Chapter 4 – PREVENTION OF SUICIDE AND STRESS DISORDERS IN EMERGENCY SITUATIONS

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(Mr. Nichiporenko gave the talk for Mr. Shamrey.) The topic of interest is stress disorder problems, PTSD. There is still a lot of controversy surrounding several issues (e.g., structure, dynamics of acute implications). People debate "Who should be saved?" "What's the priority?" "What approach should be used?" "Who should receive aid?" A number of departments are involved, primarily the Ministries of Health and of Defence. Specialists have their own opinions and the differences in opinion are a liability.

As far as PTSD statistics, according to Susan Solomon, 5 – 12 % of civilians have it, 30% of the military and 50 – 80 % of first responders. The prevalence of PTSD in combatants is 20 – 25 %. All of this is a result of changes in the world. The World Health Organization (WHO) has identified social stress factors. These include: unfavourable life situation(s), poverty, social deprivation, high violence, wars and civil unrest. People with PTSD have a high tendency to commit suicide; that is people suffering from PTSD comprise a large percent of the suicidal population. The rate of suicides is 14.5 per 100,000 worldwide, 24 in Russia and 30 in China. The rate of suicides is also high in Europe (Lithuania and Estonia versus Finland). The World Health Organization has predicted that 1 out of 5 million people will commit suicide, but the total numbers are actually higher by 10 – 20 times. There is one death by suicide every 20 seconds, with an attempt every 10 seconds. Much of this is the result of dealing with post traumatic stress disorder. Some say the high incidence of post traumatic stress disorder is due to combat or childhood disorders, survivor guilt or childhood trauma.

Anxiety and depression as well as addiction to drugs and/or alcohol are the direct result of suicidal tendencies. Mobilization is the first phase necessary to save victims. Acute problems, like the loss of property or income, lack of finances or housing can cause suicidal behaviours to increase. The main principles of providing psychiatric aid apply here – reinforcing the need for continuity of aid and provision of aid to rescue personnel and victims. Interoperability of different departments is important, but it is often difficult to achieve cohesion due to personality differences in commanders. Immediate aid, including psychological aid, should be efficient, minimal in scope and tailored to the emergency, followed by evacuation and specialized aid in hospitals. An emergency is seemingly over after the victims are evacuated, but this is not true. Both medical and social/psychological assistance needs to be provided. Mass media efforts are important and public awareness is needed. In emergencies, mass media can cause panic, etc. Mass media is also important in the way that ex-combatants are portrayed. Often images of ex-combatants are not presented or framed positively. Also treatment of ex-combatants has been inconsistent; for example, bonuses were declared for ex-combatants, but they were only granted once; there was no follow-through. After that the ex-combatant was expected to be a "regular" citizen but the transition to civilian life was not always so smooth.

The Ministry of Defence doesn't have much to do with retirees, but other (civilian) agencies don't take enough responsibility, resulting in increased incidence of psychological trauma and apathy. This is also true for those serving on nuclear submarines. Those who serve should be carefully selected and prepared and given psychological training, including training to build resilience. The training and resilience level of "saviours" is important – if they know what to do, there is no true emergency and their health should not be affected. The terms of training for their adaptation (to stressful situations/environments) should be increased. In the long term, servicemen should get high-level professional training that approximates closely the conditions they'll be facing (e.g., the servicemen trained in Tashkent prior to deploying to Afghanistan). They should be confident that they would get prompt medical care, even in the case of psychological trauma. Rotation of servicemen is important for dealing with trauma, stress – they must come back home from time to time.

Optimism is a very important factor. One issue is the scale of implementation of individual resources to deal with the problem. If an individual has internal resources and good communication skills, they will have a positive experience in critical situations. It is critical to detect those (through screening or by intervening when military members speak about suicide) prone to suicidal behaviour, considering all influences including the media and the environment. Sometimes through attempts to treat grief, we can find the groups of people who are at risk. When an individual attempts suicide, we give him acute care and then tend to ignore him in the long run. In the West, the prevailing wisdom is that they should follow that person to detect individuals prone to suicide – a good idea. In the Army, the number of suicides is lower, but the situation is worse because suicide is a tragedy for the family.

Indirect preventive measures should be used as well. There must be agencies responsible for the psychological health of military forces, to include those that will provide special psychological support before enlistment as well as during operations. The commander of each unit should have responsibility for the psychological health of all their servicemen (using direct measures such as suicides and talking about suicide). Suicide is complicated. Some believe they can't prevent suicide, but it is possible to work with those at risk – those with psychological versus psychiatric problems. Suicide is often a reaction to situational stress and not a product of a psychological disorder. We cannot always identify suicide-prone psychological profiles and intellectual capacity is not a shield from it. Durkheim said that any subjectively perceived event can trigger the idea to commit suicide. There is not a neat set of specific features that help identify a situation that would lead to suicide or identify people prone to suicide.

4.1 DISCUSSION

How do you make a diagnosis of post traumatic stress disorder? We have a definite understanding of stress disorders, of PTSD. Some people think that during a mission a person can get schizophrenia, but that is a difficult thing to determine.

(Tarabrina) We find two kinds of diagnoses. When we compare the results here with result obtained outside Russia, we find that they use different criteria but those clinical practitioners don't deal with these cases as frequently. These diagnoses are rare. There is some data recently published from a cross-cultural study on PTSD that was completed in accordance with PTSD standards. We studied Afghanistan veterans. They are consistent with results from a US study. We have 18% in Afghanistan with PTSD – the number in other places is higher (20 – 25 %). We cannot always identify specific PTSD symptoms or determine definitively whether a person has PTSD.