When Safety Is Disrupted

Mental health, trauma, and psychological recovery after emergencies.

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SAFETY PREDICTABILITY CONNECTION AGENCY

GROUNDING QUESTION

What Makes an Emergency Overwhelming?

> Danger is only part of the answer. Helplessness, uncertainty, isolation, and shattered meaning amplify trauma.

Physical safety is the baseline; psychological injury extends far deeper.

30-SECOND REFLECTION

Recall a significant disruption in your work or life.

What was lost besides immediate physical security?

AGENDA

The Presentation Path

01 Disruption

What emergencies break beyond physical structures.

02 Response

Expectable biological and emotional survival states.

03 Recovery

Capacities and timelines that rebuild stability.

04 Care

Practices to regulate acute distress effectively.

PILLAR DISRUPTION

What Crumbles Under Crisis?

SAFETY

“Am I protected?”

Loss of physical security and bodily integrity.

PREDICTABILITY

“What is next?”

Shattered expectations and routines.

CONNECTION

“Who is with me?”

Separation from vital social anchors.

AGENCY

“Can I affect it?”

Complete loss of autonomy and choice.

MEANING

“How do I cope?”

Collapse of coherent worldview and trust.

Trauma risk accelerates when immediate threat combines with acute helplessness and social isolation.

RESPONSE PROFILE

Early Reactions Across Four Domains

Body

Cardiovascular: Racing heart and palpitations
Sleep: Severe insomnia or fatigue
Motor: Heightened startle and tension
Somatic: Appetite loss and bodily pain

Mind

Executive: Acute confusion and brain fog
Focus: Inability to concentrate
Intrusion: Unwanted recurring images
Decision: Severe decision paralysis

Emotion

Affect: Intense terror, rage, or sadness
Defense: Emotional numbness or disbelief
Self-blame: Survivor guilt or unearned shame
Contrast: Confusing waves of relief

Behavior

Attachment: Severe withdrawal or clinging
Interpersonal: Rapid conflict and agitation
Coping: Escalating substance use
Agitation: Pacing and inability to rest

Key takeaway: A strong initial reaction is an expectable human response, not clinical pathology.

CLINICAL TRIAGE

When Distress Becomes Concerning

Expectable Acute Trajectory

Tide-like ebb: Distress gradually softens over days

Function holds: Basic eating and hydration maintained

Responsive: Accepts human comfort and grounding

Orientation: Preserved reality testing and context

Urgent Red Flags

Escalation: Distress is intensifying rather than easing

Functional collapse: Total breakdown of basic self-care

Loss of safety: Disorientation, psychosis, or delirium

Lethality: Suicidal ideation or dangerous behaviors

TEMPORAL PROGRESSION

The Diagnostic Lens Across Time

PHASE 1

0 – 2 Days

Acute Stress Reactions

Support physical safety, practical survival needs, and emotional containment.

Action: Monitor & stabilize

PHASE 2

3 Days – 1 Month

Acute Stress Disorder (ASD)

Trauma intrusions, negative mood, dissociation, avoidance, and functional impairment.

Action: Targeted intervention

PHASE 3

Beyond 1 Month

Consider PTSD & Comorbidities

Assess for ongoing PTSD, major depression, prolonged grief, and substance coping.

Action: Specialized clinical care

Clinical Reminder: Diagnosis helps organize care—it should never eclipse the individual's context or story.

CONTEXTUAL FORMULATION

One Event, Different Psychological Realities

SCENARIO

Catastrophic Power Outage

A single disruption creates completely distinct survival threats depending on baseline vulnerability.

OLDER ADULT

“Will my oxygen machine stay on?”

Direct threat to physiological life support.

PERSON WITH SMI

“Will I lose access to medication?”

Fear of psychiatric decompensation.

PERSON WITH IDD

“Why did the routine vanish?”

Extreme sensory disorientation.

UNHOUSED INDIVIDUAL

“Where can I safely cool down?”

Absence of basic refuge or shelter.

CLINICAL FORMULATION

Five Forces That Shape Impact

01

Exposure

Duration, physical proximity, and direct loss.

02

History

Prior trauma, attachment, and adversity.

03

Resources

Housing stability, wealth, and transit access.

04

Relational

Available caregivers and trusted support.

05

Meaning

Belief systems, stigma, and internalized blame.

RELATIONAL LENS

Psychological Containment

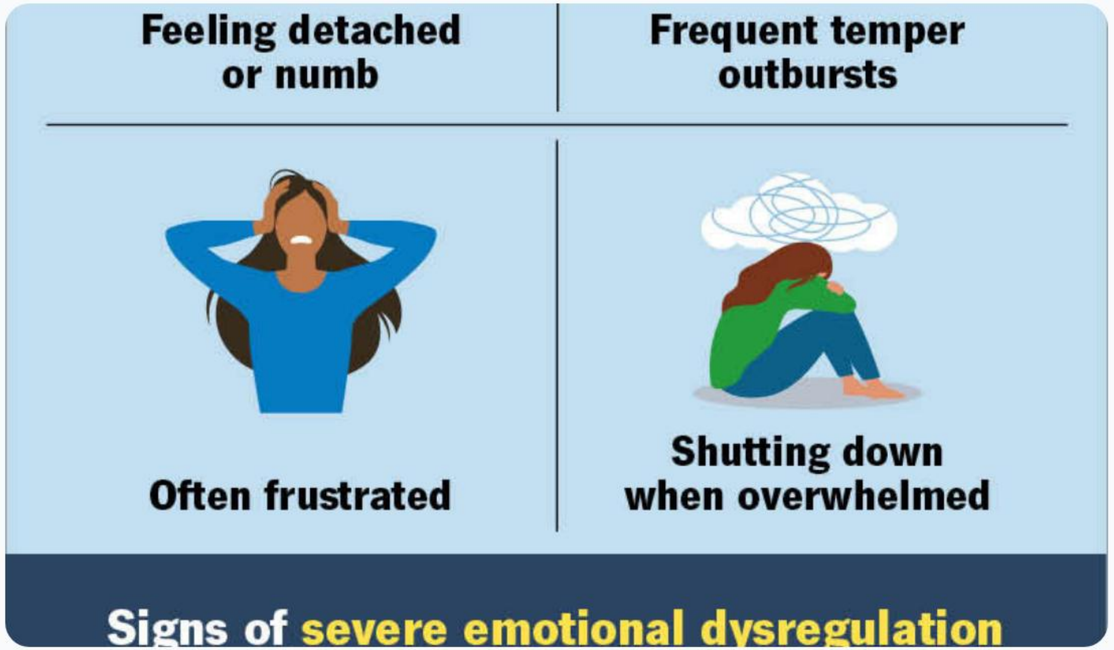
Uncontained State

Raw terror • autonomic overdrive • chaotic fragments • frantic action without reflection.

Contained State

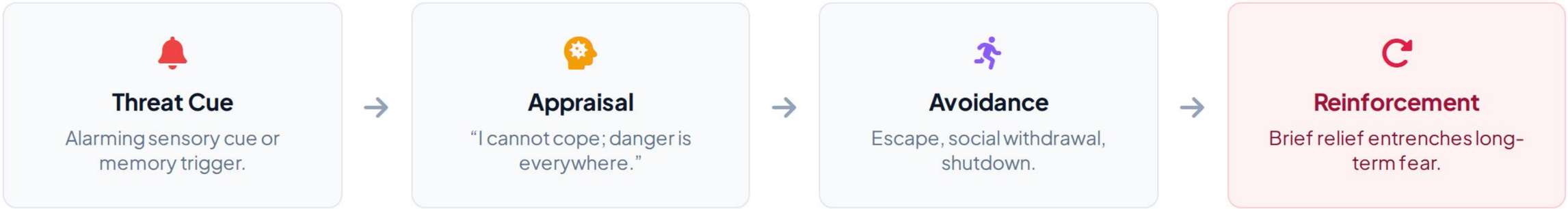
Explicitly named • organized • shared with trusted others • rendered psychologically manageable.

The helper's primary task: Temporarily lend calm, structure, and coherence until the survivor can reclaim them.



COGNITIVE-BEHAVIORAL FRAMEWORK

The Threat–Avoidance Maintenance Loop



Clinical Antidote: Accurate information • Somatic grounding • Gradual re-engagement • Practical problem solving

EMPIRICAL CORE

Five Capacities Supporting Recovery

CAPACITY 01

Safety

Physical environment and protected bodily integrity.

CAPACITY 02

Calm

Autonomic down-regulation to tolerable arousal.

CAPACITY 03

Connection

Reliable, accessible community and relational ties.

CAPACITY 04

Efficacy

Actionable personal agency and problem solving.

CAPACITY 05

Hope

A believable, navigable horizon for tomorrow.

Core Principle: Every intervention must specifically target the missing capacity.

PRACTICE STANDARDS

Trauma-Informed Care in Action

01 Safety

Actively minimize avoidable threat cues and environmental stress.

02 Trust

State clearly what you know—and openly admit what is still unknown.

03 Choice

Offer real, bounded choices to immediately restore personal agency.

04 Collaboration

Partner actively with survivors: “Do with, never to.”

05 Empowerment

Affirm existing survival strengths and active coping steps.

06 Culture

Adapt language, accessibility requirements, and cultural meaning.

OPERATIONAL PROTOCOL

Regulating the First Five Minutes

STEP 1

Approach

Move slowly. Clearly introduce yourself. Lower ambient sensory chaos.

Calm Presence

STEP 2

Orient

State where we are, what just happened, and exactly what comes next.

Contextual Grounding

STEP 3

Ask

Inquire into immediate needs, medical supports, and communication modes.

Active Assessment

STEP 4

Offer

Present 1–2 real choices and one concrete, manageable next action.

Agency Restoration

STEP 5

Connect

Bridge directly to loved ones, critical medications, or ongoing care.

Relational Bridge

CLINICAL APPLICATION

Case: Heat & Group Home Power Loss

THE SITUATION

Residents evacuated to crowded cooling shelter.

One resident begins frantically pacing, yelling, and attempting to leave. Staff respond by repeatedly stating: *"You need to calm down."*

Pitfall: Demanding calm without meeting survival needs fuels agitation.

WHAT THE BEHAVIOR COMMUNICATES

Physiological strain: Unaddressed heat, pain, thirst, or medication side effects.

Sensory overload: Loud shelter noise and completely disrupted routine.

Attachment terror: Fear of abandonment or separation from caretakers.

Communication gap: Lack of clear, accessible explanation of events.

Reasserting control: Flight response as an attempt to regain bodily agency.

OPERATIONAL VS. RELATIONAL

Case: A Person Reported Missing

Operational Imperatives

Search grids: Coordinate search and rescue deployment.

Inter-agency sync: Unify first responder communications.

Documentation: Maintain real-time incident logs.

Public updates: Control perimeter and media alerts.

Psychological Containment

Contain uncertainty: Provide honest pacing without false hope.

Direct updates: Establish predictable check-ins for family.

De-stigmatize: Use language that reduces shame and self-blame.

Post-resolution: Build debriefing and ongoing trauma care.

SPECIALIZED NEEDS

Adapt the Response—Not the Person

Children

- Caregiver proximity
- Direct, honest words
- Restore play routine

Older Adults

- Sensory access aids
- Medication stability
- Avoid infantilizing

IDD

- Concrete visual tools
- Trusted caregivers
- Low-sensory corners

SMI

- Psychiatric refill sync
- Baseline vs crisis
- Integrated follow-up

Homelessness

- Dignity-first focus
- Never assume immunity
- Practical shelter link

WORKFORCE PROTECTION

Responders Shape the Response

⚠ Warning Signs in Staff

Cognitive: Tunnel vision and impaired decision-making

Interpersonal: Uncharacteristic irritability and team friction

Emotional: Numbing detachment or intrusive thoughts

Physical: Chronic sleep disruption and compulsive overwork

Operational Protections

Structure: Enforced shift rotations and role clarity

Biology: Mandated food, hydration, and resting intervals

Peer checks: Buddy system paired with supervisor access

Clinical access: Confidential psychological debriefing

THE CORE TAKEAWAY

When Recovery Truly Begins

Psychological recovery takes root the moment an individual can re-experience:

> **“I am safer now.”**

> **“I know what will happen next.”**

> **“I am not alone in this.”**

> **“I still have meaningful choices.”**

> **“A future is once again imaginable.”**

Thank You.
Questions & Discussion

Three Takeaways to Keep:

1. Normalize early reactions without underestimating danger.
2. Intentionally rebuild safety, predictability, and agency.
3. Match support directly to the survivor's recovery phase.

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CRISIS RESOURCE

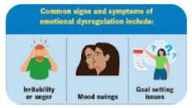
Disaster Distress Helpline

Toll-free, 24/7, multilingual crisis counseling:

1-800-985-5990

Call or text available nationwide • samhsa.gov

Image Sources



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