



Appalachian Search and Rescue Conference  
Center for Emergency Medicine of Western Pennsylvania

# Wilderness EMT Lesson Plan

## Part 19: Stress Management and Critical Incident Stress Debriefing (CISD)

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## **The ASRC-CEM Wilderness Emergency Medical Services Institute**

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The ASRC-CEM *Wilderness Emergency Medical Services Institute*, previously named the *Wilderness Emergency Medicine Curriculum Development Project*, is devoted to developing curriculum for wilderness EMS providers and medical control physicians, and fosters wilderness EMS research. It is a cooperative venture of the Appalachian Search and Rescue Conference and the Center for Emergency Medicine of Western Pennsylvania. The ASRC is a large, tightly-knit wilderness search and rescue organization with eight teams throughout the mid-Appalachian states. The Center for Emergency Medicine is an emergency medicine and prehospital care research and teaching organization. It provides a medical helicopter service, an emergency medicine residency, Emergency Medical Services for the city of Pittsburgh, and conducts a variety of related projects.

## **The WEMSI Wilderness EMT Curriculum**

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This Lesson Plan is one part of the ASRC-CEM Wilderness Emergency Medical Technician Curriculum. In concert with a textbook, the Curriculum has been in development since 1986, and took as its starting point a program Dr. Conover developed for the National Association for Search and Rescue in 1980. The Project has also drawn on other sources. These include the Wilderness EMT program offered by SOLO (Stonehearth Open Learning Opportunities), the WEMT program developed by Wilderness Medical Associates for the National Association for Search and Rescue, and the Winter Emergency Care Course of the National Ski Patrol. The Wilderness Medical Society's educational and research publications provide needed background for the Curriculum. The National Association of EMS Physicians has published clinical guidelines for delayed/prolonged transport that apply to WEMTs.

With its prerequisites, this Curriculum complies with the Wilderness Prehospital Emergency Care curriculum established by the Wilderness Medical Society. We assume that students have the knowledge and skills of an EMT-Basic or EMT-Paramedic. (The curriculum can accommodate both EMTs and paramedics in the same class.) The other prerequisite is certification to the Virginia Ground Search and Rescue Field Team

Member standards or equivalent. EMT standards are available from state EMS offices or the U.S. Department of Transportation. The Virginia GSAR standards are available from the Virginia Department of Emergency Services, 310 Turner Road, Richmond, VA 23225-6491. The curriculum is competency-based rather than hours-based, but can be completed in roughly five intensive days. The curriculum also provides a checklist of recommended clinical training.

## **WEMT Lesson Plan Development**

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An outline for each of the twenty sections of the WEMT curriculum was created by a Task Group of five to twenty selected members, but draws on many published sources and consultants. A Task Group Leader guides the Task Group in reviewing and revising the section, and the Project Coordinator actively supervises all aspects of curriculum development. Each Task Group provides references to support its statements and for further reading, and a glossary.

They also have been refined through seven pilot classes, several which have been held under the auspices of the Virginia Department of Emergency Services and Division of Emergency Medical Services. These agencies played a major part in development of the curriculum.

When the outline satisfies the Task Group, it goes to our **Editorial Board**. This Board includes officers of the ASRC and Center for Emergency Medicine, experts in emergency medicine, search and rescue, and education, and a State EMS director. Once it is acceptable to the Board, we release the Lesson Plan to the public.

Because we expect many good suggestions from the public, we are publishing these Lesson Plans, in a sense, as "drafts." We will distribute these individual Lesson Plans as widely as possible. After all Lesson Plans have had a year of public review, we will review and revise as appropriate, then issue a single comprehensive curriculum. We will continue to review and revise the curriculum regularly.

We actively solicit suggestions from anyone reading this. Please send your comments to the Task Group Leader as listed on the title page.

We are writing a textbook based on the material in the lesson plans. The Project Coordinator is the Editor-in-Chief, and works closely with Task Groups to consolidate and revise the material into a comprehensive textbook. All who have contributed to the curriculum will be acknowledged as contributors. The textbook will be submitted for publication in 1997.

## Notes: Stress Management and Critical Incident Stress Debriefing (CISD)

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Anyone who is taking a Wilderness EMT course is likely to share the traits of other emergency services workers, including a macho attitude toward psychological stress. EMTs know all about denial in their alcoholic patients, and may be aware of stress in a theoretical way, but seldom does stress management become part of the EMT's training. This section aims to correct that fault.

Though this section mentions stress management for the WEMT's patient, the WEMT and the WEMT's wilderness coworkers are the true objects of the section. Judging by the criteria that Dr. Mitchell popularizes for critical incidents, almost **every** wilderness search and rescue operation qualifies. This section should prepare the WEMT to recognize immediate stress reactions, provide on-scene psychological "first aid," and recognize the need for and value of CISD.

We are privileged to have the participation of Dr. Jeff Mitchell, the "father" of CISD for emergency services workers in the U.S., in our Task Group.

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## XIX. Stress Management and Critical Incident Stress Debriefing

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### A. Educational Objectives

1. Describe the critical incident stress concept and its long-term consequences, and define Critical Incident Stress Debriefing.
2. Define three major types of stress reactions.
3. Give examples of the physical, emotional, cognitive, and behavioral effects of immediate stress reactions.
4. Describe the signs and symptoms of delayed stress reactions.
5. Describe six major psychological characteristics of emergency services workers.
6. Describe appropriate stress management for WEMTs and others involved in critical incidents. Specifically, discuss the effects of
  - a. shift length,
  - b. briefing about expected sights or smells,
  - c. body part recovery,
  - d. food,
  - e. soap and water for hand-washing,
  - f. caffeine and tobacco use,
  - g. relief of those with behavioral clues suggesting the beginning of a stress reaction,
  - h. post-operation CISD briefings, and
  - i. criteria for instituting mandatory CISD sessions.
7. Describe stress factors that are common in wilderness search and rescue operations, including
  - a. the experience and "hardening" of wilderness search and rescue personnel,
  - b. the role of cumulative stress in wilderness search and rescue,
  - c. the constant nature of environmental stress for wilderness search and rescue personnel, and
  - d. the need for CISD workers, especially mental health professionals, to use restraint in "pulling" personnel, lest this cause additional stress.
8. Outline the principles of on-scene psychotherapeutic "first aid" during a wilderness search and rescue operation. Specifically, discuss:
  - a. rest breaks,
  - b. behavioral clues to an immediate stress reaction,
  - c. sensory isolation,

- d. the role of group vs. one-on-one debriefing for on-scene use,
  - e. techniques for starting a debriefing session, and
  - f. methods for dealing with a person who “breaks down” during debriefing.
9. Identify four major kinds of CISD.
10. Name and describe seven major phases of a CISD session.
11. Describe stress management techniques that can be used for wilderness and disaster patients. Specifically,
- a. describe the applicability of these stress management methods (ones designed for emergency services workers) to a victim of a wilderness or other disaster;
  - b. describe the three most prevalent psychological states seen in the survivors of a disaster;
  - c. outline a screening mental status exam to be used for classifying disaster survivors;
  - d. outline the criteria for classifying a survivor as having psychosis; and
  - e. outline a management plan for shocked and hysterical disaster survivors.
- b. marital problems, sometimes leading to divorce
  - c. other psychological disturbances
4. Critical Incident Stress Debriefing (CISD) teams now found across world; CISD is a limited intervention that can greatly decrease delayed problems from critical incident stress
5. WEMT’s understanding of concept and CISD process can:
- a. help WEMTs recognize and manage stress in themselves and in other search and rescue team members
  - b. help WEMTs understand and deal with stress reactions in their patients
  - c. help WEMTs recognize situations requiring CISD
  - d. allow WEMTs to diagnose immediate stress reactions and start psychological “first aid”

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### **B. Critical Incident Stress**

1. critical incident stress: the psychological and physical reaction to a highly distressing event; recognized since W.W. II; when at most severe, may result in Post Traumatic Stress Disorder (PTSD)
2. widespread recognition of stress effects on emergency services workers, due to Dr. Jeffrey Mitchell, in recent years
3. long-term consequences of unresolved immediate stress reactions:
  - a. severe depression, sometimes leading to suicide

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### **C. Critical Incidents**

1. **Critical Incident:** any situation faced by an emergency services worker that generates unusually strong emotional impact:
  - a. serious injury or death of an emergency services worker in line of duty
  - b. serious injury or death of a bystander from an emergency services operation
  - c. multiple deaths or serious injuries
  - d. serious injury or death of a child or infant
  - e. any situation that attracts an unusual amount of attention from the media
  - f. any loss of life after extraordinary and prolonged search and rescue efforts
  - g. any situation that is charged with emotion and that causes an emotional response that is beyond normal coping mechanisms of emergency services workers

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### D. Stress Response Syndromes

1. **Immediate Stress Reactions:** at scene or within 24 hours (old term was “acute stress reaction”)
  2. **Delayed Stress Reactions:** variable time after stressful incident; often triggered by something that reminds of first stressful incident
  3. **Cumulative Stress Reactions** (“burn-out”): from mild but unrelenting stress (“not devoured by lions, but nibbled to death by ducks”)
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### E. The Immediate Stress Reaction

1. **Immediate stress reactions** may include physical, emotional, cognitive, and behavioral components, and occurs at time of incident or within 24 hours: **an immediate stress reaction is the response of a normal person to an abnormal situation, and not a sign of any psychological weakness or chronic psychiatric problems.**
2. **Physical symptoms:**
  - a. profound fatigue and weakness
  - b. fine tremor or muscle twitches
  - c. diaphoresis
  - d. vasovagal orthostatic hypotension or vasovagal syncope (simple fainting)
  - e. nonspecific lightheadedness
  - f. nonspecific headache
  - g. difficulty focusing one’s eyes
  - h. nonspecific difficulty hearing
  - i. palpitations
  - j. dyspnea and chest pain with or without hyperventilation
  - k. nausea, vomiting, diarrhea, or abdominal pain
  - l. sensation of lump in throat (globus hystericus)
3. **Emotional symptoms:**

- a. anticipatory or generalized anxiety
- b. strong fear or even panic reactions
- c. psychological shock
- d. survivor guilt uncertainty
- e. acute grief reactions
- f. depression
- g. intensified or inappropriate emotional reactions to normal occurrences

#### Cognitive symptoms:

- h. blaming others (sometimes even those who are logically blameless) for the critical incident
- i. generalized confusion
- j. inability to concentrate
- k. inability to perform simple calculations
- l. poor attention span
- m. memory lapses
- n. anomia (inability to find right words)
- o. inability to distinguish difference between serious and trivial concerns
- p. inability to make decisions
- q. greatly increased (or greatly decreased) alertness and awareness of surroundings

4. **Behavioral symptoms:** relative to person’s normal behavior patterns, which may vary widely between individuals:
  - a. changes in normal activity patterns
  - b. changes in speech patterns
  - c. withdrawal
  - d. angry outbursts
  - e. hypervigilance (increased suspicion and attention to one’s environment), or even outright paranoid behavior
  - f. changes in interactions with others (wife, friends, team members, etc.)
  - g. increase or decrease in appetite or alcohol consumption
  - h. sleep disturbances, including early morning awakening, early insomnia, hypersomnia, and generalized fatigue

- i. visits to health professionals (possibly including team WEMT) for seemingly minor or even nonexistent problems

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## F. Delayed Stress Reactions

### 1. Delayed stress reaction

- a. more than three weeks of symptoms
  - b. symptoms continuous or intermittent
  - c. usually from 2-3 days after incident to 3-4 weeks after
  - d. may last weeks, month, or years
  - e. sometimes after “trigger” stimulus reminiscent of critical incident
2. symptoms include:
- a. behavioral, cognitive, physical, or emotional symptoms as for immediate stress reactions
  - b. constricted affect (limited range of emotions)
  - c. sense of detachment from normal life events (“derealization”)
  - d. guilt over survival (when others didn’t survive)
  - e. recurrent dreams, or intrusive waking images, about incident (“flashbacks”)
  - f. fear and anxiety, sometimes overwhelming, and particularly, fear of another similar incident
  - g. regression (retreat to infantile or childish defense mechanisms)
  - h. avoidance behavior (avoiding circumstances or places that remind person of stressful incident)
  - i. preoccupation with death
  - j. sleep disturbances as described for immediate stress reactions
  - k. olfactory (smell) hallucinations

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## G. Cumulative stress reaction

1. **Cumulative stress reaction (“burn-out”)** beyond scope of WEMT training;

Mitchell’s *Emergency Services Stress* provides more on cumulative stress<sup>1</sup>

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## H. Emergency Services Workers

1. Emergency services workers do not respond to some psychotherapeutic approaches
2. example: one technique, which answers question with another question, is ineffective: (“Why do you think I am having trouble sleeping?” “What makes you believe that you’re having trouble sleeping?” “Dammit, that’s what I came to you for help with!” [Emergency services worker walks out. Or, if the emergency services worker is particularly action-oriented, emergency services worker punches mental health worker in the nose!!].)
3. techniques for use with emergency services workers are effective for others, too
4. emergency services workers:
  - a. have **obsessive/compulsive** personality traits
  - b. like to be **in control**
  - c. are **risk oriented**
  - d. are **action-oriented**
  - e. **“need to be needed”**
  - f. are **dedicated**

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## I. Stress Management and the WEMT

1. guidelines for disaster (and search and rescue) stress management:
2. maximum of 12 hour shifts (sustained SAR stress level is lower than most disasters; for SAR, the 12-hour “maximum” is an ideal, not a rule)
3. brief those new on-scene, especially about disturbing sights or smells

4. those recovering bodies or body parts likely to need early relief
  5. food: no skin, bones, or fat, and not burned; no concentrated sweets (like caffeine, sweets may accentuate stress response, and tend to cause hypoglycemia later; also require large amounts of water for digestion)
  6. for psychological reasons, those dealing with bodies or body parts, even if wearing gloves, must have water and soap for hand-washing
  7. caffeine and tobacco
    - a. increase stress reactions
    - b. 700 mg of caffeine = 7 cups of coffee causes primary psychiatric symptoms even if no stress; 2000 mg = 20 cups of coffee is fatal dose for adult
    - c. hot cocoa has theobromine, similar but less potent than caffeine, and is good alternative; herbal teas also good
    - d. keep stressed people away from caffeine and nicotine for at least 4 hours
  8. relieve anyone who shows significant changes in behavior
  9. may want to ask CISD team to respond to mission early, if likely stressful
  10. for any critical incident, all released from Base need pre-release session with information about stress reactions, ways of dealing with them, and where to get help
  11. formal CISD sessions mandatory if: suicide, many casualties, serious injury or death of SAR team member or EMT in line of duty (or even not in line of duty if unexpected or particularly disturbing)
    - a. quick defusing in 8-12 hours
    - b. full debriefing in 3-7 days
    - c. if needed, debriefings for coworkers and spouses as second and third separate sessions
  12. If major stressful incident occurs during SAR mission (E.g., team member seriously injured but lost person still lost):
    - a. CISD professionals “spot check” for individuals showing stress
    - b. perform a defusing with Field Team when back to Base
    - c. hold formal CISD after mission completed
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### **J. Wilderness SAR and Stress**

1. “hardening”
  - a. emergency services workers are “hardened” to grisly sights and smells
  - b. wilderness search and rescue personnel have less exposure to such, so WEMT must consider background when estimating psychological impact
2. many SAR operations are not critical incidents, but may leave lingering stress brought out by subsequent missions; search and rescue debriefings may bring out stresses from prior missions
3. in most critical incidents, stressed person may be brought out to psychologically safer area; in wilderness, stress is from hostile environment itself; leaving hazard area may take a long time
4. be conservative in “pulling”
  - a. mental health professionals and WEMTs should be conservative in “pulling” SAR personnel from operations
  - b. SAR personnel accustomed to levels of long-sustained chronic stress
  - c. may show signs of an early stress reaction, yet continue to be completely functional for long time
  - d. “pulling” may increase stress on person, and on those who must take up extra burden

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**K. Psychotherapeutic First Aid**

1. WEMTs capable of on-scene psychotherapeutic “first aid”
2. WEMT should look for those with signs of immediate stress and arrange rest breaks
3. identify those with immediate stress reactions:
  - a. person walking about aimlessly
  - b. person sitting and staring blankly (unless simply exhausted)
  - c. person behaving irrationally
4. isolate person from sights, sounds, and smells of incident
  - a. have person face away from incident, or put person on other side of a vehicle
  - b. if smells are prominent, person should be moved upwind
  - c. if patient should not be moved, place an object to block patient’s view
5. When engaged in on-scene psychological “first aid,” peers (e.g., WEMTs) can ask “Hey, are you OK?” (CISD-trained peer must be emergency services worker; for SAR personnel, ideal “CISD-trained peer” is SAR team member with CISD training) However, this is **not** acceptable coming from a mental health worker at the scene
6. For psychological “first aid,” WEMT just needs to lend a sympathetic ear
  - a. if you need to prompt person to start talking, start asking about facts first, and only after some rapport is established, start asking about feelings
  - b. section describing formal CISD process provides an outline that may be used in individual sessions
7. When an emergency services worker “breaks down” in formal debriefing or informal peer debriefing:

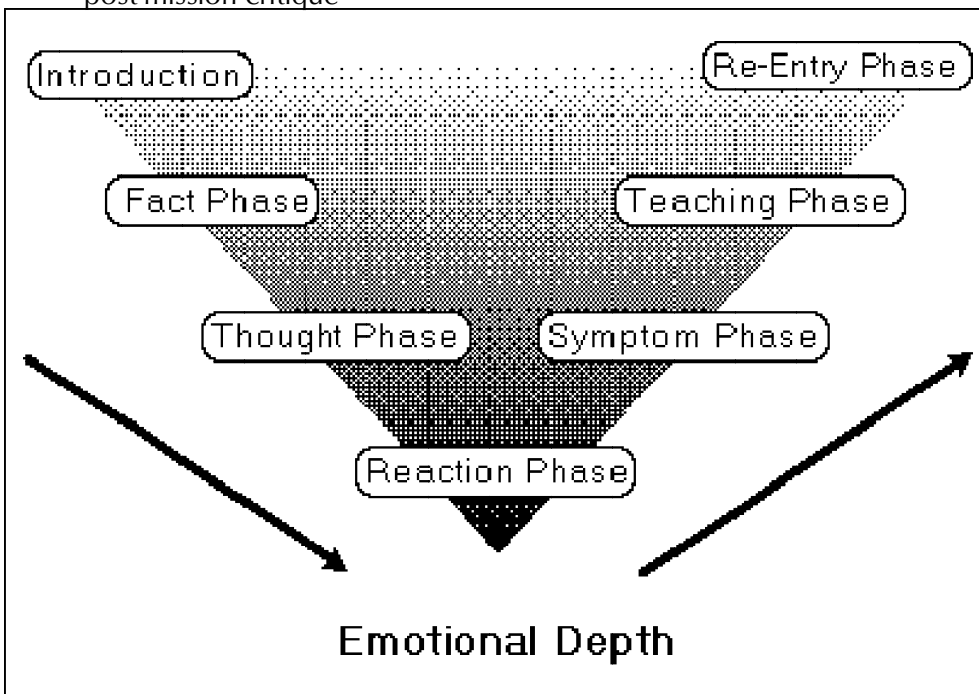
- a. **validate** person’s feelings (“Hey, this is pretty hard for **all** of us to take.”) then
  - b. **back off**, going to another person or another topic; do not abandon the person, but monitor him or her; arrange extra help if it seems necessary
  - c. arrange for additional help later
8. Group intervention **never** appropriate at scene where hazards still a problem
    - a. group intervention moves participants from cognitive level to emotional level
    - b. emotional ventilation important for long-term mental health
    - c. however, intensive emotional charge of group session causes diminished cognitive function, which can interfere with ability to deal with hazards of wilderness SAR
    - d. group debriefing might be appropriate at stable Base Camp, but only when people will have several hours of rest after group session, and thus be able to regain cognitive function
    - e. an initial defusing session at Base Camp at end of each shift might be appropriate for certain stressful operations
    - f. formal CISD sessions **only** when away from hazards and distractions of search Base Camp during the search; may sometimes be appropriate to have session at Base, but after operation concluded

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**L. Critical Incident Stress Debriefing**

1. four types of critical incident stress services:
2. **On-Scene Support Services**
  - a. usually by CISD-trained peer support personnel and sometimes by mental health professionals; similar to one-on-one WEMT psychological first aid,

- is almost always one-on-one (group debriefing **rarely** appropriate except for certain teams or shifts)
  - b. "Spot check" for those showing signs of stress
  - c. advise Incident Staff on psychological aspects (e.g., whether Field Team should go back into field or rest)
  - d. assist with disaster victims, bystanders, or family members; even though not part of CISD team's role, may be best available for such problems; techniques for dealing with emergency services workers work for general public
  - e. is effective in reducing post-traumatic stress disorder in military and civil disasters<sup>2</sup>
- 3. Defusing**
- a. within few hours of critical incident, preferably led by CISD professional or CISD-trained peer; for remote SAR missions, may be led by IC if CISD-trained personnel not available
  - b. lasts about an hour; **separate** from any post-mission critique
- c. atmosphere **must be** positive and supportive, with an interest in feelings of those present
  - d. all present should be encouraged (not forced) to express their feelings, and no one should be criticized for their feelings by IC or anyone else
- 4. Formal CISD** is described below
- 5. Follow-up Services**
- a. when needed, for several weeks after an incident
  - b. includes:
    - (1) telephone conversations
    - (2) visits to a fire or police station, or to SAR team meeting
    - (3) one-on-one contacts
    - (4) small group sessions
  - c. often start with single group meeting one week after full CISD session, for assessment of need for particular services
  - d. may take on aspects of general psychotherapy, and may be extended into additional group sessions



**Figure 1. The Phases of CISD.**

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### M. CISD Phases

1. as session proceeds, discussion moves into more emotionally-charged topics, then gradually comes back out into less-emotional discussion; the seven phases are:
2. the **Introduction:** ground rules, such as confidentiality, are laid down
3. the **Fact Phase:** situation and aspects which made it difficult briefly reviewed; emphasis on how those facts produced emotions
4. the **Thought Phase:** participants state their first thoughts upon exposure to worst part of incident
5. the **Reaction Phase:** participants state their overall feeling or emotional reaction to situation
6. the **Symptom Phase:** group discusses cognitive, physical, emotional, and behavioral symptoms at scene, or within days or weeks
7. the **Teaching Phase:** group leader reassures that group is experiencing normal reactions to bad incident, and not going crazy
8. the **Re-entry Phase:** group asks questions and clarifies what has occurred; may then make referrals for additional help

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### N. Obtaining CISD Teams

1. CISD teams generally available through local law enforcement, fire, or EMS
2. International Critical Incident Stress Debriefing Team Coordination Center: 1-410-313-2473 (Emergency Only)
3. General CISD information: American Critical Incident Stress Foundation, Inc., P.O. Box 204, Ellicott City, MD 21041; (410) 750-0856

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### O. Managing Patient Stress

1. studies of psychological impact of disasters apply to the wilderness patient, who is the victim of small but psychologically devastating disaster<sup>3</sup>
2. everything above about stress reactions in emergency services workers applies to victims of disaster or wilderness rescue
3. most disaster victims fall into one of three classes:
  - a. 1/3 function adequately; may show a few signs of immediate stress reaction
  - b. 1/3 are stunned and in psychological shock
    - (1) may show physiologic signs of a hyperadrenergic state, including diaphoresis, clammy skin, dull eyes, dilated pupils
    - (2) may be inactive and withdrawn
    - (3) when asked questions, may respond slowly or not at all
  - c. 1/3 are hysterical; agitated, physically very active, and generally out-of-control
    - (1) most not truly psychotic, but unable to slow down enough to think clearly, or even to talk rationally
    - (2) may have amnesia for recent events, or may develop hysterical paralysis of limbs
    - (3) despite what one learns from television, **never** slap a hysterical person or use force
4. first, do quick baseline mental status exam
  - a. if all three items are appropriate, person is adequately functioning
  - b. if any one is inappropriate, person is hysterical or shocked
  - c. use **SEA-3** mnemonic for the 3 items:
    - (1) S- Speech
    - (2) E- Emotional status or response

- (3) A-3- Alertness, Awareness, and Actions (behavior)
- 5. a disaster survivor with severe thought disturbances, or hallucinations or delusions, shows some degree of psychosis
  - a. a very few disaster victims will be overtly psychotic
  - b. detailed guidelines for diagnosing and dealing with psychotic reasoning in section on General Medicine
  - c. evacuate psychotic patients to a medical facility for therapy
    - general rules for dealing with hysterical and psychologically shocked people:
  - d. isolate person from sights, sounds, and smells of incident
  - e. give simple, clear, gentle directions
  - f. find something constructive for person to do
  - g. Example: say “You’re psychologically shocked from this disaster; right now, the best thing for you, and for the rest of us, is for you to help out by bringing water up from the creek.” (validates person’s perception of not functioning normally, provides something to do, and gets person away from scene)
  - h. once initial shock wears off, gently “wean” people into making own decisions
    - i. honesty:
      - (1) all dealings with these people must be completely honest
      - (2) cooperation depends on credibility
    - j. many will benefit from having someone to talk to; if you have psychologically secure victims, ask them to talk with psychologically “walking wounded”
  - k. protect victims from the media
    - l. isolate disruptively hysterical people, preferably with a stable person who can “talk them down.”
  - m. avoid sedatives and psychotropic drugs unless absolutely necessary;

they may mask physical injuries, and are a poor substitute for evacuation and counseling

- n. if sedation is absolutely needed, 1 to 5 milligrams of haloperidol (Haldol®) IM or PO is first choice; sedatives and antipsychotic medications discussed in detail in Pharmacology section
- o. Disaster section also discusses psychological impact of disasters

**Glossary**

**Affect:** When used in the psychological or mental status exam context, **affect** means the physical signs of emotion; someone who shows no signs of emotion has a flat affect, and someone who is depressed may show a sad affect.

**Anomia:** inability to find the right words.

**Critical incident:** An incident causing such a high level of psychological stress that many exposed to it develop immediate or delayed stress reactions.

**Critical Incident Stress Debriefing:** CISD is a form of limited intervention that is highly effective in preventing many of the ill effects resulting from exposure to a critical incident and its attendant immediate and delayed stress reactions.

**Critical incident stress:** psychological stress resulting from specific critical incidents that cause high levels of psychological (but not necessarily physical) stress.

**Cumulative Stress Reaction:** a set of abnormal and maladaptive responses to chronic high levels of stress.

**Delayed Stress Reaction:** a psychological reaction, characterized by unusual physical, emotional, cognitive, and behavioral signs and symptoms, occurring weeks or months after exposure to a critical incident, and often triggered by a seemingly innocuous stimulus.

**Globus hystericus:** sensation of a lump in the throat due to stress.

**Hallucinations:** sensory impressions of objects or people that do not exist in reality; hallucinations may be visual, auditory, or even tactile or olfactory.

**Hypersomnia:** sleeping too much.

**Hypervigilance:** increased suspicion and attention to one’s environment.

**Immediate Stress Reaction:** a psychological reaction, characterized by unusual physical, emotional, cognitive, and behavioral signs and symptoms, occurring at, or soon after, exposure to a critical incident.

**Insomnia:** Inability to go to sleep normally.

**Olfactory:** relating to the sense of smell.

**Peer:** “1. a person of the same civil rank or standing; an equal before the law. 2. one who ranks with another in respect to endowments or other qualifications; an equal in any respect.” When talking about trained peers in respect to CISD, we mean people who have similar enough backgrounds to be regarded as “one of us.” Thus, a CISD-trained peer must be an emergency services worker. For SAR personnel, an ideal “CISD-trained peer” is a member of a SAR team with CISD training.

**Post-traumatic Stress Disorder (PTSD):** a psychiatric disorder caused by an exposure to a severe stress. PTSD usually needs special treatment by a mental health professional.

**PTSD:** Post-Traumatic Stress Disorder.

**Regression:** retreat to infantile or childish defense mechanisms.

**Theobromine:** a chemical found in cocoa and chocolate that has stimulant actions similar to caffeine.

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