

Caring Responsibly for People Affected by Fire Disasters

Erik de Soir, PhD, PhD

Trauma Psychologist - Fire Rescue Service Psychologist

De Weg Wijzer - Centre of Expertise for Trauma and Grief Support

Leopoldsburg (Belgium)

This text is intended for professionals and policy makers who work with survivors of fire disasters and their family members. Each part of this text may be freely used provided correct and clear source attribution is given.

Fire disasters are among the most devastating calamities that individuals and societies can be confronted with. They not only cause acute physical injuries, but also lead to profound psychological, relational and existential disruption in both directly affected individuals and their family members.

Since the Switel hotel fire of 1994-1995, I have accompanied a number of survivors of fire disasters in my capacity as a trauma psychologist. In what follows, I present three concise testimonies from respectively: **L.H.**, who survived the Switel fire (New Year's Eve 1994-1995); **C.L.**, who survived the café fire in Volendam (New Year's Eve 2000–2001); and **S.D.**, who describes his survival during the technological disaster of Ghislenghien (2004).

These testimonies show, in an intense and complementary way, how the consequences of such disasters unfold over time and what implications this has for care provision, policy and training.

In the acute phase, immediately after the fire or explosion, affected individuals function almost exclusively in survival mode. Their actions are automatic, reflexive and hardly guided by conscious reflection. In both **L.H.** (Switel fire) and **S.D.** (Ghislenghien), we observe clear signs of peritraumatic dissociation: fragmentation of consciousness, distorted perception of time, narrowed attention, and behavior driven by primitive action patterns such as fleeing, crawling or searching for cooling. Cognitive processing of what is happening is hardly possible in this phase. This explains why victims sometimes appear to respond in an apparently inappropriate manner to their situation, for example through euphoria, emotional numbing or minimizing their injuries, while in reality they are in shock.

L.H. – Survivor of the Switel Fire (1994–1995)

“I was making music. That may be the strangest thing: I was standing on a stage, with light, sound and people laughing. The new year had only just begun. Everything felt safe. Too safe, in retrospect.

Suddenly there was light, but not the kind of light you know. It wasn't fire at first, more like movement. A flash of flame that seemed to run through the hall. I heard bangs. Then the lights went out. What remained was smell: smoke, something sweet and something metallic. Later I would know that it was the smell of burning flesh.

From that moment on there was no more thinking. Only moving. My legs took over. I don't know why I didn't go with the crowd to the exit. I went another way. I have asked myself that for years, but there was no choice. It just happened.

I ended up in a small space. Dark. Hot. I felt along walls, touched cupboards, pots, something falling over. I sat down on the floor. I remember that very sharply. I thought: this is it. I am going to die here. And while I thought that, I saw my life pass by. Not like a film, more like loose images. My parents. A summer day. Music.

And then suddenly there was energy again. One last surge. I stood up, stormed forward and felt a door. Outside. Cold air. Sirens. People shouting. I stood there, as if I had returned from another world.

Only then did the pain begin. First tingling, then burning, then something I can no longer describe. My skin was hanging loose. People told me to sit down. Someone put a jacket around me. I asked where my friends were, but no one answered.

In the hospital I said that I was fine. I even laughed. The doctors looked at me strangely. Only later did I understand that I was in shock. I thought it was over, but in fact it was only just beginning.

The months that followed were a blur of surgeries, bandage changes and sleepless nights. But the hardest part came later. When everyone else moved on. When the press was gone. When the conversations stopped.

What kept me going was my general practitioner. He had known me from before. He didn't just ask how my wounds were doing, but also how I was doing. Sometimes he said nothing. Sometimes he said: 'This is normal after what you have been through.' That one sentence has saved me more often than any medication.

I have never become the same person again. But I am still here. And that is not self-evident. That is what I have learned."

C.L. – Survivor of the Café Fire in Volendam (2000–2001)

"It was just after midnight. Everyone was cheerful, packed close together, steam in the air. I remember thinking: in a moment I'll step outside for some fresh air. That moment never came.

When the fire broke out, I didn't understand at first what I was seeing. The ceiling suddenly seemed to move. People started pushing. I felt heat, as if my skin no longer belonged to me. What I remember most is sound: screaming, breaking glass, someone calling my name. After that everything is a blur.

In the hospital I told my parents that it wasn't too bad. I even laughed. My hands were bandaged, my face felt tight, but I thought: I'm alive, so let's not talk about it. Only weeks later, when I got home, did the real fight begin.

I no longer dared to enter cafés. Even birthday parties were too crowded. My friends continued with their lives. I was left behind. Everyone said I was 'strong'. But at night I saw the ceiling burning again.

What saved me was not one therapy or one conversation. It was my general practitioner, who had known me since before. He knew when to remain silent and when to ask further questions. He stayed, even when the attention faded.

I have never become the same person again. But I am alive. And slowly I have learned that that may be enough.”

S.D. - Survivor of the Ghislenghien Disaster (30 July 2004)

(written as a descent into hell in ten steps)

“I don’t call it a memory. It is a journey. A journey that I have to make again and again. At moments when the reliving of what happened that day once more gains the upper hand.”

Step 1 - The shock

There was a sound. Not loud, but all-encompassing. I immediately knew: this is wrong. My body was faster than my head. I ran.

Step 2 - The heat

The heat was not heat. It was an assault. As if my entire body was struck at once. I screamed, but did not hear myself.

Step 3 - Powerlessness

I did not know what was attacking us. It had no form. No face. Only pain. I understood: I will not win against this.

Step 4 - Freezing

I lay on the ground. The earth was cooler. I rolled. It happened automatically. I did not think: this helps. My body did it.

Step 5 - Hell

I saw people burning. I heard sounds that were no longer human. I knew: this is what death is.

Step 6 - The choice

I tried to help someone. I felt his skin come loose in my hands. I had to choose. I chose myself. I carry that choice with me every day.

Step 7 - Rescue

I got away. Not rescued, rather released by hell. My body trembled. I knew I was alive, but did not understand how.

Step 8 - Suffering

In the hospital the pain truly began. The smell. The sounds. The other bodies. I thought I had ended up in the underworld.

Step 9 - Mourning

I mourned who I had been. My body. The man I had to leave behind. The life that was over.

Step 10 - Return

I returned, but not as the same person. I learned that surviving is not a victory. It is a task.

What helped me were people who did not try to explain or cure. People who stayed. My general practitioner. Some colleagues. Fellow survivors.

I have returned from the realm of Hades, god of the underworld and the dead. But a part of me remained there.”

Parallel to this, family members find themselves in their own acute crisis. They are confronted with uncertainty, insufficient or contradictory information, fear of loss and a sense of total powerlessness. The practice analysis of the Switel fire shows how this uncontrolled influx of emotions and questions initially even threatened to undermine medical care, underlining the importance of structured psychosocial support that is not only aimed at victims, but explicitly also at their relatives.

In the days and weeks following the disaster, the focus shifts to a phase of early processing and stabilization. A recurring and crucial element in all sources is the need for victims to repeatedly tell their escape and survival story. For **L.H.** and **C.L.**, being able to reconstruct their experience for hours and days constituted an essential part of their recovery. In **S.D.** as well, this process is described as a necessary step to mentally conclude the “descent into hell” and to reconnect with life. This storytelling is not mere ventilation, but an essential mechanism for organizing fragmented memories, attributing meaning to what happened, and regaining a sense of control and identity. It is even the case that survivors of other disasters, who for years were often prevented from doing so by caregivers trying to keep them in the here and now so as not to ‘retraumatize’ them, under my guidance sometimes still give shape to this process more than ten years after the disaster - sometimes even with the help of their first responders, whom I re-engage for this purpose.

At the same time, deeper emotional themes emerge in this phase, such as survivor guilt, shame about behavior during escape, and moral injury resulting from choices made in extreme circumstances, for example leaving others behind. These experiences transcend the classical symptom descriptions of post-traumatic stress and touch on existential questions of life, death and responsibility. Family members meanwhile go through their own process of adjustment, in which they not only carry fear and grief, but also have to learn to deal with a victim who has changed physically and psychologically. The Switel experience shows that neglecting this family dimension can seriously hinder the recovery process. Victims also struggle with the fear that, due to their injuries, they will no longer be attractive enough to be loved or will no longer be able to lead a dignified life.

In the long term, months to years after the disaster, the lasting consequences become visible. Fire disasters are often accompanied by chronic residual injuries: scars, loss of function, persistent pain and occupational limitations. In **L.H.**, this led, among other things, to the loss of his professional musical career, prolonged incapacity for work and permanent disability. These physical limitations often amplify the psychological impact, with symptoms such as avoidance behavior, hypervigilance, fear of crowded or enclosed spaces and recurrent reliving.

In **S.D.**, this process is aptly described as progressive trauma: psychological suffering deepens as the realization grows that the damage is irreversible and that the former life is definitively over.

Yet the testimonies also show that post-traumatic growth is possible. Some survivors develop, often after a long and painful process, a renewed appreciation of life, a stronger sense of meaning and an engagement with fellow survivors. **L.H.** ultimately describes himself as a “happy man,” despite severe losses, explicitly emphasizing the importance of long-term, coherent and professional psychosocial support.

These insights lead to important implications for caregivers, policy and training. First, they make it clear that psychosocial care in fire disasters is not an optional supplement to medical care, but an integral and necessary component of it. There is a need for a clear, shared vision of good practice that is applied in a comparable way across all hospitals and care institutions. This vision must address the acute phase, long-term follow-up, the role of family members and the necessity of continuity of care.

In addition, scientific follow-up and evaluation of all care initiatives is essential. Without systematic monitoring, it remains unclear which interventions - intended to help - actually contribute to recovery and which may cause unintended harm. Experience shows that well-intentioned but short-lived, insufficiently coordinated initiatives can leave victims out in the cold once they disappear, reinforcing feelings of abandonment and insecurity.

This also highlights the necessity of bundling all spontaneous support initiatives from the population and mandating their coordination by government authorities. Disasters often elicit a wave of solidarity, but without central coordination a proliferation of initiatives quickly emerges that overlap, counteract each other or disappear after a short time. This can lead to inefficiency and even additional harm to victims. Government steering is therefore not a restriction of solidarity, but a condition for making that solidarity sustainable and effective.

Finally, the Ghislenghien disaster (De Soir, 2015) convincingly demonstrates that victims are often most satisfied with support that is close to their everyday life. Care providers from their own environment, such as the general practitioner, prove to play a crucial and stable role. They offer continuity, trust and recognizability, and often form the anchor point when other structures are temporary or project-based. Future-oriented policy should therefore explicitly integrate these first-line actors into disaster plans and psychosocial care models. Professional care and supervision should then ideally focus on supporting these natural helpers.

In summary, these experiences teach us that dealing with the consequences of fire disasters requires a long-term vision, supported by science, policy and practice alike, in which coordination, continuity and humanity are central. Only in this way can it be prevented that victims, after the initial wave of attention and assistance, are once again left alone with their injuries and their story.

FACT SHEET 1 - Recommendations for POLICY

1. Develop a national vision on good practice

- Develop a single, uniform, evidence-based psychosocial care model for disasters and fire incidents.
- Ensure that this vision is mandatorily applied in hospitals, primary care, burn centers and psychosocial emergency structures.
- Avoid project-based and temporary approaches without follow-up.

2. Structurally embed psychosocial care

- Psychosocial support is not an optional add-on, but an essential component of care, just like surgery and intensive care.
- Provide long-term funding, at least over multiple years.
- Avoid abrupt termination of initiatives: discontinuity causes secondary traumatization.

3. Central governance of all support initiatives

- Bundle all spontaneous support initiatives (citizen initiatives, volunteers, associations).
- Make governmental coordination mandatory: registration, alignment and quality assurance.
- Prevent uncontrolled proliferation and competition between initiatives.

4. Invest in scientific follow-up

- Make the following mandatory: systematic monitoring, longitudinal research and effectiveness evaluation of interventions.
- Use these data to continuously adjust policy and practice.

5. Anchor the role of primary care

- Structurally integrate general practitioners into disaster response plans.
- Provide them with: specific training in psychotrauma, clear communication channels and access to specialized networks.
- Acknowledge that caregivers from the “inner circle” are often experienced as the most reliable and provide additional support for this network.

FACT SHEET 2 – Recommendations for CARE PROVIDERS

1. Understand trauma as a process over time

- Trauma does not end at hospital discharge. Trauma often truly begins when the euphoria of survival is overtaken by secondary suffering.
- Be alert to: progressive traumatization, late-onset complaints and relapse moments (commemorations, media attention or the disappearance thereof).

2. Respect peritraumatic reactions

- Apparently inappropriate behavior (euphoria, denial) is often neurobiologically explainable.
- Avoid pathologization in the acute phase and ensure that survival behavior is correctly understood and explained (to victims and relatives).
- Focus on: safety, stabilization and simple, clear communication.

3. Facilitate the telling of the story

- Allow room for repetition of the escape and survival narrative.
- Do not interrupt too quickly. Allow the story to unfold with the necessary emotions.
- Remember: telling = organizing = recovery.

4. Systematically involve family members

- Family members are co-affected.
- Provide: separate support moments, clear information and continuous support in the context of long-term care burden.

5. Work interdisciplinarily and in a coordinated manner

- Avoid fragmentation of care.
- Coordinate between: medical, psychological, social and primary care actors.

6. Take care of yourself as a caregiver

- Confrontation with severe burn injuries and existential despair requires: supervision, intervention and psychological support for caregivers.
- Ensure moments of self-care and decompression.

FACT SHEET 3 – Recommendations for FAMILY MEMBERS

1. Understand that behavior may change

- Irritability, withdrawal or anxiety are often normal responses to abnormal events.
- Do not take this personally. Regaining control over emotional regulation is a long-term and fragmented process.

2. Be present, not solution-oriented

- You do not have to “fix” anything. Remain patiently present.
- Listening is often more important than giving advice.

3. Respect the pace of recovery

- Do not expect linear progress.
- Relapse does not mean failure.

4. Take care of yourself as well

- Feelings of guilt (“I shouldn’t complain”) are counterproductive.
- Seek support in a timely manner.

5. Hold on to trusted caregivers

- The general practitioner can be an important bridging figure.
- Continuity and trust are crucial.