THEORETICAL APPROACH ABOUT THE
ADAPTIVE RESPONSES IN DISASTER
PSYCHIATRY

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DISTASTER PSYCHIATRY

The term "disaster" comes from Latin and has the following meaning: "dis" = cons and "Astrum" = star - stars unlucky.

A common feature is that the stressful event is so severe, that exceeds the coping capacity and threaten the functioning and safety of individuals and the community. Disaster situations fall into two categories:
- Natural: hurricanes, floods, earthquakes
- Caused by people

This distinction is arbitrary because natural disasters are partly due to people (also: building houses in floodplains, landslides cleared sites, building houses without respecting the proper distances between them, global warming).

PRINCIPLES OF DISASTER PSYCHIATRY

Understanding disaster psychiatry involved changing several paradigms:
- The first major change involves the focus of care on those that have not yet changes of illness
- In disaster situations, the diagnosis of a mental disorder arises carefully after preliminary examination.
- In the acute phase psychiatrist have a duty to make psycho-education and encourage natural recovery, spontaneous rather than treat.
- In terms of disaster, the physician should treat the person on site.

Studies of psychiatric disorders resulting from disasters belong to a broader range of research on stress. Developed theories propose the following model: external needs (represented by the traumatic event that is the primary stressor) require a response that is based on internal or external resources. Loss or reduction of these resources, either specific (social, financial) or symbolic (beliefs, expectations) are considered as secondary stressors and can have severe impact on recovery.

The incidence of PTSD and functional impairment in the general population following a disaster is significantly lower than that evidenced in the directly exposed population.

CONCLUSION

Disaster psychiatry, a newer but very important branch of psychiatry has a decisive role in prevention, response and psychic recovery of people in a disaster case. It is a new way of working in psychiatry, often held to the spot of a traumatic event and which requires multiple approaches - short and long term approaches, in order to eliminate any negative consequences on the human psychic.

Keywords: Disaster psychiatry, stress, posttraumatic stress disorder (PTSD)

The prevention model of somatic diseases

It was taken as an example an outbreak of an infectious disease and was elaborated in order to be applied in psychological interventions and behaviors which would be a considered as a response to the disaster. In such cases, the doctor identifies pathogens, source and exposed persons. For the model to adapt to psychiatric the pathogens correspond to stressful psychological and social events. It will be also identified the group of people most exposed to trauma and will be made a thorough reconstruction of the catastrophic events and the series of actions which arose, ensuring that there are no groups of people left without care.

RISK FACTORS

Among the factors that favor the emergence of serious or lasting psychological disorders, the most important is the severity of exposure. This was defined as a combination of factors including: the number of stress factors on which the person was directly exposed, the self injury or of a family member, life-threatening situations, pathological grief, panic reaction in the time of the disaster, loss of home or significant financial losses.

Other contributing factors are:

1. Premobid risk factors:
a) Individual characteristics:
- Females
- Age 40-60 years
- Poor economic status
- Psychiatric history
- A history of psychological trauma
- Cognitive impairment

b) Family background:
- Parental dysfunction, disputes, conflicts
- Family history of psychiatric disorders

c) The way of coping in stressful situations and external support:
- Coping mechanisms based on avoiding trauma
- Poor social support

2. Risk factors appeared in the disaster:

a) Environmental Factors:
- Reduction / depletion of resources
- Loss of social support
- Criticism of contact persons
- Marital dysfunction

b) Reactions to the trauma:
- Derealisation or temporal distortion
- Emotional indifference
- Psychomotor restlessness
- Reliving the trauma (flashes)
- Anticipatory anxiety

c) Postevent stressors and reactions:
- Statements to the authorities (police, security services)
- Excessive attention of the media
- Extended stay in victims camp
- Extended separation of family and friends
- Confusion, disorientation
- Uncertainty
- The disappearance of a family member

Theoretical psychological models of reactions to trauma

Several theories have been proposed to explain the psychological and behavioral reactions occurring after disasters. Studies of psychiatric disorders resulting from disasters belong to a broader range of research on stress. Developed theories propose the following model: external needs (represented by the traumatic event that is the primary stressor) require a response that is based on internal or external resources. Loss or reduction of these resources, either specific (social, financial) or symbolic (beliefs, expectations) are considered as secondary stressors and can have severe impact on recovery.

Following trauma and disasters psychological and behavioral reactions can occur, as follows:
- Anger;
- Intense sadness;
- Paroxysmal anxiety;
- Excessive fear;
- Increased irritability;
- Sleep disorders;
- Increased consumption of alcohol, coffee, tobacco.

They constitute tertiary stressors and according to the stress theory can lead to a further reduction of personal resources.

For most people, these posttraumatic symptoms with acute onset disappear spontaneously while to other people may persist and can be included in the diagnostic criteria of mental disorders.

The most important psychiatric disorders highlighted by studies made post - disaster include:
- PTSD
- Acute Stress Disorder
- Dissociative disorders
- Severe depressive episodes
- Anxiety disorders
- Sleep disturbances
- Adaptive Disorders
- Pathological mourning
- Alcohol and psychoactive substances abuse.

The incidence of PTSD and functional impairment in the general population following a disaster is significantly lower than that evidenced in the directly exposed population. Thus, following the terrorist attacks of September 11 in the U.S., in the entire population of New York, the incidence of these events was 7.5% in a few days post-disaster and decreased with time, reaching 0.6% to 6 months after the event. Instead, to those directly involved, the rates were 37% in consecutive days, ie 30% to 6 months.

Some authors consider that the stress theory can not explain enough the occurrence of PTSD. They propose cognitive models which emphasize the importance of other factors in the pathogenesis of PTSD, such as excessive negative evaluation of trauma, memory disturbance processes (contextualization or prevalence associative memory), factors that will determine intrusive recollections of the trauma and which will not be removed once the loss of stress factors.

Another theory proposes a dual representation of trauma, namely: a cognitive model associated with a
pattern of emotional experiences. This suggests that information and traumatic memories are stored at multiple levels:

1. "propositional" level from where they are available for verbalization;
2. analogical level taking form of visual, olfactory, auditory, gustatory and proprioceptive images and which are not subject to voluntary control;
3. schematically level taking form of abstract, generic notions.

According to the theory, the fully integrated information is organized in schematic representations. Depending on how new information which is contrary to earlier representations is processed (either inhibited or integrated), we have several forms in which the individual reacts to trauma and recovers thereafter.

Implications of the theory are:

a) the body's response to the threat remains active until it restores physical safety, the person being unable to integrate traumatic experience as long as the fear reaction is activated;

b) For the people with negative schematic pre-traumatic representation of the world exposure to trauma-related memories will be more harmful;

c) because fear is a prospective emotion, exposure to recalls of the trauma in a safe environment will reduce this anxiety as the memory will integrate new information from this safe environment in which it was placed later. On the other hand, emotions such as anger, guilt and shame are retrospective emotions and reactivation of the memory on trauma will only accentuate them.

Another theory is the social cognitive one that considers the individual as an active contributor to the adaptive process and which gives communities an active role in the recovery process.

CONCLUSION
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