"				
B-16	Postponing the start of new, not quite standard and usual things "on the back burner"				
B-17	Difficulties in gathering information for a good willingness even to the inevitable case in the near future				
B-18	They often postpone "until tomorrow" non-routine and familiar things, even small and clearly feasible				
B-19	Long anticipation and pondering of constantly postponed things, not included in the routine and habit.				
The amount of points on columns					
Total Scale B					

C. Scale of activity

No.	Description of the symptom	The symptom is pronounced –	The symptom is noticeably	The symptom is poorly	The symptom is absent –

		3 points	expressed – 2 points	expressed – 1 point	0 points
C-1	They live from day to day in many respects, find it difficult to plan in the long run.				
C-2	They strictly follow the given, even not very logical instructions and understandable, feasible requirements.				
C-3	They prefer unvaried, monotonous, well-mastered activities				
C-4	They avoid assuming leadership of anything (people or actions) because of unwillingness to be responsible for the results of even their own actions, and even more for the activities of people.				
C-5	Avoiding risk as much as possible				
C-6	They often do not see the existing (or impending) danger				
C-7	They do not feel or have weakened sense of danger from other people				
C-8	In collective actions, they try to choose more passive and lighter parts of the common work				
C-9	It is difficult for them to build interpersonal relationships, not only for mutually beneficial activities, but even in the case of the possibility of obtaining personal gain				
C-10	The sense of the situation is weakened, they do not notice changes in the situation or the moral atmosphere in the team when discussing or performing actions				
C-11	Rigidity, inflexibility of thinking under changing circumstances, when new information appears				
C-12	Starting a new work with enthusiasm, but making sure that it requires significant mental or physical (not monotonous) efforts and costs, or even requires overcoming obstacles, they leave the work unfinished				
The amount of points on columns					
Total Scale C					

D. Auxiliary scale of symptoms of psychasthenia

No.	Description of the symptom	The symptom is clearly present – 2 points	The symptom is partially present – 1 point	The symptom is absent – 0 points
D-1	Tendency to doubts and anxious doubts [Gannushkin PB, 1933]			
D-2	Initial (basal) anxiety			
D-3	General passivity			
D-4	Defensivity (from Latin *defensio* – to defend, to protect) – a person's tendency to take an avoidant or passive-defensive position when faced with life difficulties.			
D-5	They periodically get stuck in one or another emotional state (emotional viscosity, inertia, stiffness, lethargy)			
D-6	Wounded pride			
D-7	Feeling of inferiority			
The amount of points on columns				
Total Scale D				

5. Mathematical processing of test results

The test consists of 69 questions in total. We propose the following formula for the transition from "raw" points to the final result:

$$FR = 1{,}3 * 0{,}25 * A + 1{,}0 * 0{,}333 * B + 0{,}8 * 0{,}333 * C + 0{,}6 * 0.5 * D$$

where:

- FR is the final result;
- the first multiplier in each member of sum is the scale importance coefficient;
- the second multiplier in each member of sum is the coefficient for bringing the sum of "raw" points on this scale to a single value of the number of points (as if the maximum score for each question in each scale is 1.0);
- the third multiplier in each member of sum is the sum of "raw" points on this scale.

Accordingly, the maximum test result can theoretically reach 73.1 final points.

6. Use of the DIT-M test

Initially, it is clear that some of these symptoms are also included in the clinical finding of obvious oligophrenia or other types of developmental delay, and a differentiated approach to the diagnosis of these conditions is required. Oligophrenia and mental retardation are diagnosed with slightly different tests.

It should be noted that the main feature of the test (in contrast to many types of known and used tests and questionnaires) is the impossibility of objectively filling out the test neither by the subject himself/herself or by a person observing the subject for a short time, for example, during a psychological/mental examination. Only a fairly objective person who observes the patient for a long time in numerous situations and possesses a certain level of special knowledge can fill out the above questionnaire and, moreover, draw conclusions according to it (the teacher must fill it out the most often, and the psychologist (clinical psychologist, pathopsychologist) or a psychiatrist should draw diagnostic conclusions).

The very fact of filling in the test by an expert is no exception. Other existing and widely used expert tests in pathopsychology include the Montgomery-Asberg Depression Rating Scale (MADRS), the Informant Questionnaire of Cognitive Decline in the Elderly (IQCODE), the Vineland Adaptive Behavior Scale (VABS) (S. Sparrow. D. Balla & D. Cicchetti. Vineland Adaptive Behavior Scales American Guidance Service, 1984) and others.

It is rare that parents have the necessary level of objectivity in assessing their child and the necessary understanding of the meaning of this test. Because of this, it is difficult for a psychologist to fill out such a questionnaire, for example, according to the stories and assessments of parents during their very brief observations of the child, with a few situations, only in the multiplicity of which an expert could see certain signs of infantilism or, conversely, signs of its absence. The proposed test is an expert test (a test filled by an expert), and therefore it does not include the usual scales of lie and reliability when the subjects themselves fill in the test or questionnaire.

In addition, for the indicated reasons, we did not combine the scales into a single list of questions mixed with different scales, which are separated only when processed with keys containing the numbers of questions related to a particular scale. On the contrary, we found it useful to explicitly separate the scales in order to enable the examiner to better focus on the features of a particular scale.

It can be added that the more complex and important this scale is in the overall assessment of the subject, the more differentiated assessment of the state is provided in it. Thus, the most significant scale A is equipped with five grades of assessment, and the last one, scale D, in terms of its weight in the overall assessment of the state of the subject – only with three.

It is clear that most patients (tested by the method of filling out the test by an expert) will almost never have all the listed symptoms.

The abundance of the proposed parameters allows for a more differentiated diagnosis than simply establishing the presence or absence of the fact of infantilism. We believe that it is possible to propose the following assessment boundaries based on the points obtained with a pronounced symptom (scale A – 3 points for a symptom, other scales – 2 points). Then the real maximum score for assessing infantilism will be following:

$$1{,}3 * 31 * 3 * 0{,}25 + 1{,}0 * 19 * 2 * 0{,}333 + 0{,}8 * 12 * 2 * 0{,}333 + 0{,}6 * 7 * 2 * 0{,}5 = 55{,}1 \text{ points}$$

It is quite accepted for diagnosing a state (in this case, infantilism) to take 75% of the maximum score. In our case, this will amount be 41 points. Then the diagnostic scale can be represented as follows:

Absence of signs of infantilism – 18 or fewer points (33% or less of the accepted maximum);

Borderline state – 19-26 points (the width of the diagnostic zone is 8 points);

Infantilism of the I degree (the mildest degree) – 27-33 points (the width of the diagnostic zone is 7 points);

Infantilism of the II degree (medium degree) – 34-40 points (the width of the diagnostic zone is 7 points);

Infantilism of the III degree (a very vivid expression of infantilism) – 41 or more points.

7. Conducting the DIT-M test. Its further use

The DIT-M test was conducted on a very small, unrepresentative group of adolescents. The group consisted of 42 subjects from four grades – two fourth and two sixth grades. The tests were filled in, respectively, by four class teachers (9-12 pupils from each class). These tests showed quite high both the validity and reliability of the test, checked with the characteristics given by the teachers to the tested pupils before the teachers filled out the tests. The tests can by no means be considered complete due to the smallness of the group involved in these tests. Therefore, the first task in promoting the DIT-M test and its use is to continue its use in a trial, verification mode with a comparison of the diagnostic results when using the

DIT-M test with expert opinions on the state and level of infantilism according to this test.

It should be also noted that when conducting the test, we were faced with a noticeable number of cases when the main feature that sticks out in all other classifications of signs of infantilism – egocentrism – was not only the leading characteristic of the subject, but sometimes was not even a noticeable characteristic of a person. In these cases, the diagnosis of infantilism rather followed from insufficient ability to analyze the situation and insufficient decision-making capabilities of the subjects with good learning indicators, which rather confirms the view of researchers that infantilism more often than we might assume follows from a latent form of oligophrenia or from the diagnosis of MCD.

References:

1. Gannushkin P. B. Clinic of Psychopathies, Their Statics, Dynamics, Systematics. Moscow, Sever Publ., 1933.

2. Gilyarovsky V.A. Psychiatry. Moscow, Medgiz Publ., 1954.

3. Gurevich M.O. Psychopathology of Childhood. Moscow, Gosmedizdat Publ., 1932.

4. Eliseev K. Infantilism: The Path to Childhood or The Path to the Grave. 23.06.2013. Available at: https://eot-leningrad.livejournal.com/9354.html.

5. Freud S. Essays on the Psychology of Sexuality. Moscow, Azbuka Publ, 2014.

6. Infantile child at school. Available at: http://shishkinily.narod.ru/infant.html.

7. Jung C. Conflicts of the Child's Soul. Moscow, KANON + Publ., 1997.

8. Kraepelin E. Introduction to a Psychiatric Clinic. Moscow, Binom. Laboratory of knowledge Publ., 2009.

9. Makushkin E.V. et al. Clinical Guidelines for the Diagnosis and Treatment of Infantilism in Minors. Moscow, 2015. Available at: https://psychiatr.ru/download/2247?view=1&name=KlinRek2.pdf.

10. Pervyy V.S. et al. Psychiatric Dictionary. Rostov-on-Don, Feniks Publ., 2013.

11. What is Infantilism – Signs, Types, What is Infantilism in Men, Women? Available at: http://kak-bog.ru/chto-takoe-infantilnost-priznaki-vidy-chto-takoe-infantilizm-u-muzhchin-zhenshchin.

УДК 614.2
ГРНТИ 76.75.75

ДИНАМИКА ПОКАЗАТЕЛЕЙ СМЕРТНОСТИ ОТ ТУБЕРКУЛЕЗА И ВИЧ-ИНФЕКЦИИ В РОССИИ В НАЧАЛЕ XXI ВЕКА

Цыбикова Эржени Батожаргаловна
Федеральное государственное бюджетное учреждение «Центральный научно-исследовательский институт организации и информатизации здравоохранения» Минздрава России

UDK 614.2
GRNTI 76.75.75

Аннотация

Заголовок статьи: Динамика показателей смертности от туберкулеза и ВИЧ-инфекции в России в начале XXI века

Ф.И.О. автора: Цыбикова Эржени Батожаргаловна

Название организации и адрес: Федеральное государственное бюджетное учреждение «Центральный научно-исследовательский институт организации и информатизации здравоохранения» Минздрава России, 127254, Москва, улица Добролюбова, дом11.

Резюме: в России в начале XXI века (2006-2018 гг.) наблюдается стабильное снижение смертности от туберкулеза, значение которой в 2018 г. достигло 5,3 на 100 тыс. населения. При этом средние значения уровня смертности от туберкулеза сместились в сторону старших возрастных групп населения, достигая максимальных значений в группе 45 лет и старше. Смертность от ВИЧ-инфекции, напротив, за этот же период времени возросла в 8 раз - с 1,6 до 13,0 на 100 тыс. населения, с ее максимальной концентрацией в молодых возрастных группах 35-44 года. В результате, в России в начале XXI века смертность от ВИЧ-инфекции в молодых возрастных группах населения заняла лидирующее положение в структуре смертности от инфекционных болезней, вытеснив при этом смертность от туберкулеза. Значительный рост смертности от ВИЧ-инфекции в России был обусловлен широким распространением туберкулеза среди пациентов с ВИЧ-инфекцией и ростом среди них числа смертельных исходов.

Abstract

Article title: Dynamics of mortality rates from Tuberculosis and HIV infection in Russia at the beginning of the XXI century.

Author: Tsybikova Erzheny Batozhargalovna

Organization name and address: Federal Research Institute for Health Organization and Informatics of Ministry of Health of the Russian Federation

Summary: in Russia, at the beginning of XXI century (2006-2018) there is a steady decline in mortality from tuberculosis, which in 2018 was 5.3 per 100,000 of population. At the same time, the average values of the