Psychological Responses and Treatment Following Disasters

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What is the Problem?

Most people exposed to disasters recover fully from any psychological effects within a few months to a year

50% -65% experience subclinical reactions that interfere with quality of life

10-35% may require more intensive services

Many do not self-identify as needing services

Many will never seek formal help, or not until much time has passed

Community capacity is often stretched

Funding is transient

Common Reactions

- In the immediate aftermath, it's normal to experience intense stress reactions
  - Intense or unpredictable feelings, or restricted emotions/numbing
    - Shock, fear, anxiety, grief, survivor's guilt etc.
  - Sensitivity to environmental factors
  - Changes to thoughts and behavior patterns
  - Strained relationships
- Natural Recovery process
  - Psychological debriefing/critical incident stress debriefing
    - Ample evidence this can cause more harm than good
    - Overrides/impairs natural recovery process and risks retraumatizing

Common Reactions: Behaviors

- Social withdrawal
- Increased:
  - Conflict, hostility and anger
  - Prevalence of child and spousal abuse
  - Use of alcohol, drugs, or cigarettes
  - Concentration problems
- Avoidance behaviors
  - Avoidance of own thoughts and feelings
  - Avoidance of places/reminders

Slide credit: National Center for PTSD

Common Reactions: Health Problems

- Injuries from the disaster
- Worsening of pre-existing health problems
- Sleep disruption
- Increased somatic complaints
  - Headaches, nausea, chest pain, muscle tension

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Common Reactions: Changed Perceptions

- Loss of positive beliefs about the world
- Decrease in optimism
- Decline in perceived level of social support
- Decline in self-efficacy and perceived control
- Increase in feelings of vulnerability

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Immediate Reactions

There are a wide variety of positive and negative reactions that survivors can experience during and immediately after a disaster. These include:

Domain	Negative Responses	Positive Responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numb, irritability, guilt and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviors
Physiological	Fatigue, headache, muscle tension, stomachache, increased heart rate, exaggerated startle response, difficulties sleeping	Alertness, readiness to respond, increased energy

Common negative reactions that may continue include:

- Intrusive reactions
- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again ("flashback")

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event (places and people connected to what happened)
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Impact: Toddlers (1-3 years)

- Take cues from parents
- Expectable reactions to stress:
  - Tantrums
  - Irritability
  - Sadness

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Impact: Preschool Age Children

- Take cues from parents

- Expectable reactions to stress:
  - Confusion, surprise, guilt
  - Disruptive behaviors/tantrums
  - Regressive behaviors
  - Change is stressful

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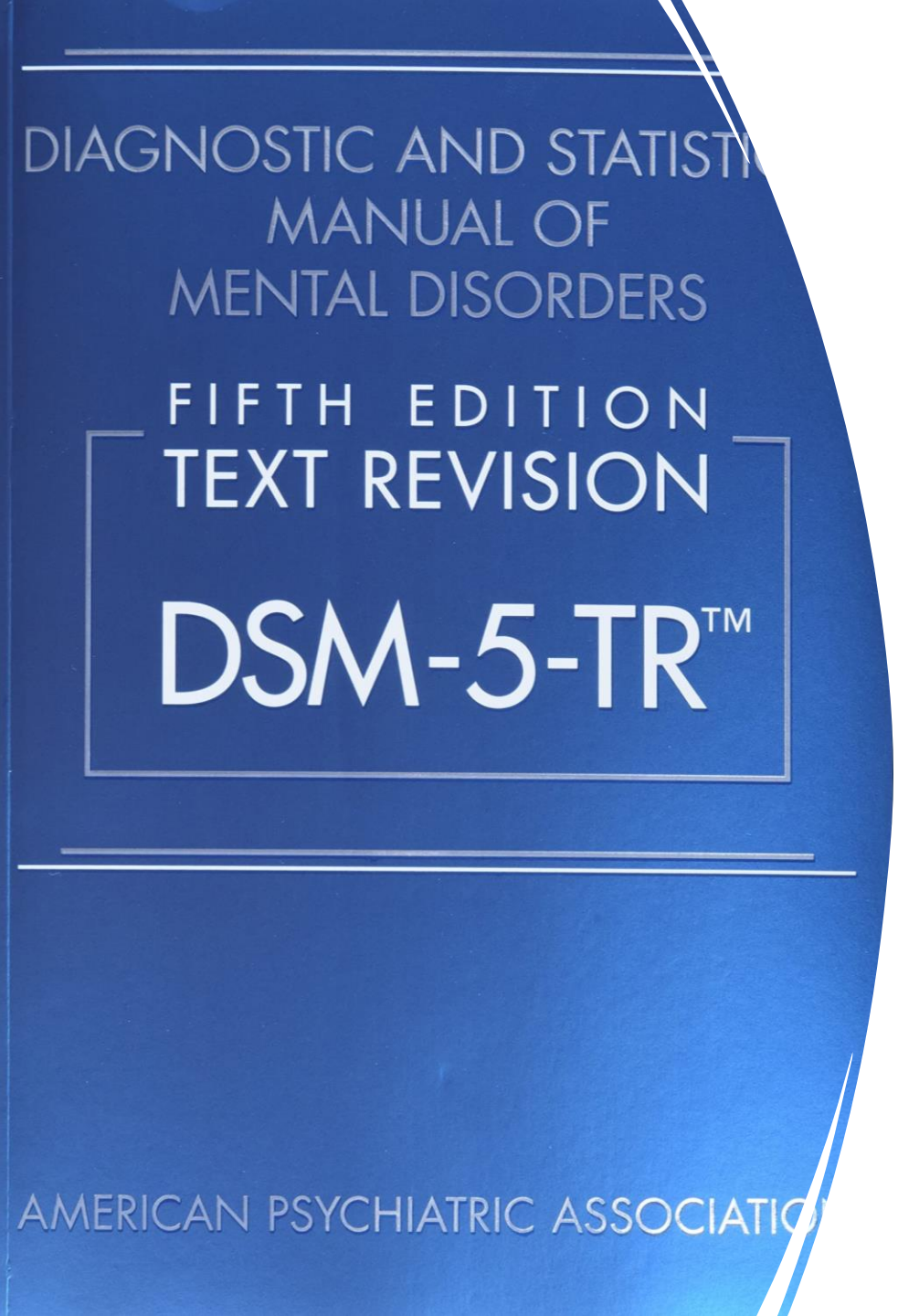
Impact: School Aged Children

- Sadness, anger, separation anxiety, guilt, loneliness
- Feeling responsible
- Behavior problems
- Somatic complaints
- Attention seeking

Impact: Adolescents

- Feeling of foreshortened future, anger, denial
- Growing older = growing awareness of danger
- Taking on “parental roles”
- “I don’t care”
- Risky behaviors
- Focus on peers

Image Credit: National Center for PTSD



Common Reactions: Diagnoses

- Acute Stress Disorder
- Adjustment Disorder
- Depression
- Complicated/Traumatic Bereavement
- Generalized Anxiety Disorder
- Panic Disorder
- Post-Traumatic Stress Disorder
- Substance Abuse/Misuse

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What contributes to risk?

- **Trauma and Stress**
- High exposure to disaster
- Type of disaster
- Community highly disrupted
- High secondary stress
- Perception of health risk

- **Survivor Characteristics**
- Female
- Mid age, child, or fragile elder
- Little experience
- Neuroticism
- Ethnic minority
- Socioeconomic
- Pre-disaster distress, history

Negative Coping

- Self-blame
- Rumination
- Negative appraisals
- Avoidance coping
- Assignment of blame

Community Context:

- Low cohesion
- Lack of resources
- Perceived inequity
- Displacement

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What contributes to risk?

Family Context:

- Children in home
- Parental distress
- Someone significantly distressed
- Interpersonal conflict
- Lack of supportive atmosphere
- Rebuilding or financial concerns
- Media viewing
    - Often important to limit this

Resources

- Few, weak, or deteriorating practical or social resources
- Belief in ability cope

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What protects?

Demographic / biological factors

Social and emotional resources

Personality factors:

- Low negative affectivity
- Capacity for hope
- Optimism
- Emotional stability
- Agreeableness
- Coping self efficacy

Adaptive abilities to:

- Reframe
- Use distraction when appropriate
- Fit coping strategy to the context
- Make meaning
- Use positive religious strategies
- Seek support from others

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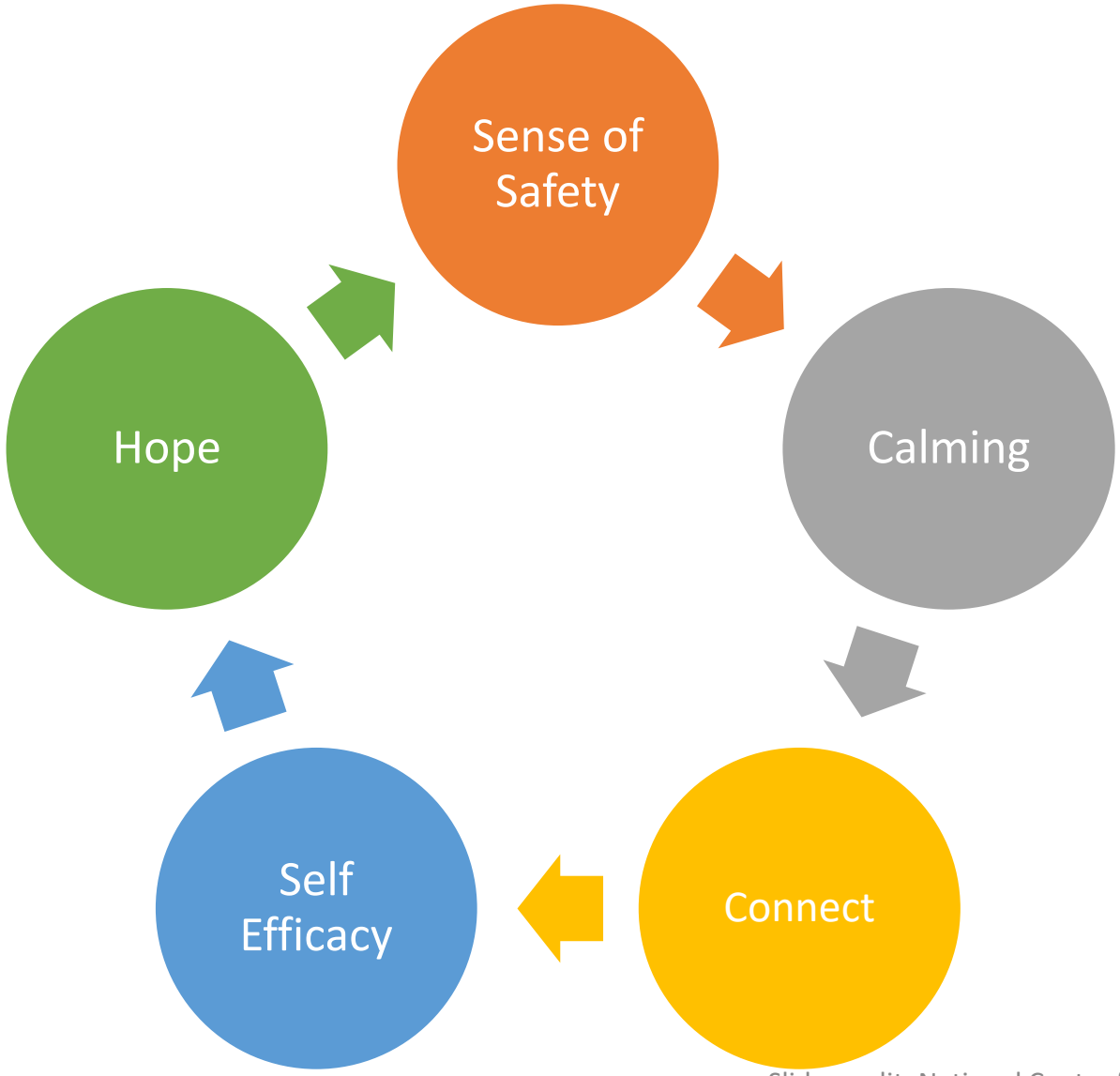
Essential Elements in Recovery From Adversity and Stress



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Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention: Empirical Evidence

Stevan E. Hobfoll, Patricia Watson, Carl C. Bell, Richard A. Bryant, Melissa J. Brymer, Matthew J. Friedman, Merle Friedman, Berthold P.R. Gersons, Joop T.V.M de Jong, Christopher M. Layne, Shira Maguen, Yuval Neria, Ann E. Norwood, Robert S. Pynoos, Dori Reissman, Josef I. Ruzek, Arieh Y. Shalev, Zahava Solomon, Alan M. Steinberg, and Robert J. Ursano

Providing Support after a Disaster

Safety and well being

- **Questions**: "How has the current situation affected your sense of safety? If it has, what can we do to help?"
- **Statements**: "We are committed to helping you with your health and wellbeing."
- **Actions**: Foster a sense of psychological safety and comfort

Calm

- **Questions**: "How are you doing? What changes have you experienced regarding sleep, feelings of being on edge, or ability to stay calm? If you're having trouble staying calm, is there anything we can do to help?"
- **Statements**: "There are no set rules for working through something like this. Be patient with yourself."
- **Actions**: Allow people to speak frankly about the event, their reactions, and their concerns. Discuss the importance of being more disciplined in self-care. More information about self-care is included in Self-Care After Disaster Events.

Connect

- **Questions**: "Has there been an impact on how you talk with each other, work morale, or connecting with family and friends? Is there someone you feel comfortable talking with about this? Has anyone you know done or said something that really helped? Do you feel the need for practical support right now?"
- **Statements**: "We'll make it through this together as a community. Be sensitive to those around you. Talk when you need to; listen when you can."
- **Actions**: Encourage people to consider staying in touch others and to be sources of support and connection.

Providing Support after a Disaster

Competence

- Questions: "Do you have any concerns about being able to handle what's going on in your life, deal with your stress reactions, or do your work? What are some things that you have done to cope that have been helpful in the past, or have been helpful recently? What else could we do that would help?"
- Statements: "If you've found a coping strategy that works for you, consider sharing it with others."
- Actions: Offer the resources available at your organization. Encourage use of resources.

Confidence

- Questions: "Have you noticed any change in your confidence in your ability to take care of things? Are you feeling guilty or wish you could do something differently? Do recent events hold special meaning or connect with other experiences in any way? What else could help?"
- Statements: "Try to take things one day at a time. The situation is unprecedented and ever-changing, and we're all doing the best we can under challenging circumstances. Remember to be patient with yourself and others. Don't let the worst elements of the situation overshadow your belief in yourself or your commitment to what you do. Help is there whenever you need it."
- Actions: Check in regularly. Share optimistic news. Increase positive encouragement, reinforcement, and gratitude.


Safety
Trustworthiness and transparency
Cultural, historical, and gender issues
Trauma-Informed Care
6 Core Principles
Peer support and mutual self-help
Empowerment, voice, and choice
Collaboration and mutuality

TRAUMA-INFORMED CARE:

What does it look like?

@therecoverycenterusa

Language and Communication

Helpers use non-judgmental and empathetic language. They avoid making assumptions about an individual's past experiences. For instance, instead of asking, "What's wrong with you?" they might ask, "What happened to you?"

Providing Choices

In healthcare settings, offering choices to patients can be empowering. For example, allowing a patient to choose their meal preferences or the time of their therapy sessions gives them a sense of control.

Sensory-Friendly Environments

Recognizing that sensory sensitivities can be triggered by trauma, trauma-informed care might involve providing calming sensory rooms or ensuring that lighting and noise levels are adjustable to individual preferences.

Active Listening

Helpers actively listen to individuals without interrupting or rushing through appointments. They validate their feelings and experiences.

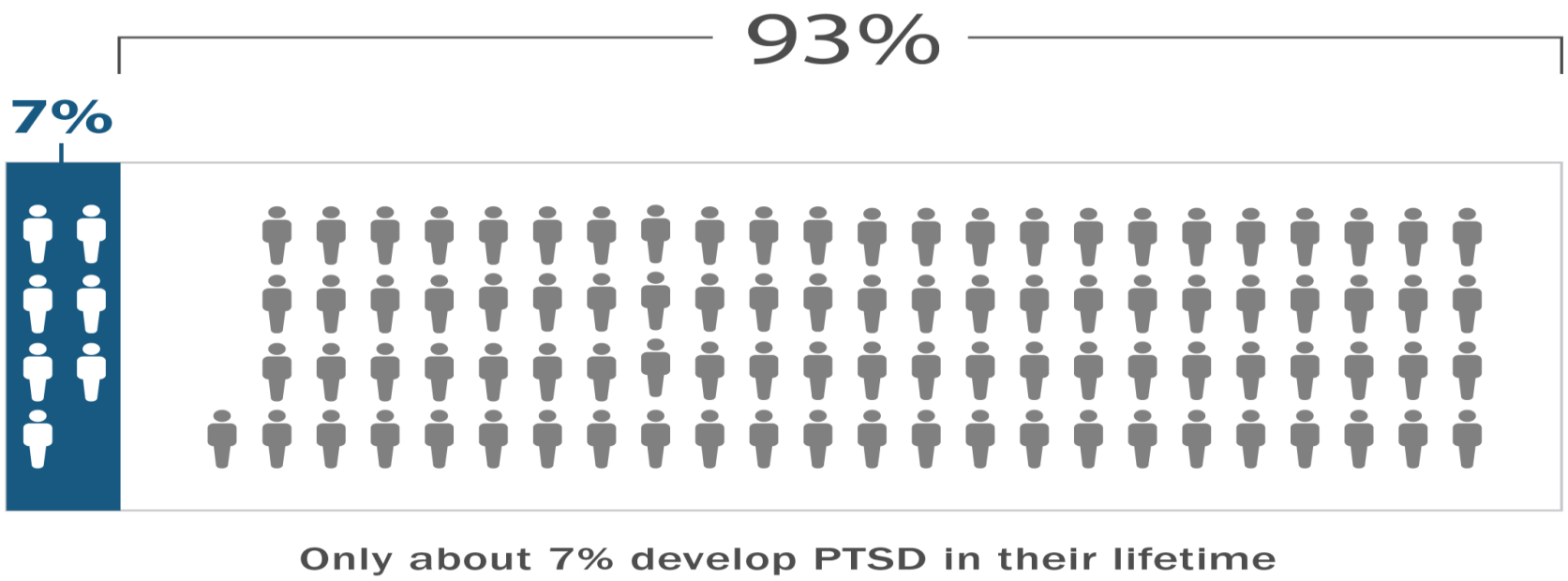
Training and Self-Care

Healthcare staff are trained in trauma-informed care principles and are encouraged to practice self-care to prevent burnout. This ensures that they can provide the best possible care to their patients.

De-escalation Techniques

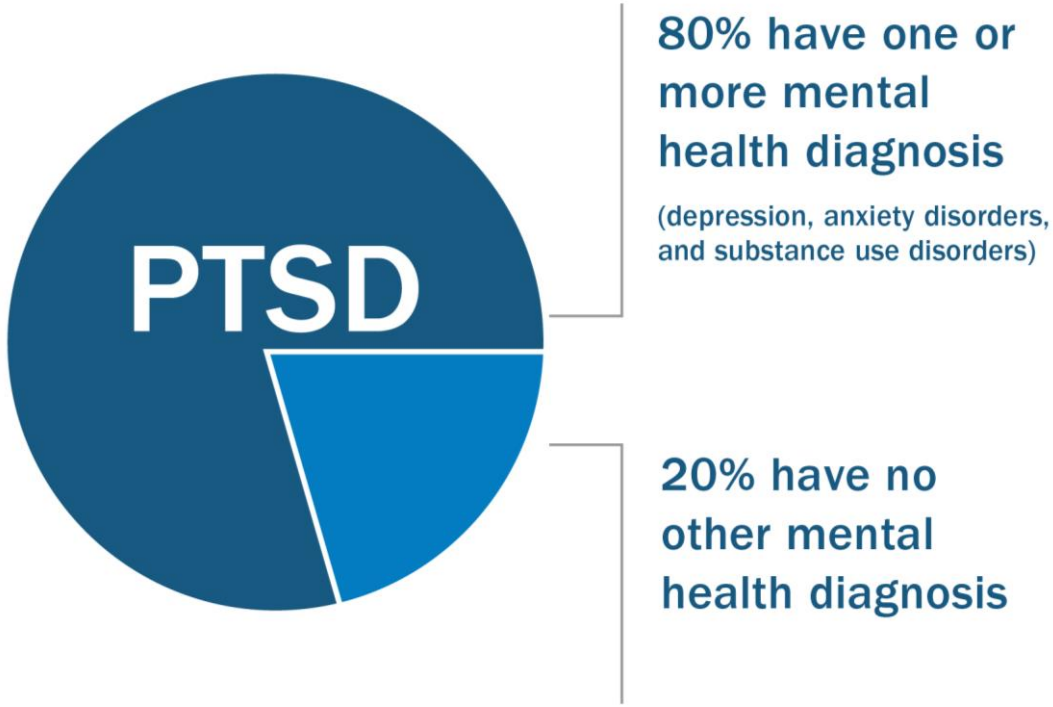
In situations where patients may become agitated or distressed, trauma-informed care involves de-escalation techniques that prioritize safety and minimize re-traumatization.

How common is PTSD?



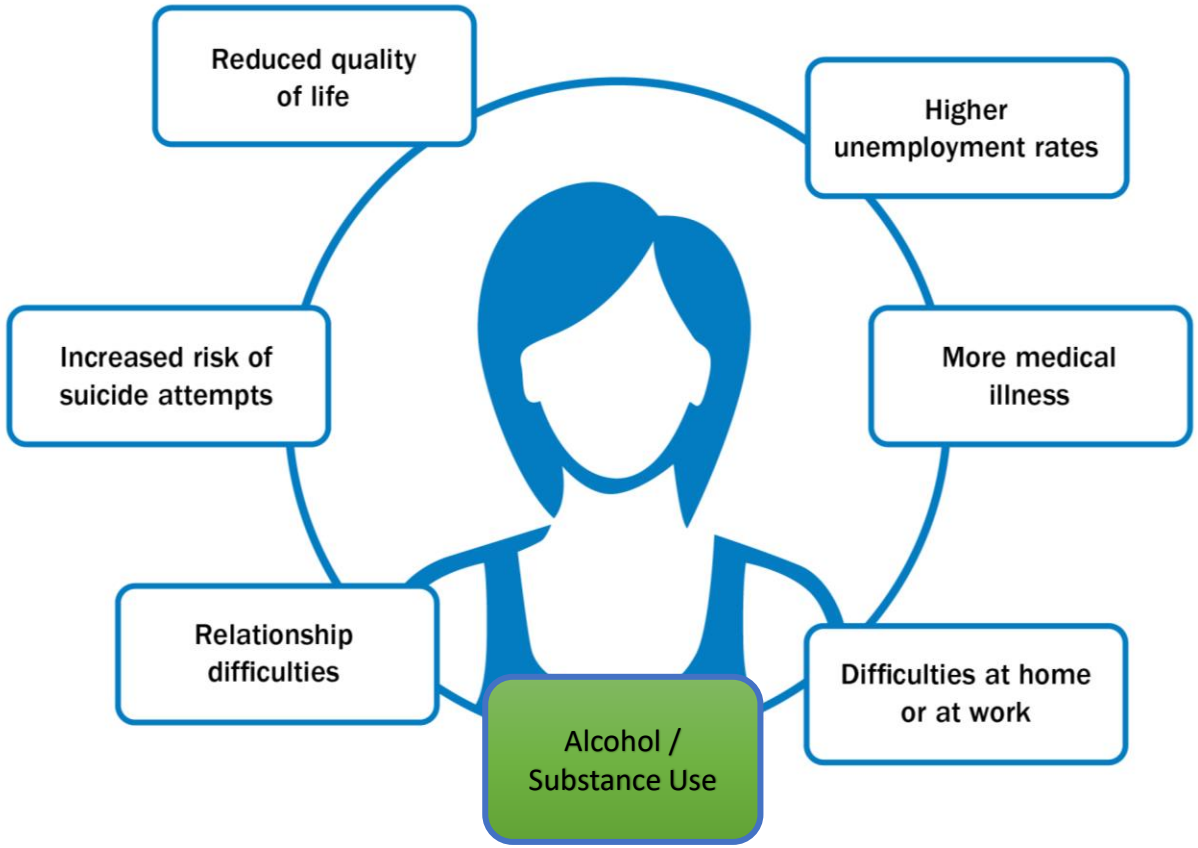
Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*(12), 1048-1060.

PTSD often co-occurs with other problems.



Source: Kessler, RC, Sonnega, A, Bromet, E, Hughes, M and Neslon, CB. (1995) Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52: 1048-1060. doi:10.1001/archpsyc.1995.03950240066012

Other Co-occurring Problems



Criterion A: Traumatic Event

- Directly experiencing a traumatic event
- Witnessing, in person, an event that happened to someone else
- Learning about the violent or unexpected death of a friend of family member
- Experiencing repeated or extreme exposure to aversive details of traumatic events

Symptom Clusters

Symptom Clusters (II)

- **Intrusion Symptoms**
  - Recurrent distressing dreams or memories (intrusive thoughts)of the event; acting/feeling as if the event is happening again (“flashbacks”)
  - Intense or prolonged psychological or physiological reactions to trauma cues
- **Avoidance Symptoms**
  - Avoiding memories, thoughts, feelings, people, places or activities that are reminders of the event
    - Negative reinforcement paradigm:
      - Avoidance provides immediate relief from distress
      - That immediate relief is reinforcing, which makes it more likely that avoidance will be used in the future to deal with distress
    - In the long-term, however, avoidance interferes:
      - Keeps trauma survivors from emotionally processing their experiences
      - Feeds unhelpful beliefs about self, others, and the world (i.e., doesn’t allow for corrective experiences)
    - In sum, avoidance acts as the engine that drives PTSD. It maintains/exacerbates the problem!

Symptom Clusters (III)

- **Negative alterations in cognitions and mood**
  - Inability to recall parts of the trauma, diminished interest in activities, feeling detached, inability to feel positive emotions, negative emotions, distorted blame of self or others, exaggerated negative beliefs or expectations
- **Arousal and reactivity symptoms**
  - Irritable behavior, outbursts of anger, reckless or self-destructive behavior, problems concentrating, hypervigilance, exaggerated startle, sleep disturbance

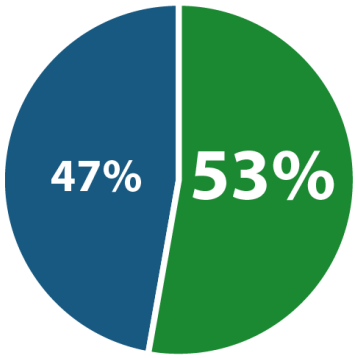
Trauma-focused psychotherapy is the best treatment

Did You Know?

Trauma-focused Psychotherapy

53 OUT OF 100

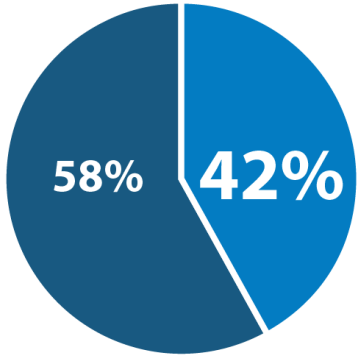
people who receive trauma-focused psychotherapy will no longer have PTSD after about 3 months of treatment.



Medication

42 OUT OF 100

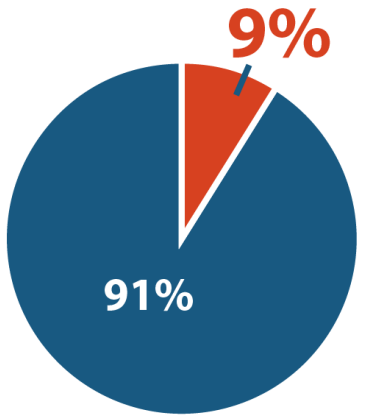
people who take medication will no longer have PTSD after about 3 months of treatment.



No Treatment

BUT ONLY 9 OUT OF 100

people who don't get treatment will no longer have PTSD after about 3 months.



Treatment Modalities

- Trauma Focused Individual Therapy
  - Several different approaches utilized
- Group Therapy
  - Beneficial to help universalize the common themes of PTSD, helps develop trusting relationships (may or may not directly specifics of each member's trauma)
- Family Focused Interventions
  - May be first priority of treatment for some, assisting in educating family, bringing family together, important in recovery process
- Psychiatric Medications
  - Medication interventions are based upon individual needs and preferences.
  - Help to manage symptoms (sleep, depression, anxiety, irritability), but do not directly treat PTSD

Goals of PTSD Treatment

- Symptom reduction
- Integrate thoughts (neocortex) and feelings (limbic system)
- Create new memories, new understanding
- Foster interpersonal connection
- Register observations other than trauma-based
- Promote chosen action, rather than only flight-fight reaction
- Make meaning of the trauma

Trauma-focused Psychotherapies

- **Prolonged Exposure (PE):** In PE you confront situations you have been avoiding until distress decreases.
- **Cognitive Processing Therapy (CPT):** In CPT you examine and challenge thoughts about the trauma until you can change the way you feel.
- **Eye Movement Desensitization and Reprocessing (EMDR):** EMDR helps you process and make sense of your trauma while paying attention to a back-and-forth movement or sound (like a finger moving side to side, a light, or a tone).

Trauma-focused Psychotherapies (II)

- **Brief Eclectic Psychotherapy (BEP):** You will practice relaxation skills, recall details of the traumatic memory, reframe negative thoughts about the trauma, write a letter about the traumatic event, and hold a farewell ritual to leave trauma in the past.
- **Written Exposure Therapy:** This therapy involves writing about the trauma during sessions. Your therapist gives instructions on the writing assignment, allows you to complete the writing alone, and then returns at the end of the session to briefly discuss any reactions to the writing assignment.
- **Integrative psychotherapy**
  - May include: Psychoeducation, stabilization, skill building, interpersonal and attached focus, graded trauma processing

Evidence-based Pharmacological Treatments

First line medications

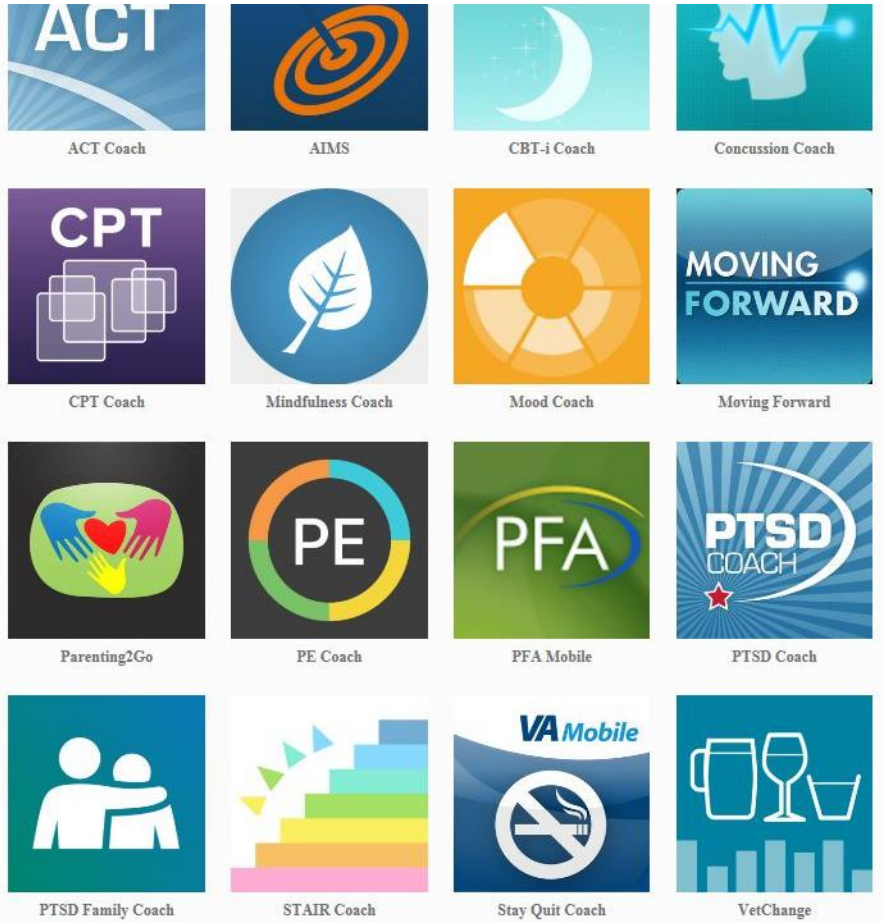
- Selective Serotonin Reuptake Inhibitors (SSRIs)
  - paroxetine (Paxil)
  - sertraline (Zoloft)
  - fluoxetine (Prozac)
- Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
  - venlafaxine (Effexor)

Warning: Benzodiazepines (e.g., Xanax, Valium, Klonopin)

- Limited efficacy
- Increased safety concerns
- Even more risk for older people
  - Confusion, awkwardness, falls
- Not recommended for PTSD

Mobile Apps

- Apps are focused on PTSD, related health problems (e.g., insomnia, alcohol use, etc.), or general well-being.
- There are apps for patients, providers, and for use with patient-provider dyads.



Disaster Resources

National Center for PTSD:

www.ptsd.va.gov

Psychological First Aid Handouts

https://www.youtube.com/watch?v=ovuis4VcnH8

Thank you!

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