THE GLOSSARY OF TERMS IN CRISIS INTERVENTION AND DISASTER MENTAL HEALTH

A Collection of Definitions, Illustrations, and Instructional Annotations

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Introduction

Vocabulary is a beast few can master.
It shapes your interpretation and your expression. It has the power to inform or mislead. If not tamed it will surely lead to chaos.

A fundamental understanding of key terms and concepts is critical to understanding any field of endeavor. When I was a student entering a new field of knowledge or practice, I was often frustrated by the lack of a small highly focused glossary of key terms and concepts. Voluminous dictionaries I found to be too cumbersome and seldom focused enough to be of value. It seemed to me the fields of psychological crisis intervention and disaster mental health could benefit from a small-focused glossary of key terms and concepts. So, 50 years later, I decided to offer one such glossary.

The lack of a standard nomenclature can hinder progress in any field of endeavor. This has been true in the fields of crisis intervention and disaster mental health. Though I've lived this experience for decades, it was brought to my attention by none less than a frustrated former Assistant Surgeon General of the United States and Director of the National Institute of Mental Health, Dr. Bertram Brown, as we discussed the emergence of the nascent field of disaster mental health in 1991. He noted the ambiguity that plagued these endeavors. The frustrating nature of semantic ambiguity is by no means new. This notion was beautifully exemplified in Lewis Carroll's Alice's Adventures in Wonderland and Through the Looking Glass. Alice Pleasance Liddell (1852 – 1934) was the little girl who inspired Lewis Carroll's famed book. In the story, Alice meets Humpty Dumpty. Upon telling Humpty her name, he comments that her name is a "stupid" name because it doesn't mean anything. Alices responds by asking if a name must always mean something. This prompts Humpty to respond in a scornful tone, "When I use a word," it means just what I choose it to mean – neither more nor less." It seems such arbitrariness plagues many newly emerging fields of inquiry. But words remain the essential currency of research and practice.

Sadly, vocabulary can be an unruly beast difficult to tame for most. Even in lofty academic circles, George Engel noted that rational discourse is predicated on the consistent use of terms. Similarly, as TS Eliot once noted, words decay with imprecision, and as words decay, ideas decay, and ideas decay, practice decays. This is clearly problematic in the fields of early psychological intervention and disaster mental health, wherein the current state of affairs still evidences no prevailing standard nomenclature. The story of Alice and Humpty above raises the question of whom or what should be the final arbiter of words and their definitions? When deciding how a

word should be used, seminal and primary sources (as in any academic endeavor) should be given the initial consideration. That said, there are some terms that, with more "modern" or informed usage or research, must be modified. To offer a potential beacon of clarity, here is a glossary of terminology relevant to the extant enterprise. As is the standard of practice in any such denotational pursuit, seminal and primary sources are given the greatest credibility. Secondary and tertiary sources, due to their inherent weaknesses of low reliability and validity, are given lower credibility but may be worthy of mention, if for nothing else to correct misuse. Lastly, many of the terms included herein are presented from the perspective of psychological crisis intervention and Critical Incident Stress Management (CISM). This makes the current volume highly unique but also limited in scope.

Disclaimer: Given the aforementioned descriptions, it should be noted that this glossary is not intended to be all-encompassing. It focuses on terms and concepts which, in the opinion of the author in his 50 years of experience as teacher and trainer, are most relevant to the understanding and practice of psychological crisis intervention, CISM, and disaster mental health. While the definitions offered range from the simplistic to the complex, in the aggregate, they are not intended to be comprehensive in depth nor scope. Some may even seem arbitrary. So, in the final analysis and spirit of full disclosure, this glossary reflects the biases, albeit informed, of the author as is the case in any dictionary, glossary, or compendium of terms.

Acknowledging the aforementioned disclosure, those new to psychological crisis intervention and disaster mental health, especially those without a mental health background or formal training should still find this glossary useful. Not only are there "definitions" contained herein, but this glossary contains many detailed annotations with source citations that go far beyond what one would likely find in most dictionaries or glossaries. Thus, the "peer" interventionist should find the volume highly useful. The psychologist, psychiatrist, and social worker should find this glossary useful, perhaps not as an endpoint but as a useful beginning.

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Adrenaline – If there is one physiological dynamic that is essential in understanding human stress and trauma, it is adrenaline. Adrenaline is a catecholaminergic hormone released primarily from the adrenal medullae. It serves as a stimulant during the stress response and is a key feature of the "fight or flight" response. It increases strength and endurance. More importantly, it appears to be responsible for encoding memories associated with stressful events. This hormone may be the key to understanding posttraumatic stress disorder in that the intrusive thoughts and images are likely directly related to the cascades of adrenaline that occur in traumatic stress. It is a reasonable inference that high levels of circulating adrenaline may be associated with a higher risk of developing posttraumatic stress and even PTSD. Adrenaline in high levels and chronic elevations may be cardiotoxic. Sustained elevations in heart rate and blood pressure can be due to high levels of adrenaline.

Aldosterone – Aldosterone is a mineralocorticoid hormone released from the adrenal cortices. It has the capability of causing electrolyte retention and, therefore, fluid retention. Subsequent elevations in blood pressure may be seen. It may also be associated with irritability if it leads to neural edema. Aldosterone can be present in and an underlying contributor to disorders associated with chronic stress.

Alpha Error – In inferential statistical research, there are two errors that can be made: Alpha error and beta error. The alpha error is "a false positive." It is the error of "finding something that is not there." In other words, the researcher concludes the existence of an effect or outcome that, in actuality, does not exist within a research study. Or, the alpha error could appear as a clinician concluding the presence of a disease or disorder that, in actuality, is not present. The alpha error is what is routinely reported with a corresponding P-value of .05. The alpha error is the reciprocal of true negative specificity (accurately inferring the absence of an effect).

Alzheimer's Dementia – Alzheimer's Dementia is the most common form of dementia (impairment in thinking). It was discovered in 1906 by Dr. Alois Alzheimer. It is caused largely by the death of brain cells within the hippocampus and the prefrontal cortex of the brain, secondary to the development of large concentrations of beta-amyloid (waste products within the brain) and clumps and entanglements of nerve cells (tau bundles). There is no cure currently. There exist some treatments which can delay the progression of the disease. See *Dementia*.

Amygdala – If adrenaline is a key to understanding the physiological dynamics of human stress and trauma, then the amygdala is the key anatomical substrate.

The term amygdala refers to two almond-shaped anatomical centers within the

mammalian brain. Functionally, the amygdala is the center of the "fight or flight" stress response. It also is the "doorway" for the storing of emotional and stress/trauma-related memories (McGaugh, 2004). Stress and trauma-related memories are more rapidly and impactfully stored than are everyday memories, which are typically processed via the hippocampus. The amygdala is considered a core anatomical and functional feature of posttraumatic stress disorder.

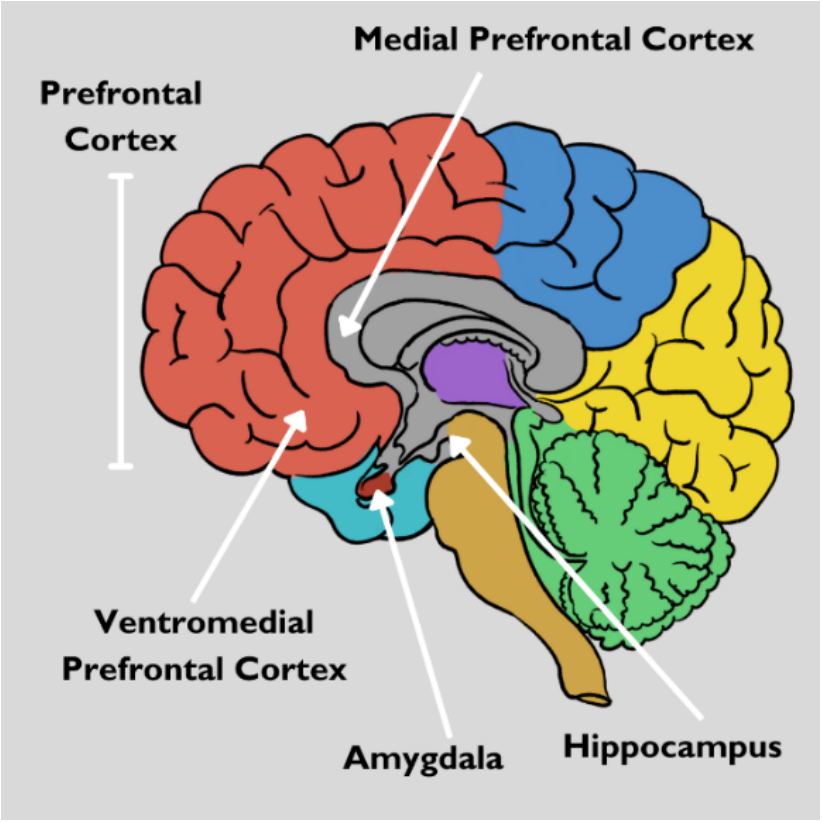

FIGURE 3 – AMYGDALA – HUMAN BRAIN DIAGRAM

FIGURE 3 depicts a medial sagittal section of the human brain. This view reveals the amygdala in relation to the hippocampus and prefrontal cortex. Under normal circumstances, the prefrontal cortex regulates amygdaloid responsiveness to environmental cues.

Amyloid Plaques - Amyloids plaques are anatomical hallmarks of dementia. Plaques begin as strings of amino acids called amyloid-β (Aβ) peptides. When they are not effectively cleared, they accumulate, subsequently interfering with normal neuronal transmission.

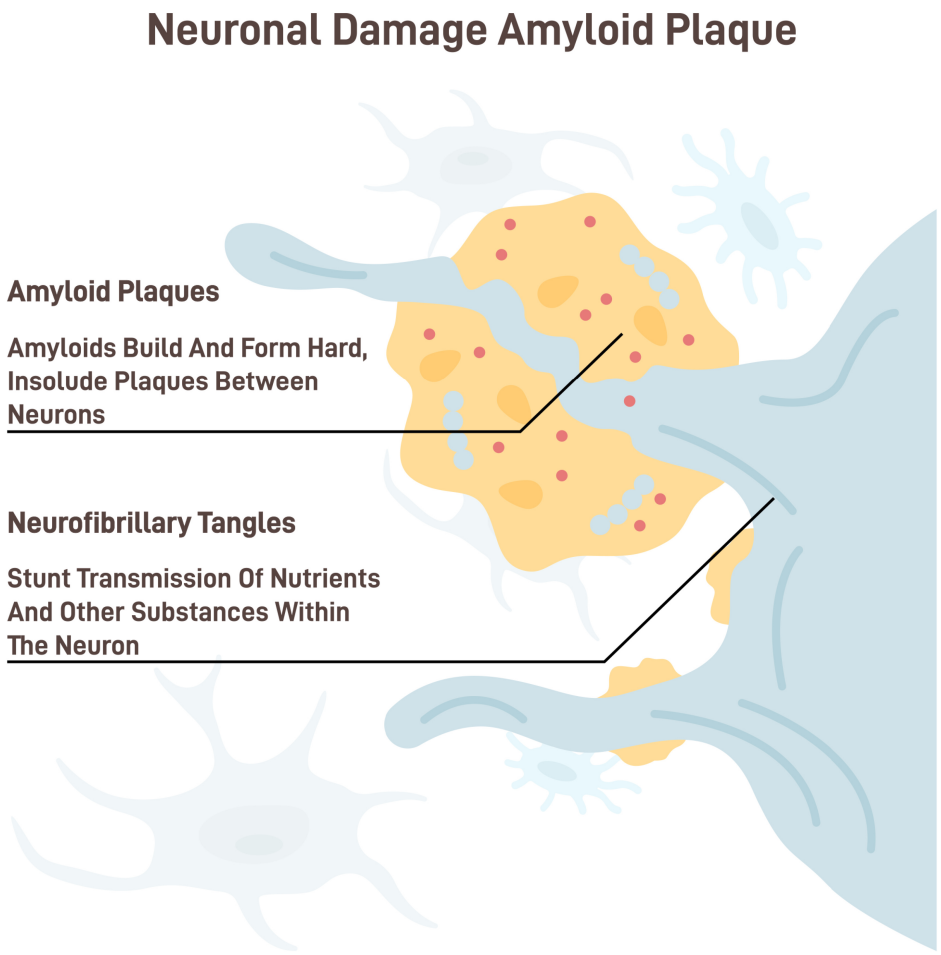

FIGURE 4 – AMYLOID PLAQUES – NEURONAL DAMAGE AMYLOID PLAQUE

Analysis of Variance (ANOVA) – Analysis of variance is an analytic tool used within the scope of inferential statistics. The ANOVA was created by Ronald Fisher as a mechanism to test for statistically meaningful differences between two or more means of two or more measured variables. ANOVA solves the problem of the additive risk of error associated with repeated use of t-tests. T-tests are useful for the comparison of two means at a time, but multiple use within the same analysis increases the risk of an alpha error.

Anniversary Reaction – An anniversary reaction, as used in the current context, refers to a psychological or stress-related physical reaction that occurs on the anniversary of

some highly meaningful event. It is often associated with loss or trauma. It can consist of depression, anxiety, traumatic stress, and a reliving of reactions experienced when the event originally occurred. Anniversary reactions do not have to be dysphoric. They may occur as a sense of relief or some other positive feeling. It is imperative that the crisis interventionist is aware of the potential dysphoria that may arise on the anniversary of any given critical incident. Anniversary reactions can affect individuals, organizations, and even communities. Planning for anniversary reactions would be considered best practice from a CISM perspective.

Anticipatory Guidance – Anticipatory guidance, in the context of stress management and human resilience, is similar to a warning. The term refers to information shared with another person pertaining to a given situation, event, or reaction that may result. This information is shared prior to the actual occurrence. This form of guidance is typically used in the context of advising individuals about the likely effects of exposure to stressors, communicable illnesses, or even medications. Anticipatory guidance allows an individual to understand, normalize, and prepare for potentially adverse reactions. is a way of returning a sense of control to those who may seem overwhelmed.

Antidepressants – Psychiatric medications are seldom used in field application of crisis intervention. That said, some familiarity with them may be useful.

Antidepressants are a class of psychiatric medications that are associated with the treatment of depression. About 9 million people are prescribed antidepressants each year in the United States. There has been almost a 40% increase in prescriptions in the 5 years. This class of medications contains drugs that exert their antidepressant effects through varied and diverse mechanisms. Below is a summary of the major classes:

First-Generation Antidepressants:

- *Monoamine Oxidase Inhibitors (MAOIs)*: inhibit monoamine oxidase which prevents the breakdown of neurotransmitters. Rarely used due to toxicity and potentially lethal food and drug interactions.
- *Tricyclic Antidepressants (TCAs):* Inhibits reuptake of neuro-transmitters; mostly epinephrine and serotonin. Due to side effects and the potential for fatal overdose, it is now seldom used.

Second Generation Antidepressants:

- *Tetracyclic and Unicyclic:* variability inhibit serotonin and norepinephrine reuptake.
- *Serotonin Antagonist and Reuptake Inhibitors (SARIs):* Prevent reuptake of

serotonin as well as stopping it binding to cell receptors.

- *Selective Serotonin Reuptake Inhibitors (SSRIs):* Inhibit reuptake of serotonin. High toxic dose and mild side effects. The most widely prescribed antidepressants in many countries.
- *Serotonin-norepinephrine Reuptake Inhibitors (SNRI):* Inhibit both serotonin and norepinephrine reuptake. Studies have shown that they may have a modest increase in efficiency compared to SSRIs. They also have milder side effects.

Anxiety – Anxiety is a much-misunderstood term with many connotations and denotations. For simplicity's sake, the following is offered. Anxiety may be thought of as a psychological state of apprehension and physical arousal in response to some ambiguous, ill-defined stimulus. Anxiety is often confused with fear. See *Fear*.

Arborization – Arborization refers to a mechanism of neuroplasticity in which the neural axon sprouts branches. In doing so, it increases response sensitivity.

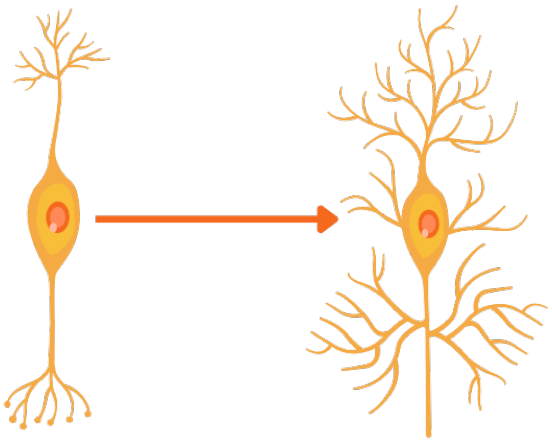

FIGURE 5 - INCREASED ARBORIZATION- NEURON

Assaulted Staff Action Program (ASAP) - "The Assaulted Staff Action Program (ASAP) … is a voluntary, peer-help, systems-wide crisis-intervention approach for coping with the psychological aftermath of violence. ASAP is a Critical Incident Stress Management approach that includes individual crisis counseling, group debriefings, an employee-victims support group, employee-victim family outreach, and professional referrals when needed" … ASAP has demonstrated a 25%-62% reduction in staff assaults" (Flannery, 2001). Designed by Dr Ray Flannery, ASAP has received several national awards for its effectiveness in protecting healthcare personnel (Flannery, 2022).

Attitudes of Equanimity (Calm) – Wellness programs represent proactive interventions on the CISM continuum. It may be argued that the foundation of all successful wellness programming is attitude. Attitudes are far-ranging in their scope and applicability.

Evidence has shown that there are at least four attitudes that one can voluntarily invoke that serve to reduce activity in the stress-related amygdaloid nuclei. Those are the attitudes I refer to as the "four attitudes of equanimity" (calm). They are:

- Gratitude,
- Forgiveness,
- Acceptance, and
- Hope.

Functional neuroscience has shown these attitudes activate the angular gyrus, the anterior cingulate cortex, and the prefrontal cortices, all of which have the ability to dampen acute arousal in the amygdala almost instantaneously. In doing so, they can provide an opportunity to pause, reflect, reassess, and perhaps react differently. More specifically, gratitude mitigates loss and envy. Forgiveness extinguishes anger and vengeance. Acceptance can quash worry, frustration, and misdirected protestation. And hope offers transcendence.

Autonomic Nervous System (ANS) – The immediate response one experiences to a stressful situation is mediated through the autonomic nervous system. Anatomically, the autonomic nervous system is an aspect of the peripheral nervous system. It carries nervous impulses that are concerned with the regulation of the body's internal environment and the maintenance of homeostasis (balance). The autonomic network, therefore, innervates the heart, the smooth muscles, and some endocrine glands. The ANS can be further subdivided into two branches, the sympathetic and the parasympathetic. The sympathetic branch of the ANS is concerned with preparing the body for action. Its effect on the organs it innervates is that of generalized arousal (fight or flight response). The parasympathetic branch of the ANS is concerned with restorative functions and the relaxation of the body. Its general effects are those of slowing and maintenance of basic bodily requirements, thus it is the antithesis of the fight and flight response.

Countertransference – In psycho-analytic traditions, countertransference is the process when the therapist or crisis interventionist projects their own conflicts, traumas, values, and assumptions upon the person they are trying to assist. In the broadest terms, anything that interferes with the objectivity of the interventionist may be thought of as countertransference. Peer interventionists are especially vulner-able to complicating counter-transference reactions. See *Transference*.

Crisis Intervention – Crisis intervention is a short-term helping process consisting of providing brief psychological assistance. Crisis intervention targets a person's reactions to a problem or incident with the goal of stabilizing acute distress (keeping it from getting worse), mitigating acute distress (reducing the acute distress), if possible, and assessing the need for further assistance, facilitating access to such care if necessary. It typically does not focus on problem-solving per se but rather on helping people manage their reactions to their problems. Sometimes, after crisis intervention, people will be referred to professional counseling to continue the support process. Crisis intervention can be conducted by almost any adequately trained adult. Formal mental health training is not necessary. It can be conducted individually, in small groups or in large groups. That said, crisis intervention is a set of skills distinct from counseling and psychotherapy. Training in the latter does not instill competence in the former. See *Psychological Crisis Intervention* below.

Crisis Leadership – See *Leadership*.

Crisis Management Briefing (CMB) – The CMB was developed by George S. Everly, Jr, based on historical and empirical research. It is an information-based group crisis intervention, the goal of which is to provide a forum and formulaic structure for the provision of information. It is based upon the principle that information is an essential aspect of resilience for both individuals and adults. It is applicable for school assemblies and town hall meetings, as well as organizational and even military briefings. It provides a structure for disseminating information after critical incidents and disasters. The CMB typically lasts 30-45 minutes. Questions and answers are held at the end. See TABLE 1 on the following page.

TABLE 1 – CRISIS MANAGEMENT BRIEFING (CMB)

CRISIS MANAGEMENT BRIEFING (CMB)	
STEP 1	Assemble participants (responders, victims, family members)
STEP 2	Provide accurate information about the incident: • What happened? • What was the cause? • What are the real and/or anticipated effects? • What's being done about it? • What's being done to prevent in the future?
STEP 3	Anticipate and discuss potential stress reactions differentiating mild from those of concern
STEP 4	Review resources available for psychological support (community, organizational) Review personal stress management specific to the group's needs

Crisis Triad – The Crisis Triad is an aggregation of three commonly encountered reactions to stressful situations or events:

1) *An impulsive urge to act in a self-defeating, self-injurious manner*, usually based upon an acute loss of future orientation or a feeling of helplessness or hopelessness.
2) *Diminished cognitive capabilities* (insight, recall, problem-solving), but most importantly, a diminished ability to understand the consequences of one's actions.
3) *Diminished functional capacity*; the inability to perform necessary functions of living (self-care, caring for others, working, personal hygiene, logistics of disaster recovery).

While there are myriad reactions that may be experienced in the midst of a crisis, the crisis triad is a constellation of reactions that are of importance for those doing crisis intervention and disaster mental health intervention. Impulsivity, combined with an inability to fully understand the consequences of one's action, portends a most tenuous future and perhaps future catastrophe. Diminished functional capacity in and of itself warrants immediate intervention as it denotes the inability to perform necessary functions of life.

Critical Incident – A critical incident is any event or situation that creates a significant risk of substantial physical or psychological harm to individuals, groups, organizations, or communities. Critical incidents can also be growth-promoting experiences. There are three types of critical incidents:

1) Emergencies,
2) Disasters, and
3) Catastrophes/cataclysms.

Critical Incident Stress Debriefing (CISD) – CISD is a 7-phase psychological crisis intervention conducted in small interactional groups (roughly 3-30 persons) after some highly stressful event. CISD was developed by Dr Jeffrey Mitchell in the 1970s, specifically for use with emergency services personnel. The unique goal of the CISD is to provide a platform not only for ventilation, normalization, and teaching stress management but for psychological closure as well. In this context, closure does not mean "forgetting about" a critical incident; rather, it refers to facilitating the ability to psychologically "move past" the incident, in other words, moving past fixation.

Appropriate timing for the CISD is essential. When used with emergency services personnel in the wake of an incident, a window of 24-72 hours was originally prescribed. This was not a temporal prescription but rather a logistical and psychological one. In other applications, especially disaster applications, that window of opportunity for psychological closure is much different. After the terrorist attacks of September 11, 2001, for example, CISDs were conducted only after the end of deployments or after the closing of Ground Zero in May 2002. CISDs should only be used after the operational deployment is complete. The CISD is most likely the best opportunity for psychological closure to be approximated, although closure may sometimes be attained after a defusing or CMB. Simply said, timing for the CISD is psychological and logistical, not temporal.

The CISD has seven discrete phases:

1) Introduction Phase,
2) Fact Phase,
3) Thought Phase,
4) Reactions Phase,
5) Physical Symptom Phase,
6) Teaching Phase, and
7) Re-entry/ Summary Phase.

The use of the CISD has been expanded to the military and various other professional groups.

Group CISD has been validated as effective through the use of randomized controlled trials. CISDs are never to be done with individuals, one person at a time. CISD was accepted into the SAMHSA Registry of Evidence-based Practices in 2017.

See *Debriefing Debate*, *Critical Incident Stress Management (CISM), Defusing,* and *Crisis Management Briefing*.

Critical Incident Stress Management (CISM) – CISM is a strategic crisis and disaster response planning system wherein multiple crisis and disaster response interventions are coordinated along an integrated continuum of care. The system was developed in the 1980s by Dr Jeffrey Mitchell for use with emergency services and disaster response personnel. Research has supported its effectiveness. CISM is commonly confused with CISD. CISD is one component of CISM. CISM-like programs are very popular in law enforcement and in healthcare settings and have been validated in disaster settings and healthcare (Boscarino, Adams, & Figley, 2005; Flannery, 2022)). It may be argued that peer-based CISM-like intervention systems are the standard of care for psychological support in the law enforcement profession (Sheehan, FBI Law Enforcement Bulletin, 2004; Federal Law: COPS, 2021), air traffic control, and in the healthcare professions (ASAP; Johns Hopkins RISE and MESH programs; Flannery, 2022; Moran, Wu, Connors, et al. 2017; Wu, Connors & Norvell 2022). CISM is a virtual "toolbox" for numerous and varied psychological crisis interventions and other preparatory and subacute interventions.

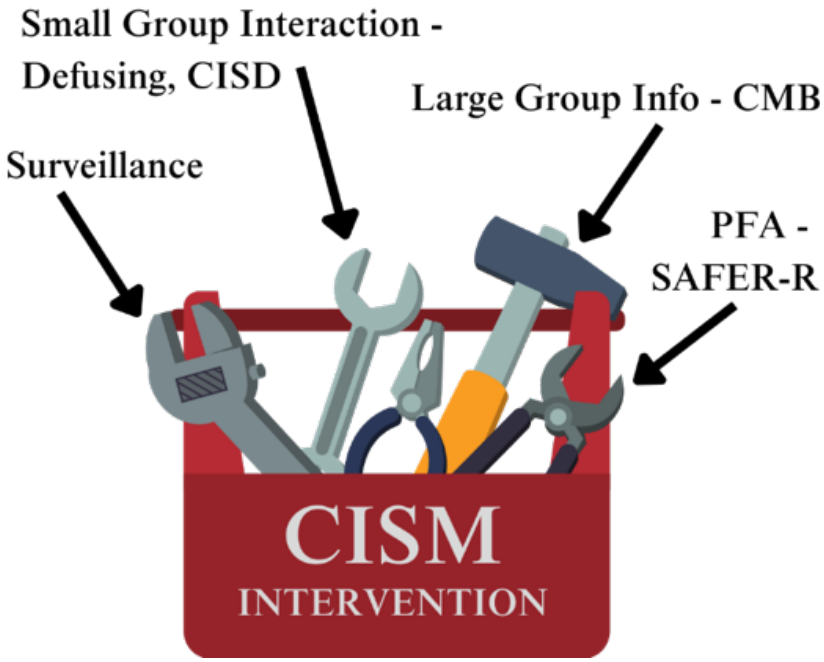

FIGURE 12 – CISM – CISM TOOLBOX