

INTRODUCTION TO DISASTER (Hagan et al., 2005)

In the course of training in Psychological First Aid (PFA), terms such as disaster, traumatic event, catastrophe, or even terrorism may at times be used interchangeably. As a starting point, it is important to define what it is we mean when speaking of a disaster. As well, an overview of some of the reactions to disaster may prove useful.

A disaster is defined as “a calamitous event that generally involves injury or loss of life and destruction of property; disasters can affect both small and large populations” (American Academy of Pediatrics, 1995). These events are traumatic in nature, outside the scope of normal human experience (i.e., not an “everyday matter”), and are likely to involve psychological as well as physical injury. Disasters can be natural in origin (e.g., ice storm) human-caused (e.g., Bhopal), or an interaction between the two (e.g., Titanic). In an extreme form, disaster may involve the direct attempts to kill or maim others, such as seen in war or terrorism.

Reactions to Disaster

There is much talk in the media about post-traumatic stress disorder (PTSD) following a disaster, but with little understanding of what this really refers to, and whether such a reaction is normal or not.

The DSM-IV, the principal diagnostic manual used by North American psychiatrists and psychologists, refers to two related disorders that can occur in the wake of a traumatic event. Adults or children can both be diagnosed with these disorders. **Please note, that you are neither expected nor qualified to make these diagnoses. Quite the contrary – it is essential that survivors’ reactions not be pathologized. Rather, the intent is to familiarize you with some of the possible reactions that PFA looks to mitigate, and explain some of the terminology that gets used.**

Acute Stress Disorder (308.3). ASD Diagnostic Criteria:

A. The person has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) the person’s response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

- (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
- (2) a reduction in awareness of his or her surroundings (e.g., “being in a daze”)
- (3) derealization (i.e., a sense that the experience is not real)
- (4) depersonalization (e.g., feeling that you’re watching from outside your body)
- (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience of distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, or impairs the individual’s ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug, a medication) or a general condition.

Post-traumatic Stress Disorder (309.81). PTSD Diagnostic Criteria:

A. The person has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) the person’s response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behaviour

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in themes or aspects of the trauma are expressed
- (2) recurrent distressing dreams of the event. **Note:** In children there may be frightening dreams without recognizable content
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated. **Note:** In young children, trauma-specific re-enactment may occur
- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect (e.g., unable to have loving feelings)
- (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In contrast to the diagnoses of ASD and PTSD, as providers of PFA, you should be prepared to recognize a wide range of emotional or physical reactions that occur in the wake of a disaster. While they may present as quite unusual, it is essential that they be recognized as “**normal reactions to an abnormal situation.**” The following table (Fasshauer, 2004) provides a useful breakdown of such reactions.

<u>Emotional</u>	<u>Cognitive</u>	<u>Behavioural</u>	<u>Physical</u>	<u>Spiritual</u>
Fear Anxiety Depression, sadness Feeling hopeless or helpless Feeling numb Irritability Extreme emotional responses Anger Guilt Denial Agitation Overwhelmed	Confusion Difficulty concentrating and making decisions Memory Problems Shortened attention span Overly critical Preoccupied with the event Inability to recall all or part of event Overly sensitive Flashbacks Hypervigilance	Social withdrawal Silence Suspiciousness Emotional outbursts Changes from typical behaviour Avoiding thoughts and feelings related to event Difficulty talking or writing Changes in sexual functioning Loss or increase of appetite Feeling uncoordinated	1000 yard stare Nausea/diarrhea Shallow breathing Dizziness/faintness Chills/sweating Easily startled Fatigue Changes in appetite Sleep disturbances/nightmares Headaches Grinding teeth Inability to rest	Emptiness Loss of meaning Doubt Feeling unforgiving Martyrdom/being punished Looking for magic Loss of direction Cynicism Apathy Needing to prove self Alienation Mistrust

These same five headings serve as a backdrop for coping strategies that can be suggested to those experiencing such disturbances. The following are some alternatives that have found to be helpful.

<u>Emotional</u>	<u>Cognitive</u>	<u>Behavioural</u>	<u>Physical</u>	<u>Spiritual</u>
Moderation Permission to feel what is being felt It's okay to ask for help Label what you're experiencing Be assertive when needed Keep communication open with others Remember you have options Sense of humour Find a vent-partner Support Group	Moderation Write things down Make small, daily decisions It's okay to ask for help Plan for the future Get the most info you can to help make decisions Anticipate needs Plan “B” Remember you have options Review previous successful problem-solving	Moderation Spend time by yourself Limit demands on time and energy Help others with tasks It's okay to ask for help Do activities that were previously enjoyable Maintain a routine Find new hobbies Remember you have options Set goals	Moderation See your doctor Moderate exercise Routine sleep patterns Minimize caffeine It's okay to ask for help Eat well-balanced and regular meals Drink water Avoid alcohol Remember you have options Take mini-breaks	Moderation Consult spiritual leader or others Meditation It's okay to ask for help Practice the rituals of you beliefs Prayer Spiritual retreat Remember you have options Find spiritual support Visit other churches/mosques/synagogues

		Have a plan Relax		Read spiritual literature
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Note: The recognition and labelling of the above reactions as normal rather than abnormal, is a key element of the educational component of PFA. However, there are some reactions that cannot be normalized, and require immediate referral to a mental health supervisor. Extreme dissociation or psychotic thinking in which the individual is out of touch with reality requires immediate attention. Also, thoughts of suicide, homicide, or physically aggressive acting out (in adults – physical acting out is not so unusual in young children) also require the immediate referral for follow-up by a mental health professional. Those with a history of substance abuse, or who present in the aftermath as intoxicated, should also be the subject of at least some consultation with a supervising clinician. Finally, we will require that you use your judgment throughout your involvement with PFA, and if you have a question or a concern, or just a strange feeling in your gut that you can't ignore, please bring it forward and consult with someone. Far better to be over-inclusive when it comes to presenting your concerns, than to omit someone in need of additional help.