OPERATIONAL STRESS FIRST AID:
Training Manual for Those Who Respond to Critical Incidents

Managing Stress for Healthier Living

COSFA developed and produced by:

Bureau of Medicine and Surgery, Department of the Navy

In cooperation with:
Combat and Operational Stress Control, Manpower & Reserve Affairs, Headquarters Marine Corps

Navy Operational Stress Control, Chief of Naval Personnel, Total Force N1 National Center for PTSD, Department of Veterans Affairs

June 2010

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With appreciation to the North American Mission Board of the Southern Baptist Convention for their adaptation of COSFA for Southern Baptist Disaster Relief and for their contribution to the QuickSeries version of Operational Stress First Aid (OSFA) first published in 2012 and revised in 2016.

Purpose

The Combat and Operational Stress First Aid (COSFA) Training manual is a companion document for the COSFA for Caregiver training course. The COSFA training is based on the concepts of the Maritime Combat and Operational Stress Control program for the U. S. Marine Corps and the U.S. Navy. The content in this manual is intended to provide information to Navy and Marine Corps caregivers about immediate responses to preserve life, prevent further harm, and promote recovery for preclinical stress injury. COSFA is not a replacement for professional judgment of leaders and clinicians or indicated clinical care.

Copyright Statement

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The views expressed in this document are those of the authors and do not reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. Government.

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STRESS MANAGEMENT and Appendices Q-V have been added by Dr. Paget in 2017

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Table of Contents

OPERATIONAL STRESS FIRST AID (OSFA)

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What are Stress and Coping?

"STRESS"

Any challenge to the body or mind
- Necessary for life and accomplishment

"DANGER"

Chinese pictogram for "STRESS"

"OPPORTUNITY"

危機

"COPING"

Changes in our bodies, minds, or environments to adapt to stress
- Coping is how we manage stress

Brief History

- Group Post Trauma Interventions
  - Individual, Defusing, CISD
- Community Disaster Response
  - Psychological First Aid (PFA)
- Military/Combat Models
  - BATTLEMIND
  - COSFA
- SBC Disaster Relief Contextualization (2011)

Psychological First-Aid

- Evidence informed modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism.
- Eight core actions.
- Focused attention on how people are reacting and interacting in the setting.
- Intended for individuals and families but can be readily adapted to groups.
- PFA adapted by American Red Cross and modified for military families facing deployment.

Field Operations Guide for Psychological First Aid published by the National Center for Child Traumatic Stress Network and National Center for PTSD (2006)

Operational Stress First-Aid (OSFA)

A multi-step process for assessment and care of stress reactions or injuries in individuals or teams

Goal:
preserve life
prevent further harm
promote recovery

Primary-Aid - safety and calming; save a life, prevent further harm

Secondary-Aid - promote recovery or facilitate appropriate referral for further evaluation or care

5

OSFA is NOT…

- An event only intervention
- A one-time only intervention
- A replacement for needed medical or mental health treatment
- A replacement for prevention efforts

OSFA Evidence Support

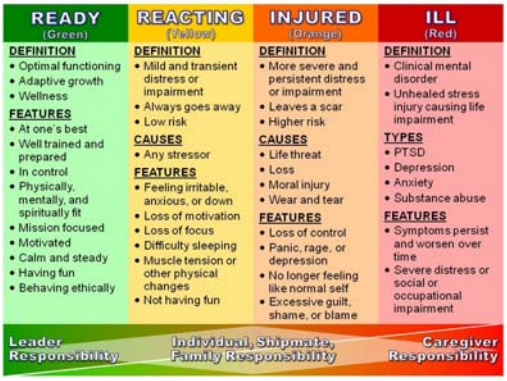
Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. Hobfall, Watson, Bell, et al., (2007). *Psychiatry*, 70 (4), 283.

1. Promote sense of safety
2. Promote calming
3. Promote connectedness
4. Promote sense of self and collective efficacy
5. Promote hope

Key Points

- Stress as a continuum
- Four sources of stress injury
- Good leaders are great medicine.
- One size does not fit all.
- Training and context matter.

Figure 1. Stress Continuum



5

Where OSFA Fits In the Stress Continuum

	READY (Green)	REACTING (Yellow)	INJURED (Orange)	ILL (Red)
Leader Tools	• Strengthen • Mitigate • Indentify • Treat • Reintegrate			• Policies • Mission Requirements
Care-Giver Tools	• Education • Awareness • Faith			• Cognitive-behavioral therapy • Medication • Other evidence-based treatments
Self, Buddy, & Family Tools	• Spirituality • Emotions • Mental (cognitive) • Physical (fitness & nutrition) • Environment • Relationships			• Information Seeking • Support • Advocacy

6

Three Faces of Stress

Stress is NECESSARY

Stress can be TOXIC

Stress can be NUCLEAR

- Stress is essential for:
  - Strength and toughness
  - Growth and development
  - Acquire new skills
  - Meeting challenges
  - Performing difficult missions
- Stress can lead to:
  - Persistent internal distress
  - Functional impairment
  - Misconduct
  - Substance abuse
  - Mental disorders

7

WHAT IS STRESS?

Getting familiar with the basics . . .

Stress is the response we have to any challenge to our minds and bodies.

Stress is normal.

Stress can be good.

Stress keeps us sharp and focused.

Distress As the Trauma Response

- The Nature of Stress

  The non-specific response of the body to any demand made upon it

  Selye

- The Internal Trauma Response

  "fight or flight"

See Appendix R, 123-126

EUSTRESS vs. DISTRESS vs. DYSFUNCTION

Three intensity levels of stress:

Eustress = Positive, motivating stress

Distress = Excessive stress

Dysfunction = Impairment

STRESS REACTION CATEGORIES

- FIGHT
- FLIGHT
- FREEZE
- FLOW

STRESS

A response to a stimulus characterized by increased physical and psychological AROUSAL

(Everly, 1999)

SIGNS AND SYMPTOMS OF DISTRESS

I. COGNITIVE

II. EMOTIONAL

III. BEHAVIORAL

IV. PHYSICAL

V. SPIRITUAL

Cognitive: Mental Response

- Cognitive-Emotional Imbalance
- Confusion
- Forgetfulness
- Lack of focus
- Disorientation
- Illogical
- Lack of reasoning

Physical: Biological Response

- Physical shock
- Rapid heart beat
- Shallow breathing
- High blood pressure
- Headaches
- Muscle spasms and pain
- Stomach aches
- Insomnia
- Heart burn

Emotional Psychological Response

- Fear
- Anger
- Grief
- Sadness
- Loneliness
- Apathy
- Resentment
- Guilt
- Hopelessness
- Rage
- Denial
- Abandonment
- Anxious
- Depression
- Overwhelmed
- Panic

Behavioral: Action Response

- Changes in eating, sleeping
  - Eating too much or not enough
  - Sleeping too much or not enough
- Emotional outbursts
- Pacing
- Withdrawal
- Substance abuse
- Changes in communication

Spiritual: Faith Response

- Challenge existing beliefs
- Anger at God
- Doubt
- Forgiveness
- Lack of trust
- Ungratefulness
- Judgmental or legalistic
- Questions about faith and God
- Seek spiritual support, reassurance, guidance
- Ask for prayer, intercession, purification
- Blaming God, the devil, demons

General Sources of Operational Stress

Physical/environmental	Heat Cold Dehydration Sleep deprivation	Injury Illness Toxins Exertion
Emotional	Anger or hatred Horror Terror	Guilt or shame Grief or loss Fear of failure Fear of injury or death
Cognitive/mental	Hyperfocus Boredom Uncertainty	Lack of information Too much information
Social/relational	Isolation Loss of personal space	Being away from loved ones and friends
Spiritual	Challenge of faith Moral conflict Anger at God	Life doesn't make sense like it used to

What is Coping?

… a change to adapt to stress

8

Ways to Manage Stress

Strengthen Yourself	
Physically	**Mentally**
Build strength	Embrace familiarity
Work on physical endurance	Be confident
Practice physical skills'	Have a positive attitude
Stay fresh and well rested	Inoculate yourself from stress
Emotionally	**Spiritually**
Acknowledge feelings and reactions	Worship
Identify the source of feelings	Pray
Vent appropriately	Read your sacred texts
Avoid compacting and denying feelings	Challenge your values and beliefs

Ways to Manage Stress

Manage Your Environment	
Physical Environment	**Relational Environment**
Wear protective equipment	Trust and support others
Take part in recreational activities	Be a team player
Be prepared for tasks	Strive for family cohesion
Reduce environmental stressors	Strive for team cohesion
Reduce unnecessary physical stressors	Be patient with others

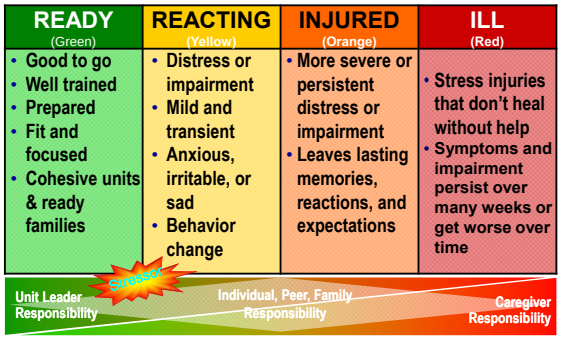
Ways to Manage Stress

Compartmentalize Stress	
Thinking	**Feeling**
Tune out dangers	Feeling numb to fear
Let go of horrors	Feeling numb to sorrow
Don't dwell on negatives	Feeling numb to suffering
Avoid self-blame	

Give impacted people language to communicate their reactions to acute distress

…most people can't tell you how they feel…

Stress Continuum



9

Most Important Distinction:
Yellow Zone Reactions vs. Orange Zone Injuries

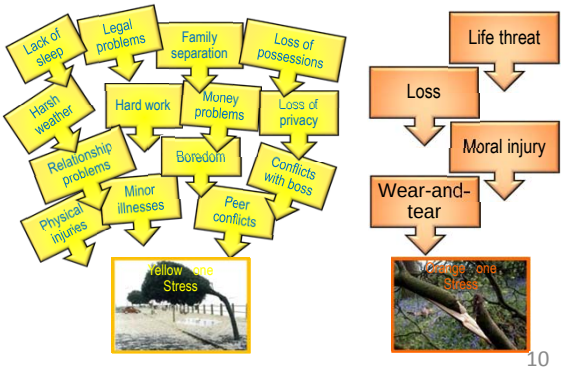
Stress Reactions

Stress Injuries

Bending from stress	Damage from stress
Very common	Less common
Normal	Risk for role failure
Always goes away	Risk for stress illness

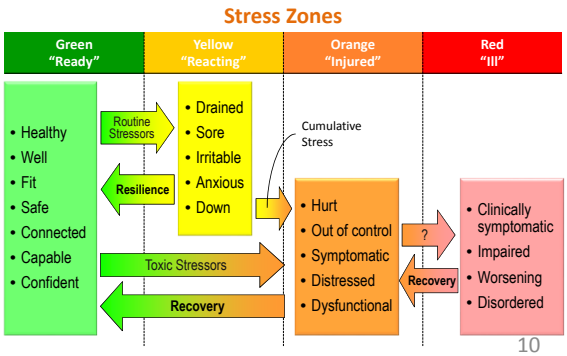
9

Many Causes vs Only Four:
Yellow Zone Reactions vs Orange Zone Injuries



10

Stress Continuum Transitions



10

Discuss with your neighbor:

- What kinds of stressors move you from GREEN to YELLOW?
- How do you react (behave, think, feel, etc.) when you are YELLOW?
- What makes you ORANGE?
- How do you react (behave, think, feel, etc.) when you are ORANGE?
- What makes you RED?
- How do you react (behave, think, feel, etc.) when you are RED?

Signs & Symptoms of Stress Injury

READY	REACTING
Calm and steady	Anxious, irritable
Confident and competent	Worried
Getting the job done	Cutting corners on the job
In control	Short-tempered or mean
Sense of humor	Irritable or grouchy
Sleeping enough	Trouble sleeping
Eating the right amount	Eating too much or too little
Working, staying fit	Apathy, loss of interest
Playing well and often	Keeping to oneself
Socially and spiritually active	Negative, pessimistic

11

Signs & Symptoms of Stress Injury

INJURED	ILL
Loss of control of body functions, emotions or thinking	Stress injury symptoms that last for several weeks after the stressors have ended or subsided
Can't fall or stay asleep	Symptoms that get worse instead of better
Recurrent, vivid nightmares	Symptoms that get better for a while, then return even worse
Intense guilt or shame	
Panic or rage attacks	
Inability to enjoy activities	
Disruption of moral values	
Serious suicidal or homicidal thoughts	

11

Four Causes of Stress Injury

- **Life Threat**
  - A traumatic injury
  - Due to an experience of death provoking terror, horror, or helplessness
- **Loss**
  - A grief injury
  - Due to the loss of cherished people, things, or parts of oneself
- **Inner Conflict**
  - A moral injury
  - Due to behaviors or the witnessing of behaviors that violate moral values
- **Wear & Tear**
  - A fatigue injury
  - Due to the accumulation of stress from all sources over time without sufficient rest and recovery

12

Key Points

- Stress as a continuum
- Four sources of stress injury
- Good leaders are great medicine.
- One size does not fit all.
- Training and context matter.

OSFA Evidence Support

Five Essential Elements of Immediate and Mid Term Mass Trauma Intervention Empirical Evidence.

Hobfall, Watson, Bell, et al., . *Psychiatry*, , .

. Promote sense of safety
. Promote calming
. Promote connectedness
. Promote sense of self and collective efficacy
. Promote hope

Five Essential Elements of Stress Intervention

Promote sense of safety

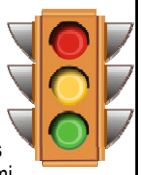
Promote calming

Promote connectedness

Promote hope

Promote sense of self and collective efficacy

How Do We Identify Stress Reactions or Injuries?



- **STOP** establish situational awareness
  - Change in function
  - Statements of internal distress
  - nown stress exposure
- **LOO** observation and report by caregivers
  - Advantages by passes stigma, denial semi objective
  - Disadvantages requires skill, familiarity, and continual monitoring
- **LISTEN** self report by service member
  - Advantages universal and immediate
  - Disadvantages stigma, denial are major barriers

Stress

- The sum total of "Wear and tear" on an organism Selye
- The non specific response of the body to any demand made upon it Selye
- Can produce growth
- Acceleration of aging Rosch
- "Fight or Flight response" W. B. Cannon

124

Perception

- The stress response is activated by our perception of events
- Our ability to change our interpretation of stressful events is a key to stress resilience!

Perception

The stress response is activated by our perception of events

Our ability to change our interpretation of stressful events is a key to stress resilience!

Stressor

- Any act or event that acts as a stimulus to place a demand upon an individual, group, or organi ation
- Can be real or imagined
- Can be perceived as positive or negative
- Can produce pleasurable, ambivalent, or antagonistic reactions

Stressors

- Physical
- Bioecological
- Psychosocial
- Personality

Stressors

- What are the unique stressors you face as a “trauma provider”
- Consider both organizational and individual stressors
- Create a “Top Ten” list for each group

Overview of the Stress Response

STRESS REACTION CATEGORIES

- FIGHT
- FLIGHT
- FREEZE
- FLOW

The stress response as a way to adapt and survive

Cumulative Stress

- "Burnout" or chronic stress
- Typically a result of work and personal stressors
- Often may not be identified for months or years
- Deteriorates health performance and relationships
- Usual coping mechanisms have not been helpful

Appendix Q 119

What Is Post Traumatic Stress?

- Stress resulting from an incident powerful enough to overwhelm the usual coping abilities of those involved.

Stress Related Disorders

- An extension of that survival mechanism that results in impairment
- Attempts to cope that are "getting in the way"
- Examples?
  - Substance abuse – drugs, alcohol
  - Violent behavior
  - Domestic violence

Post Traumatic Stress Disorder

A. Traumatic event
B. Intrusive memories
C. Avoidance, numbing, depression
D. Stress arousal
E. Symptoms last > 30 days
F. Impaired functioning

See Appendix V, 131-138

PTSD

- ACUTE (less that 3 month duration)
- CHRONIC (more than 3 month duration)
- DELAYED ONSET (onset of symptoms at least 6 months after the stressor)

See Appendix V, 131-138

7C's Stress First-Aid Model

Seven Cs of Stress First Aid:

1. **CHECK**
   Assess: observe and listen
2. **COORDINATE**
   Get help, refer as needed
3. **COVER**
   Get to safety ASAP
4. **CALM**
   Relax, slow down, refocus
5. **CONNECT**
   Get support from others
6. **COMPETENCE**
   Restore effectiveness
7. **CONFIDENCE**
   Restore self-esteem and hope

17

Where OSFA Fits In the Stress Continuum

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Self, Buddy, & Family Tools	• Spirituality • Emotions • Mental (cognitive) • Physical (fitness & nutrition) • Environment • Relationships			• Information Seeking • Support • Advocacy

6

1. Spirituality

Creativity, order, connection

Okay	Needs Work	Needs Help
❑ Enjoy worship ❑ Happy with fellowship ❑ Happy with spiritual expression ❑ Able to give and receive love ❑ Appreciating beauty ❑ Creative ❑ Comfortable with your place in world ❑ Connected, peaceful	❑ Less tolerant of different beliefs ❑ Feeling distant from God; want to get closer ❑ Don't know how to love or feel loved ❑ Feeling distant from others ❑ Struggling to understand others ❑ Not sure where you fit in ❑ Something's missing	❑ No reverence for anything outside self ❑ Alone and wandering aimlessly ❑ Spiritually empty ❑ Don't care about others ❑ Nothing seems important ❑ Feel powerless to change life ❑ Out of touch ❑ Loss of purpose ❑ Lacking a "moral compass"

61

2. Emotional/Mental/Physical Health

Fitness, wellness, self-esteem, control

Okay	Needs Work	Needs Help
❑ Sleeping well ❑ No bad nightmares ❑ Working out regularly ❑ Good nutrition ❑ Good energy level ❑ Good emotional control ❑ Able to enjoy life ❑ Not troubled by memories ❑ Feeling good about self	❑ Trouble getting to sleep ❑ Keep waking up ❑ Out of shape ❑ Eating too much or too little ❑ Loss of interest in life ❑ Feeling anxious or worried ❑ Feeling irritable ❑ Painful memories ❑ Feeling guilty	❑ Can't sleep enough ❑ Repeated disturbing thoughts ❑ Trouble pushing memories out of mind ❑ Panic attacks (heart pounding, shaking) ❑ Rage outbursts ❑ Depressed mood ❑ Keep blaming self ❑ Thoughts of suicide or homicide

3. Relationships

Spouse, significant other, family, friends

Okay	Needs Work	Needs Help
❑ Good communication ❑ Feeling close ❑ Looking forward to seeing ❑ Cooperating well ❑ Playing well ❑ Good sex ❑ Good conversation ❑ Affection ❑ Openness ❑ Responsiveness	❑ Trouble communicating ❑ Occasional fights and disagreements ❑ Uncomfortable being together ❑ Not having fun ❑ Staying apart ❑ Difficult or rare sex ❑ Complaints from partner ❑ Ambivalence ❑ Guardedness	❑ Poor comm. ❑ Frequent fighting ❑ Dreading contact ❑ Emotional coldness ❑ No sex ❑ Irresolvable conflict ❑ Criticism ❑ Contempt ❑ Defensiveness ❑ Emotionally numb ❑ Thoughts of hurting others or self

4. Roles in Life

Leader, coach, parishioner, citizen, provider

Okay	Needs Work	Needs Help
❑ Comfortable in roles ❑ Meeting your own expectations in roles ❑ Able to balance competing demands ❑ Fulfilled ❑ Energized	❑ Some strain in roles ❑ Not meeting own expectations in roles ❑ Not able to fit the pieces together ❑ Out of balance ❑ Pressured ❑ Drained	❑ Pulled apart ❑ Too many demands ❑ Tension between roles ❑ Serious conflict with others over roles ❑ Exhausted

5. Public Behavior

Driving, waiting, dealing with public, patience

Okay	Needs Work	Needs Help
❑ Comfortable in public ❑ Appropriate in public ❑ Good and careful driver ❑ Patient in frustrating situations ❑ Calm, even with rude people ❑ Friendly ❑ No police involvement	❑ Avoiding going out in public ❑ Suspicious of strangers ❑ Absent minded ❑ Getting frustrated easily ❑ Impatient ❑ Occasionally angry or irritable ❑ Driving too fast ❑ Driving recklessly	❑ Paranoid in public ❑ Road rage ❑ Picking fights ❑ Rage outbursts in public ❑ Panic attacks in public ❑ Persistent hyperactive startle responses ❑ Arrests

6. Work Function

Shop, supervisors, goals, promotion, rewards

Okay	Needs Work	Needs Help
❑ Achieving ❑ Feeling like a team ❑ Mentoring subordinates ❑ Getting rewarded ❑ Career goals progressing ❑ Job satisfaction ❑ Enjoying going to work ❑ Respected by subordinates	❑ Cutting corners ❑ Needing a lot of supervision ❑ Animosity toward peers or leaders ❑ Being apathetic or unmotivated ❑ Unrewarding ❑ Stagnating ❑ Indifferent	❑ No respect for self or others ❑ Defying authority ❑ Being a tyrant to subordinates ❑ Hostile environment ❑ Disorganized/lack of leadership ❑ Held back ❑ Unsupported ❑ Abandoned ❑ Abused

7. Money and Finances

Budget, purchases, credit, bills, savings

Okay	Needs Work	Needs Help
❑ Saving money ❑ Bills paid up to date ❑ Keeping to budget ❑ Debt under control ❑ Working a financial plan ❑ Spending in sync with spouse	❑ Minimal savings ❑ Bills past due ❑ Financial worries ❑ Uncomfortable debt ❑ Vague financial plan ❑ Conflict with spouse over spending	❑ No savings ❑ Collection notices ❑ Major financial stress ❑ Large debt load ❑ Creditors contacting command ❑ Total disagreement over spending ❑ Financial trouble

8. Substance Use/Abuse

Tobacco, alcohol, drugs, sugars, fats

Okay	Needs Work	Needs Help
❑ Good control over intake of alcohol ❑ Not tempted to use drugs ❑ Not smoking chewing more ❑ Nobody who knows you thinks you are abusing	❑ Others express concern over drinking ❑ Got drunk when didn't intend to ❑ Use alcohol to get to sleep ❑ Drinking is getting in the way ❑ Smoking or chewing more	❑ Anger when others complain about drinking ❑ Lying to keep drinking ❑ Hiding drinking ❑ Harm to life from alcohol ❑ Using illegal drugs ❑ Blackouts ❑ Frequent drinking to intoxication

Operational Stress First-Aid (OSFA)

- Remember, OSFA is:
  - A flexible multi-step process for the
  - timely assessment and preclinical care of
  - stress reactions or injuries in individuals or units with the goals to:
    - preserve life,
    - prevent further harm,
    - and promote recovery.

Continuous Aid: Check and Coordinate

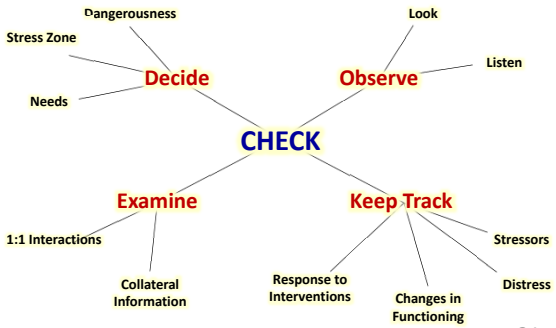
19

Continuous Aid Is Built On Several Basic Assumptions

- Operational stress affects everyone.
- Stress responses and outcomes lie along a spectrum, and are not as simple as “well” or “disordered.”
- Most individuals’ stress states change over time (they have trajectories).
- The persons we care for live and work in units and other social organizations with great potential for healing and building resilience.

19

Check: What is It?



21

Check: Why Is It Needed?

- Those who are injured by stress may be the last to know it.
- Stigma is an obstacle to asking for help.
- Matching needs to available resources requires careful, ongoing assessment.
- Stress zones and needs change over time.
- Risks from stress injuries may last a long time after the event.

21

How to Recognize Who Needs Help: Orange Zone Indicators

- What is an Orange Zone Orange Zone indicator?
  - A reason to suspect that a given individual might possibly be in the Orange Zone and in need of help
- Three forms of Orange Zone indicators:
  1. **Recent Stressor Events**: recent exposure to a events with high potential to cause trauma, grief, moral injury
  2. **Distress**: Significant and persistent distress such as unusual fear, anger, anxiety, sadness, guilt, or shame
  3. **Changes in Functioning**: Significant and persistent changes in physical, mental, social, or spiritual function
- Caregivers can learn of Orange Zone indicators directly from individuals or from other informants.

23

Discriminating Orange From Yellow: Stressors

Yellow Zone		Orange Zone
• Common, experiences • Can come from any source • Can be of any intensity • Can be taken in stride	**Stressor Characteristics**	• Extraordinary experiences • Either high-intensity events or a severe long-term accumulation • Can be overwhelming
• Money problems • Relationship problems • Health problems • Lack of sleep • Conflicts with superiors • Conflicts with peers • Legal problems • Disciplinary problems • Uncertainties about future • Missing friends or family • Loneliness • Etc.	**Stressor Examples**	• Life threat – Nearly being killed – Seeing someone else die – Aftermath of death • Loss – Death of friend or family member – Break up of marriage – Disabling injury • Inner conflict – Failing to save a peer's life – Obtaining revenge – Having trust in others betrayed • Wear and Tear – Closely repeated deployments – Excessive, persistent Yellow stress

24

Discriminating Yellow From Orange: Subjective Distress

Yellow Zone		Orange Zone
• Feels like being under strain but still one's normal self • Fluctuates during the day • Gets better with rest, exercise, or recreation • Can be controlled, set aside	**Subjective Distress Characteristics**	• Feels uncharacteristic, like not one's normal self • Fluctuates, but always there • Can significantly interfere with ability to work, rest, or have fun • Can't be controlled, set aside
• Worry • Irritability • Sad or low mood • Low morale • Decreased sense of humor • Less interest in social activities • Feeling lonely • Muscle tension • Headaches or body aches • Fatigue	**Subjective Distress Examples**	• Uncharacteristic episodes of panic anxiety or rage • Constant high anxiety or anger • Severe depressed mood • Intense guilt or shame • Inability to enjoy normal activities • Hopelessness • Feeling depleted of energy • No interest in social activities • Recurrent violent images • Recurrent intense nightmares or flashbacks • Suicidal or homicidal ideation

Discriminating Yellow From Orange: Changes in Functioning

	Yellow Zone	Orange Zone
Changes in Functioning Characteristics	• Mostly under control • Seems like usual personality • Minimal interference with work or social behaviors	• Loss of control • Noticeable change in personality • Can significantly interfere with work or social behavior
Changes in Functioning Examples	• Difficulty focusing attention • Difficulty recalling information • Difficulty making decisions • Trouble getting to sleep • Weight Loss or gain • Diarrhea or constipation • Increased visits to medical • Decreased quality or quantity of work • Trouble getting along with others	• Body – Shaking, when not in danger – Changes in speech – Loss of control of bladder/bowels • Mind – Losing track of time and place – Hearing or seeing things – Not making sense – Loss of remorse or compassion • Behavior – Pacing, can't sit still – Inert, moving very slowly – Mute or very little speech – Avoiding contact with others

Peritraumatic Behavior Questionnaire (PBQ): A Checklist of Orange Zone Behaviors

1. Not acting like their normal self
2. Acting fearless and invulnerable, as if nothing could harm them
3. Not caring about their own or others' welfare or safety
4. Feeling no remorse for doing things that would have bothered them before
5. Acting determined to get revenge
6. Being unable to stop laughing, crying, or screaming
7. Seeming helpless and unable to look out for their own welfare
8. Acting confused, having difficulty making sense of what was happening
9. Disoriented, and uncertain about what day or time it is
10. Unable to move parts of their body
11. Freezing moving very slowly, and unable to do all that they intended
12. Speech changed (stuttering, repeating words, or shaky or squeaky voice)
13. Not able to fully carry out duties (during or immediately after an event)
14. Seemed to believe they were going to die
15. Had an intense physical reaction: sweating, shaking, or heart pounding

25

First Check: Safety and Crisis Assessment

- What is First Check?
  - Safety assessment of an individual with Orange Zone indicators
- When does First Check happen?
  - As soon as possible after learning of an Orange Zone indicator
  - May be during direct observation of Orange Zone behaviors
- Goals of First Check:
  - Assess for dangerousness to self or others — need for Cover.
  - Assess for physiological arousal or emotions — need for Calm.
  - Determine whether immediate outside help or referral is indicated.
- How do you perform First Check?
  - Look and listen.
  - Assess ability of the individual to recognize and respond to threats.
  - Assess level of self-control and physical and emotional calmness.
  - If indicated, ask about impulses or thoughts for suicidal or homicide.

26

Second Check:
Thorough Assessment

- What is Second Check?
  - Detailed assessment of an individual with Orange Zone indicators
- When does Second Check happen?
  - As soon as possible after crisis has passed (if a crisis existed)
  - May occur after obtaining collateral information from other sources
- Goals of Second Check:
  - Identify current stress zone, especially whether Yellow or Orange.
  - Determine needs for Secondary Aid: Connect, Competence, Confidence.
  - Look for indicators of ability to function in their role.
  - Determine needs for other physical, emotional, social, or spiritual support or care.
  - Determine who else needs to know, and who else can help.

27

Second Check Tool:
"OSCAR" Communication

Observe: Actively observe behaviors; look for patterns

State Observations: All attention to the behaviors; just the facts without interpretations or judgments

Clarify Role: State why you are concerned about the behavior. Validates why you are addressing the issue

Ask Why: Seek clarification; try to understand the other person's perception of the behaviors.

Respond: Clarify concern if indicated. Discuss desired behaviors. State options in behavioral terms.

28

Second Check:
Procedure

- Look and listen
- Assess Orange Zone indicators in depth
  1. **Stressors**, current and recent
     - Operational stressors
     - Home-front stressors
  2. **Internal distress**, especially recent increases
  3. **Level of functioning**, especially recent decreases (SEMPER reversed)
     - Relational
     - Environmental
     - Physical
     - Mental
     - Emotional
     - Spiritual
- Assess need for Secondary Aid:
  - Level of connectedness and trust in others
  - Level of competence in job, self-regulation, and other roles
  - Level of confidence in self, mission, and values

29

Collateral Information Check: Getting Input From Other Sources

- Sources of collateral information
  - In the unit: leaders, medical department personnel, peers
  - Outside the unit: spouses, parents, friends
- When does Collateral Information Check happen?
  - Before or after each Second Check
- Goals of Collateral Information Check:
  - Gather more information about current or recent stressors, expressions of distress, or changes in functioning.
  - Confirm or refute subjective information obtained from individual.
  - Promote coordination and collaboration.

30

Coordinate: What is It?

31

Coordination

- Goals:
  1. Inform those who need to know (e.g., Key Leaders)
  2. Obtain other needed sources of help or care
- Possible reasons to inform Key Leaders
  - Risk to individual or others in unit
  - Benefit from a temporary change in assignment
  - Need for unit support for referral and treatment
- Possible reasons for referral for further evaluation and care
  - Uncertainty about stress zone, dangerousness, or level of impairment
  - Suspicion that key facts may be missing from the picture
  - Uncertainty about the strength of the working alliance with individual
  - Worsening over time, or failure to improve
  - Need for interventions OSFA caregiver is unable to provide

Primary Aid:
Cover and Calm

34

Primary Aid:
Rescue From Danger

- Primary Aid (Cover and Calm) is a rescue response to a danger situation caused by Orange Zone stress.
- In Orange Zone stress, the fire is inside the person's body and mind, though maybe creating dangers on the outside.

34

Cover:
What is It?

35

Cover: When Is It Needed?

- Orange Zone person is in external danger
  - Person in immediate life-threat situation is not thinking clearly or making good decisions because of stress
  - Person has frozen or panicked in a life-threat situation
  - Person has an intense flashback to a previous life-threat situation that impairs their current functioning
- Others in danger from person in Orange Zone
  - Person not thinking clearly due to stress while holding a lethal weapon
  - Person has frozen or panicked while operating a vehicle with other passengers
- Orange Zone person in internal danger
  - Person who has expressed serious thoughts of suicide
  - Person has threatened others

36

Cover: How Does It Work?

- Make decisions on behalf of someone who is not thinking clearly.
- Take action on behalf of someone who is not behaving in a safe manner.
- Get control of someone who is out of control.
- Provide authoritative (parent-like) presence to gain control.
- Warn and protect others who may not be aware of a danger.
- Create an environment of safety to promote recovery.

37

Cover: Procedures

- Non-verbal (from least to most intrusive)
  - Making eye contact
  - Holding up your own hands in a "stop" gesture
  - Keeping pressure on the neck or arm with one hand
  - Shaking or nudging the person to get their attention
  - Blocking a person's way with your own body
  - Pulling or dragging to safety; physical restraint
  - Taking physical control of the person's body in any way possible
- Verbal (from least to most intrusive)
  - Asking the person if they are OK
  - Asking the person if they need help
  - Suggesting an alternate, safer course of action
  - Yelling a warning to the person about impending danger
  - Forcefully commanding the person to stop

37

Cover: Potential Obstacles

- You are not thinking clearly or behaving safely either!
- You are fully occupied responding to your own life threats.
- You do not have sufficient physical strength.
- You cannot acquire the stress-injured person's attention or trust.
- There is no safer and quieter place nearby.

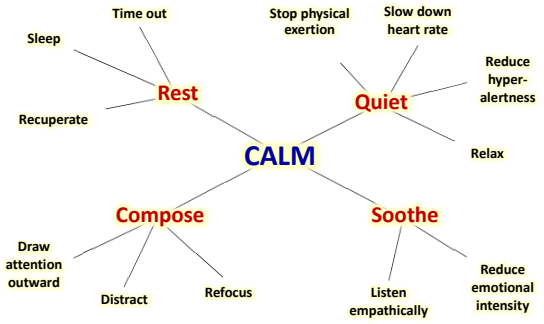
38

Cover: Mobilizing Resources

- Call for help!
- Get yourself safe first, then figure out what to do to help others.
- Involve others (leaders, peers, medical, chaplain).
- Find and get to a safer place.
- Consider medication if all else fails.
  - Antipsychotic medications
  - Tranquilizing medications

38

Calm: What is It?



38

Calm: When Is It Needed?

- When physiological arousal level is stuck too high
  - Loss of physical control: fleeing, flailing, or blindly striking out
  - Pacing or other persistent, excessive major motor activity
  - Hyperventilating
  - Shaking
  - Rocking or other repetitive self-soothing activity
- When cognitive functioning is disorganized
  - Rapid, pressured speech (talking too fast)
  - Flight of ideas (thoughts flit from one topic to another)
  - Not responding appropriately to commands or questions
  - Freezing
- When negative emotions are out of control
  - Poorly controlled fear or panic
  - Poorly controlled anger or rage

39

Calm: How Does It Work?

- Reduce muscular activity.
- Reduce mental and emotional effort.
- Slow down heart rate.
- Reduce levels of stress chemicals in the blood and brain.
- Reduce intensity of negative emotions like fear and anger.
- Increase positive emotions like safety and trust.
- Increase ability of the individual for self control.
- Restore mental clarity and focus.

39

Calm: Procedures

- Non-verbal
  - Calm, authoritative physical presence
  - Eye contact
  - Not showing disgust, fear, or anger
  - Touching or holding, if appropriate and not threatening
- Verbal
  - Repetitive, soothing phrases, such as “Easy now…” or “It’s OK…”
  - Reassurances of current safety
  - Encouragement, such as “You can do it…” or “There you go…”
  - Calming directive, such as “Calm down!” or “Relax!”
  - Attention-getting, such as “Look at me!” or “Listen to my voice!”
  - Distraction, such as by encouraging thinking about something else
  - Coaching in deep-breathing or grounding exercises
  - Empathic listening to distressing thoughts, feelings, memories

40, See Appendix P, 117-118

Calm: Potential Obstacles

- You are not yet calm yourself!
- You are too distracted or busy to attend to the person in need.
- There is no time.
- You are surrounded by too much noise, action, and chaos.
- Someone else is making the stress-injured person less calm by yelling or frantic behavior.
- You cannot hold the stress-injured person's attention or trust.

40

Calm: Mobilizing Resources

- Use calming techniques on others and yourself simultaneously.
- Find and get to a quieter, safer place.
- Involve the immediate chain of command to help.
- Direct others away from the stress-injured person if they are not helping.
- Engage supportive peers/others if they can help.
- Consider medication if all else fails.
  - Antipsychotic medications
  - Tranquilizing medications
  - Sleeping medication

41

Summary of Primary Aid

Check
- Assess
- Observe
- Listen

Coordinate
- Get help
- Refer as needed

Cover
- Provide immediate safety

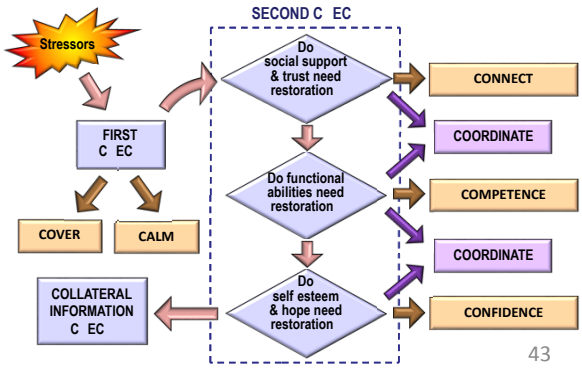
Calm
Relax, slow down, refocus

Secondary Aid:
Restore Functioning, Reduce Distress

Secondary Aid is used either after primary aid, or when primary aid isn't necessary

42

Connect, Competence, and Confidence: The Focus of Second Check



43

Connect: What is It?

45

Connect: When Is It Needed?

- When Orange Zone stress causes loss of cohesion
- When Orange Zone stress causes isolation or alienation:
  - No longer feels like "normal self"
  - Uncertain and awkward
  - Blames or is blamed
  - Ashamed
  - Fears others have lost trust in him/her
  - Afraid to talk
  - Emotionally numb and detached
  - Intensely angry
  - Exhausted and/or overwhelmed

45

Connect: How Does It Work?

Reduce isolation and alienation to promote:

- Common identity, experiences, and understanding
- Shared responsibility and suffering
- Reduced feelings of guilt, shame, or blame
- Greater forgiveness
- More hope

46

Connect: Procedures

Assess Resources	• Identify most trusted in and out of unit • Identify positive mentors / leaders
Assess Obstacles	• Perception of person, leaders, group • What has changed
Remove Obstacles	• Listen empathically / compassionately • Show persistent, respectful curiosity • Encourage / lead group social activities • Encourage seeking connectedness • Confront distortions, blame, shame • Encourage active problem solving • Foster After Action Reviews (AARs)

47

Connect:
Mobilizing Resources

Engage Leadership to:

- Lead After Action Reviews (AARs)
- Show concern and caring consistently
- Reassure individuals with Orange Zone stress
- Be a good mentor or role model
- Reduce conflict, blaming, and rumors
- Build teamwork
- Honor sacrificial service (particularly death)

48

Connect:
Potential Obstacles and Solutions

Obstacles	Potential Solutions
Busy / Distracted	•Engage peers and leaders •Connect to trusted others
Lack of Trust	•Recruit peers and leaders
Loss	•Communalize grief •Encourage other attachments
Person Ostracized	•Temporarily separate •Engage leaders
Negative Feelings	•Talk to someone you trust •Refer to someone else

48

Resources

- www.samhsa.gov
  - For free course on Psychological First Aid
- Psychological First Aid - free phone app (PFA)
- Community Stress First Aid – free phone app

Solution-Focused Therapy

- Have you ever had this problem before?
  - Yes
- What did you then that was helpful?
  - Good response
- That sounds very good. When will you do that?
- Have you ever had this problem before?
  - No
- What could you do that would be helpful?
  - Good response
- That sound very good. When will you do that?

Solution-Focused Therapy

- Have you ever had this problem before?
  - No
- What could you do that would be helpful?
  - Poor response
- That doesn't sound helpful. What else could you think of that would be helpful?
  - Good response
- That sound very good. When will you do that?

Competence:
What Is It?

50

Competence: When Is It Needed?

Orange Zone stress causes loss of previous skills or abilities:

- Mental focus or clarity, cognitive functioning
- Emotional or behavioral, physiological self control
- Enthusiasm and motivation
- Social aptitude
- Ability to see the "big picture"

Orange Zone stress causes new challenges to coping:

- Trauma or loss reminders
- Disturbing memories
- Difficulty relaxing, slowing down, or getting to sleep
- Difficulty maintaining an emotional even keel
- Dread and desire to avoid re-exposure
- Stress-induced physical symptoms

50

Examples of Need for Competence

Orange Zone Individual

- Person with significant life threat stress injury experiences persistent mental confusion and slowed, unclear thinking
- Key Leader who developed wear-and-tear stress injury loses the ability to stay calm when dealing with subordinates

Orange Zone Unit

- Key Leader who loses a member of unit becomes less able to send subordinates into hazardous situations, impacting function of the entire unit

51

Competence: How Does It Work?

Ensure that respite, sense of competence, and needed skills are obtained, which:

- Lays the foundation for recovery and healing, posttraumatic growth
- Reduces stigma of Orange Zone / Red Zone stress by minimizing impact
- Reduces potential social consequences of Orange Zone / Red Zone stress

51

Competence: Procedures

Stop	• Rest, take time to recover • Identify challenges to functional capabilities • Don't keep doing what isn't working
Back Up	• Retrain and refresh skills • Mentor / problem solve • Learn new skills • Enhance wellness
Move Forward Again	• Practice new and refreshed skills • Gradually increase responsibilities • Set achievable goals • Explore and trouble-shoot obstacles • Reinforce successes and motivation

52

Competence: Mobilizing Resources

Engage leadership to consider:

- Whether there are ways to reduce exposure to the particular Orange Zone stressors the person is dealing with
- Ways to give a person meaningful activities that will make him/her feel competent
- When and how it is appropriate for person to resume productive contributions to the unit
- Which remedial steps to offer if a person feels they didn't perform their duties to their best ability
- How to reduce persons sense of helplessness or passivity
- Ways to integrate the person back into unit

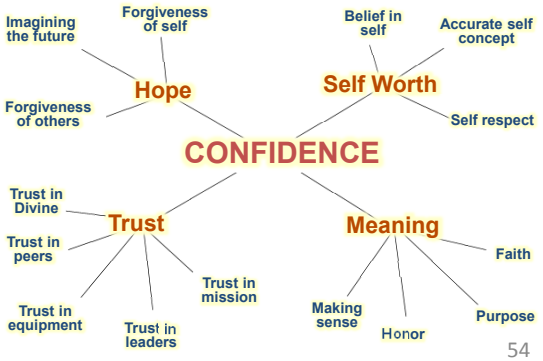
53

Competence: Potential Obstacles and Solutions

You cannot engage unit leaders	• Coordinate with others to provide leaders with behavioral observations • Coordinate with other leaders
Orange one person doesn't recognize need	• Repeatedly but tactfully describe your observations to Orange Zone person • Coordinate with others to do the same
Orange one person lacks motivation	• Appeal to Orange Zone person's loyalty to others • Coordinate with influential others
Resources are not available	• Engage leaders to supply resources
Not sure of your competence	• Consult with others, seek mentoring • Refer individual to other levels of care

53

Confidence: What Is It?



54

Confidence: When Is It Needed?

Needed by everyone who has sustained a stress injury. Examples Include:

- A feeling of having betrayed self or others
- Significant loss of self-worth and self-trust
- A feeling of having been betrayed by others
- Marked loss of confidence in leadership / mission / values
- Overly negative, rigidly-held beliefs about the self and world
- A strong sense of either shame or bitterness/anger
- Loss of faith in God or previously held values

54

Examples of Need for Confidence

Orange Zone Individual

- Person who fails to take proper precautions loses a ministry partner and feels extremely guilty and becomes self-destructive
- Key Leader who developed wear-and-tear stress injury loses respect for his leaders and becomes angry and irritable
- Person with significant life threat stress suffers lowered function, loses faith in himself as a person, as well as faith in God, and becomes depressed

Orange Zone unit

- Many members of a unit that lose a large amount of time in ministry assignment lose faith in leadership and their purpose for being in this disaster response, and begin resisting direction and losing connectedness to the persons who don't feel the same

54

Confidence: How Does It Work?

- Help restore confidence in self, leadership, mission, or core values and beliefs
- Help person make sense of what has happened and mourn losses and limitations so that self-worth is restored
- Explore possible obstacles to confidence and problem solve solutions

55

Confidence: Procedures

Confidence Step	How to Do It
• **Assess** self-image, understanding of meaning of life events, level of trust in self and others, and hope	• Listen empathically • Develop a trusting relationship • Ask questions and offer tentative observations
• **Restore** depleted resources • Foster spiritual connections	• Coordinate with all possible needed resources • Address financial, family, spiritual problems, etc. • Identify obstacles and find solutions
• **Promote Growth** • Remove excessive guilt or shame • Promote forgiveness of self and others • Establish new meaning and purpose	• Listen for and confront distorted perceptions • Appeal to trusted authority or spiritual figures • Encourage person to: –put themselves in others' shoes –make amends, or to give to others –establish new relationships / strengthen old ones

56

Confidence: Potential Obstacles and Solutions

Potential Obstacles to Confidence	Potential Solutions
The person is unable to grieve	• Encourage communal sharing of grief • Confront excessive blame • Encourage person to imagine how the deceased person would view them • Encourage spiritual guidance / memorials / ceremonies
The person has lost portions of himself or herself that are viewed as essential	• Encourage supportive relationships with spiritual mentors and/or others who have sustained similar losses and found new hope • Search for and confront excessive self-blame or blame of others • Encourage the learning and mastery of new skills and abilities

57

Confidence: Potential Obstacles and Solutions (continued)

Potential Obstacles to Confidence	Potential Solutions
The person feels unforgiveable	• Encourage the making of amends, even if that will be a life-long endeavor • Mobilize an authoritative social or spiritual mentor or image to promote forgiveness • Relentlessly point out the self-destructive nature of self-blame
The person cannot forgive others	• Relentlessly point out the self-destructive nature of blame and revenge motives • Encourage the individual to learn more about and empathize with those who are blamed • Appeal to Core Beliefs and Values

57

Confidence: Mobilizing Resources

- Consider involving other disciplines or mentors / peers who can implement Confidence either more effectively or in a complementary way to you
- Assist Leaders to:
  - Improve communication, mentoring, and information about mission, and acknowledgement of person's value
  - Make efforts to confront stigma about disaster and operational stress at individual, group, and unit levels
  - Foster and support doing things that will alleviate and mitigate harmful effects of stress at both the individual and unit levels
  - Help to re-establish beliefs in ministry partners who have stress injury

See Appendix O, 115-116

Summary of Secondary Aid

Connect
- Provide support
- Promote social interactions
- Facilitate rituals

Competence
- Mentor to full function
- Problem solve strategies
- Manage stress reactions

Confidence
- Improve leader communication
- Mourn losses
- Provide hope

123

Five Core Leader Functions

59 and see Appendix F, 82-84

Roles and Responsibilities

- Leaders are responsible for making decisions about individuals and units across the stress continuum
- Caregivers using the stress continuum and OSFA knowledge are potential tools for the leaders
- Caregivers provide both individual and unit services

Caregiver Cautions

- Act within your role.
- Be clear on the goals for the consultation and whether it is for the sake of the individual or the unit
- Care always needs to be done with the awareness, and preferably permission, of the individual
- Use the OSFA knowledge to build collaborative relations with the individual, leaders, peers, and caregivers

5 Core Leader Functions

- **Strengthen**
  - Create confidence/ forewarn
  - Inoculate to extreme stress
  - Foster unit cohesion
- **Mitigate**
  - Remove unnecessary stressors
  - Ensure adequate sleep and rest
  - After Action Reviews AARs in small groups
- **Identify**
  - now team stress load
  - Recogni e reactions, injuries, illnesses
- **Treat**
  - Rest Restoration hours
  - Caregiver Occupational Stress Training Teams
  - Chaplain
  - Medical
- **Reintegrate**
  - eep with unit if at all possible
  - Expect return to full duty
  - Don't allow retribution or harassment
  - Continuously assess fitness
  - Communicate with treating professionals both ways

59

Leader Consultation for Individuals

- A Coordinate and Secondary-Aid Action
- Focus on the individual
- Sensitive to privacy issues
- Provide leader information to facilitate decisions about the individual

Individual Based Assessment

Cover	• Potential for harm to self and others • Safety Plan • Need for voluntary versus involuntary mental health assessment
Calm	• Ability to self-regulate distress • Ability to choose and use positive calming strategies • Risk of functional impairment during missions or duties
Connect	• Ability to connect with peers • Peer ability to connect with member • Quality of mentoring relationships • Quality of unit identity
Competence	• Skills and resources to manage stressors • Problem-solving skills • Availability and quality of resources
Confidence	• Belief in ability to cope • Balance of future expectations • Belief in ability to contribute to the mission

"COORDINATE"

	Cover	Calm	Connect	Competence	Confidence
Impact	**Core Leader Functions**				
Loss	Strengthen				
Inner Conflict	Mitigate				
Fatigue	Identify / Treat / Reintegrate				

See Appendix H, 90-92

Self Assessment

60

. Spirituality

Creativity, order, connection

Okay	Needs Work	Needs Help
❑ Enjoy worship ❑ Happy with fellowship ❑ Happy with spiritual expression ❑ Able to give and receive love ❑ Appreciating beauty ❑ Creative ❑ Comfortable with your place in world ❑ Connected, peaceful	❑ Less tolerant of different beliefs ❑ Feeling distant from God; want to get closer ❑ Don't know how to love or feel loved ❑ Feeling distant from others ❑ Struggling to understand others ❑ Not sure where you fit in ❑ Something's missing	❑ No reverence for anything outside self ❑ Alone and wandering aimlessly ❑ Spiritually empty ❑ Don't care about others ❑ Nothing seems important ❑ Feel powerless to change life ❑ Out of touch ❑ Loss of purpose ❑ Lacking a "moral compass"

61

. Emotional/Mental/Physical Health

Fitness, wellness, self-esteem, control

Okay	Needs Work	Needs Help
❑ Sleeping well ❑ No bad nightmares ❑ Working out regularly ❑ Good nutrition ❑ Good energy level ❑ Good emotional control ❑ Able to enjoy life ❑ Not troubled by memories ❑ Feeling good about self	❑ Trouble getting to sleep ❑ Keep waking up ❑ Out of shape ❑ Eating too much or too little ❑ Loss of interest in life ❑ Feeling anxious or worried ❑ Feeling irritable ❑ Painful memories ❑ Feeling guilty	❑ Can't sleep enough ❑ Repeated disturbing thoughts ❑ Trouble pushing memories out of mind ❑ Panic attacks (heart pounding, shaking) ❑ Rage outbursts ❑ Depressed mood ❑ Keep blaming self ❑ Thoughts of suicide or homicide

61

. Relationships

Spouse, significant other, family, friends

Okay	Needs Work	Needs Help
❑ Good communication ❑ Feeling close ❑ Looking forward to seeing ❑ Cooperating well ❑ Playing well ❑ Good sex ❑ Good conversation ❑ Affection ❑ Openness ❑ Responsiveness	❑ Trouble communicating ❑ Occasional fights and disagreements ❑ Uncomfortable being together ❑ Not having fun ❑ Staying apart ❑ Difficult or rare sex ❑ Complaints from partner ❑ Ambivalence ❑ Guardedness	❑ Poor comm. ❑ Frequent fighting ❑ Dreading contact ❑ Emotional coldness ❑ No sex ❑ Irresolvable conflict ❑ Criticism ❑ Contempt ❑ Defensiveness ❑ Emotionally numb ❑ Thoughts of hurting others or self

62

. Roles in Life

Leader, coach, parishioner, citizen, provider

Okay	Needs Work	Needs Help
❑ Comfortable in roles ❑ Meeting your own expectations in roles ❑ Able to balance competing demands ❑ Fulfilled ❑ Energized	❑ Some strain in roles ❑ Not meeting own expectations in roles ❑ Not able to fit the pieces together ❑ Out of balance ❑ Pressured ❑ Drained	❑ Pulled apart ❑ Too many demands ❑ Tension between roles ❑ Serious conflict with others over roles ❑ Exhausted

82

. Public Behavior

Driving, waiting, dealing with public, patience

Okay	Needs Work	Needs Help
❑ Comfortable in public ❑ Appropriate in public ❑ Good and careful driver ❑ Patient in frustrating situations ❑ Calm, even with rude people ❑ Friendly ❑ No police involvement	❑ Avoiding going out in public ❑ Suspicious of strangers ❑ Absent minded ❑ Getting frustrated easily ❑ Impatient ❑ Occasionally angry or irritable ❑ Driving too fast ❑ Driving recklessly	❑ Paranoid in public ❑ Road rage ❑ Picking fights ❑ Rage outbursts in public ❑ Panic attacks in public ❑ Persistent hyperactive startle responses ❑ Arrests

83

. Work Function

Shop, supervisors, goals, promotion, rewards

Okay	Needs Work	Needs Help
❑ Achieving ❑ Feeling like a team ❑ Mentoring subordinates ❑ Getting rewarded ❑ Career goals progressing ❑ Job satisfaction ❑ Enjoying going to work ❑ Respected by subordinates	❑ Cutting corners ❑ Needing a lot of supervision ❑ Animosity toward peers or leaders ❑ Being apathetic or unmotivated ❑ Unrewarding ❑ Stagnating ❑ Indifferent	❑ No respect for self or others ❑ Defying authority ❑ Being a tyrant to subordinates ❑ Hostile environment ❑ Disorganized/lack of leadership ❑ Held back ❑ Unsupported ❑ Abandoned ❑ Abused

83

. Money and Finances

Budget, purchases, credit, bills, savings

Okay	Needs Work	Needs Help
❑ Saving money ❑ Bills paid up to date ❑ Keeping to budget ❑ Debt under control ❑ Working a financial plan ❑ Spending in sync with spouse	❑ Minimal savings ❑ Bills past due ❑ Financial worries ❑ Uncomfortable debt ❑ Vague financial plan ❑ Conflict with spouse over spending	❑ No savings ❑ Collection notices ❑ Major financial stress ❑ Large debt load ❑ Creditors contacting command ❑ Total disagreement over spending ❑ Financial trouble

84

. Substance Use/Abuse

Tobacco, alcohol, drugs, sugars, fats

Okay	Needs Work	Needs Help
❑ Good control over intake of alcohol ❑ Not tempted to use drugs ❑ Not smoking chewing more ❑ Nobody who knows you thinks you are abusing	❑ Others express concern over drinking ❑ Got drunk when didn't intend to ❑ Use alcohol to get to sleep ❑ Drinking is getting in the way ❑ Smoking or chewing more	❑ Anger when others complain about drinking ❑ Lying to keep drinking ❑ Hiding drinking ❑ Harm to life from alcohol ❑ Using illegal drugs ❑ Blackouts ❑ Frequent drinking to intoxication

64

Spiritual Assessment

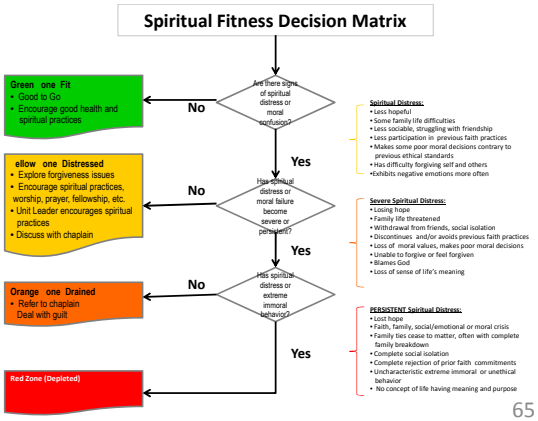
65

SPIRITUAL FITNESS GUIDE

This is a self-assessment tool to help persons consider their spiritual condition .
(This is a modified version of a model developed by the U. S. Navy Chaplain Corps)

Spiritually FIT	Spiritually DISTRESSED	Spiritually DRAINED	Spiritually DEPLETED
POTENTIAL INDICATORS	POTENTIAL INDICATORS	POTENTIAL INDICATORS	POTENTIAL INDICATORS
• Engaged in life's meaning/purpose	• Neglecting life's meaning/purpose	• Loss sense of life's meaning/purpose	• Claims life has no meaning/purpose
• Hopeful about life/future	• Less hopeful about life/future	• Holds very little hope about life/future	• Holds no hope about life/future
• Makes good moral decisions	• Makes some poor moral decisions	• Makes poor moral decisions routinely	• Extreme immoral behavior
• Able to forgive self and/or others	• Difficulty forgiving self and/or others	• Unable to forgive self and/or others	• Forgiveness is not an option
• Routinely practices faith disciplines	• Infrequently practices faith disciplines	• Discounts practices of faith disciplines	• Abandons practices of faith disciplines
• Respectful to people of other faiths	• Less respectful to people of other faiths	• Strong disrespect to people of other faiths	• Complete disrespect to people of all faiths
• Engaged in core values/beliefs	• Neglects core values/beliefs	• Disregards core values/beliefs	• Abandons core values/beliefs
• Appropriately makes worldview adjustments	• Adequately makes worldview adjustments	• Inadequately makes worldview adjustments	• Inappropriately makes worldview adjustments

65



65

Stress Management

66

Basics of Stress

- Normal psychological/physical reaction to demands of life
- Some stress is good
- Too much stress pushes you beyond your coping ability
- Brain signals a “fight or flight” response under threat
- Once threat is gone, body is meant to return to relaxed state
- Frequent high stress prevents return to relaxation

66

Stress Relief

- Identify your triggers
- Any change to your life can cause stress
- Think of strategies for dealing with your stress triggers
- Identify what you can control
- Some things are beyond your control
- See help from family and friends
- Practice stress management

66

Burnout

Too much to do, too little time, insufficient resources, lack of validation, unrealistic expectations, cumulative physical and emotional distress

See Appendix Q, 119

Burnout

- Typical causes
  - Tasks
  - Deadlines
  - Expectations

119

Burnout

- Typical reactions and symptoms
  - Emotional and physical exhaustion
  - Depersonalization
  - Reduced vocational productivity
  - Reduced personal accomplishment
  - Lack of confidence or self-esteem
  - Changes in beliefs, values, and view of workplace or world

119

Self-Care for Burnout

- Delegate
- Negotiate
- Redefine success
- Set personal boundaries
- Create margin
- Make changes in your life
- Others???

120

Empathy fatigue *is emotional and physical fatigue resulting from empathizing with other people's pain, grief, anxiety, anger, and other strong emotions over an extended period of time.*

120

Typical Causes

- Non-compartmentalized compassionate care
- "Owning" other people's problems/issues/concerns
- Over identifying with other people's distress

120

Typical reactions/symptoms

- Emotional exhaustion
- Over-personalization
- Reduced compassionate attitude
- Reduced personal ministry satisfaction
- Lack of ministry confidence or self-esteem
- Changes in beliefs, values, and view of workplace or world

120

Self Care for Empathy Fatigue

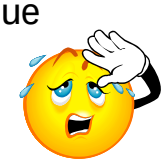
- Systematic, strategic, intentional breaks, rest, restoration periods
- Set personal boundaries
- Redefine ministry expectations

120

Compassion fatigue *is the costly result of providing care to those suffering from the consequences of traumatic events. Chaplains are especially vulnerable to compassion fatigue.*

120

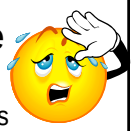
Compassion Fatigue



- Typical causes
  - Empathic connection to trauma survivor
  - Secondary traumatization from experiencing the traumatic event as though it was a personal experience

121

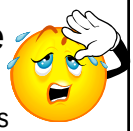
Compassion Fatigue



- Typical Reactions and Symptoms
  - Secondary traumatic stress symptoms
    - Intrusive memories
    - Avoidance or distancing
    - Stress arousal
  - Physical
    - Exhaustion
    - Insomnia
    - Headaches
    - Increased susceptibility to illness

121

Compassion Fatigue



- Typical Reactions and Symptoms
  - Behavioral
    - Increased use of drugs, alcohol
    - Absenteeism
    - Anger, irritability
  - Psychological
    - Emotional exhaustion
    - Negative self image
    - Numbed out, Depression, Hopelessness

121

Self Care for Compassion Fatigue

- Personal stress management
- Catharsis
- Self awareness
- Clarifying options
- Reframing circumstances or situations
- Intercession
- Relaxation techniques
- Pastoral counsel, therapeutic intervention

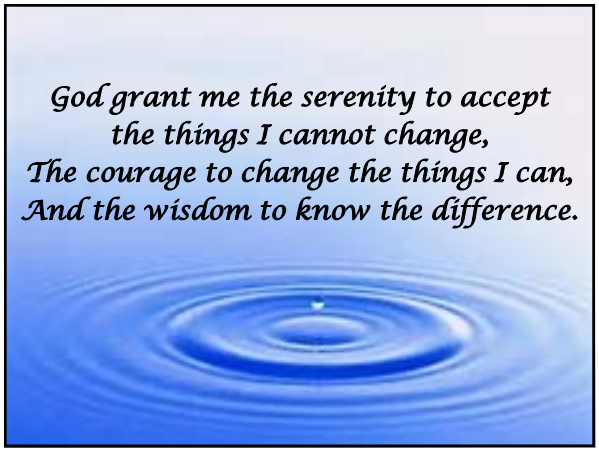
121

Relaxation Techniques

- Diaphragmatic Breathing
- Progressive muscle relaxation
- Participation in sports activities
- Lifestyle Management
- Meditation
  - Opening up attention
  - Focusing of attention
- Tai-chi, yoga
- Social Support
- Walking outdoors

Imagine life is a game in which you are juggling five balls. The balls are called work, family, health, friends, and integrity. And you're keeping all of them in the air. But one day, you finally come to understand that work is a rubber ball. If you drop it, it will bounce back. The other four balls family, health, friends, integrity are made of glass. If you drop one of these, it will be irrevocably scuffed, nicked, perhaps even shattered. And once you truly understand the lesson of the five balls, you will have beginnings of balance in your life."

ames Patterson, *Suzanne's Diary for Nicholas*



Basic Stress Management

- Minimize exposure to stressors
- Change appraisals of stressful situations
- Manage physical stress responses
  - Physical exercise
    - Walking, swimming, jogging, running, hiking, biking, sports
  - Rest
    - Regular bedtime, sleep, breaks, vacation, "time out"
  - Healthy nutrition, diet, hydration
  - Reducing environmental stressors
    - Temperature, light/darkness, noise/silence, crowds, smells, traumatic visuals

67

Basic Stress Management

- Manage emotional stress responses
  - Catharsis
    - Talking it out, "venting," counseling, therapy
    - Writing – journal, poetry, etc.
  - Enjoyable activity
    - Art, hobbies
- Manage mental stress responses
  - Diaphragmic breathing
  - Stress inoculation therapy
  - Grounding
  - Appropriate sound information
  - Positive attitude
  - Consider other possibilities – a "Plan B"

68

Basic Stress Management

- Manage spiritual stress responses
  - Meditation (mindfulness)
  - Prayer
  - Worship
  - Music
  - Connection
  - Support
  - Community
  - Reading sacred texts

68

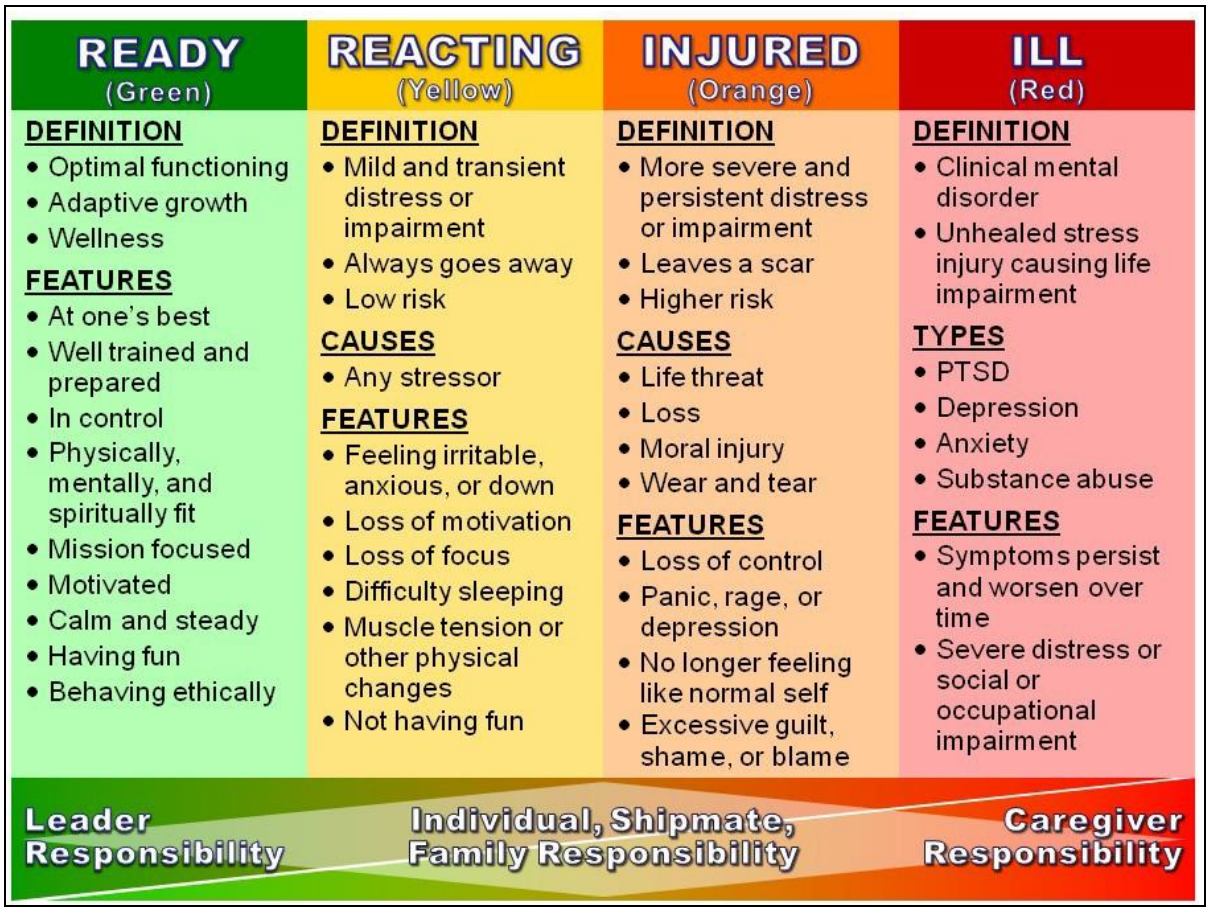
Key Points

- Stress as a continuum
- Four sources of stress injury
- Good leaders are the great medicine.
- Caregivers using OSFA support individuals, leaders, and goals of ministry assignment.
- Caregivers must use skill and knowledge because one size does not fit all.
- Check first and frequently because training and context matter.
- Use the OSFA skills to take care of each other.

INTRODUCTION

Operational Stress First Aid (OSFA) is a flexible, multi-step process for the timely assessment and preclinical care of psychological stress injuries in individuals or teams with the goals to preserve life, prevent further harm, and promote recovery. Unlike other acute stress management procedures, OSFA was designed specifically to augment the physical, psychological, social, and spiritual support structures that exist during critical incidents, and to help restore these support structures over time. In terms of the Stress Continuum, the goal of OSFA is simply to ***move towards green*** to restore health and readiness after an Orange Zone stress injury.

Figure 1. Stress Continuum Model.

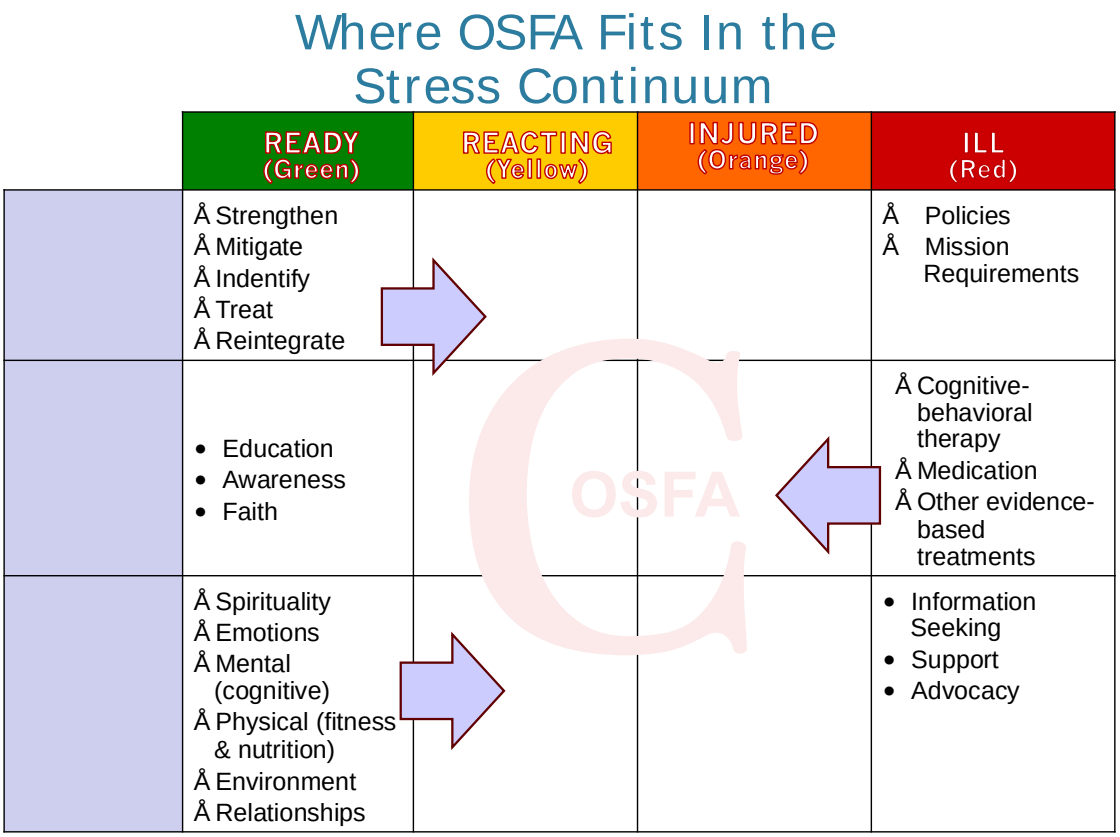


Caregivers Are the Champions of OSFA

As depicted in *Figure 2*, OSFA is a toolkit designed to fill the care gap between the resilience-building and stress mitigation tactics available to leaders and individual team and family members who are at the left end of the Stress Continuum, and the clinical treatments that can be provided by healthcare professionals, which are on the right. Just as with first aid for physical injuries, OSFA actions can serve either as emergency interventions to preserve life and safety until more definitive medical care can be provided, or in milder cases of stress

injury, as the only care that will be needed. Also like physical first aid, OSFA actions vary in complexity and the level of training and skill required to perform them. Some components of OSFA can be delivered by almost anyone, either on individualós own behalf or on behalf of others. Other components of OSFA require greater training and a higher initial level of skill at communication and leadership. In operational units, the individuals best positioned to be the ***champions of OSFA***, and most expert in its delivery and teaching, are caregivers from all disciplines, including chaplains, medical officers, peer-supporters, volunteers, religious program specialists, and mental health professionals. ***In this manual, we focus on training caregivers to become the champions of OSFA.***

Figure 2. Where OSFA fits into the Stress Continuum.



OSFA Targets Orange Zone Stress Injuries

Although individuals in both the Yellow and Orange Zones may benefit from OSFA, it is most useful for the early and ongoing care of Orange Zone stress injuries. In Orange Zone stress injuries, leadership tools for stress mitigation are often inadequate, and clinical mental health treatment may be either unavailable or unnecessary. Since OSFA targets the Orange Zone, team members and family members ***in any setting*** who are ***at risk for Orange Zone stress injuries*** should be trained in basic OSFA principles and should be supported by caregivers trained in all components of OSFA.

What is Stress?

Stress is any challenge to the body or mind, characterized by both a danger and an opportunity. In itself, stress is neutral ï neither good nor bad. It is simply a reaction to a stimulus. The reaction may be positive ï eustress, or the reaction may be negative ï distress.

Stress is necessary and essential for:

- Strength and toughness
- Growth and development
- Acquiring new skills
- Meeting challenges
- Performing difficult tasks

Stress can be toxic and lead to:

- Persistent internal distress
- Functional impairment
- Misconduct
- Substance abuse
- Mental and physical disorders

Three Faces of Stress

Some general sources of operational stress

Physical/environmental	Heat Cold Dehydration Sleep deprivation	Injury Illness Toxins Exertion
Emotional	Anger or hatred Horror Terror	Guilt or shame Grief or loss Fear of failure Fear of injury or death
Cognitive/mental	Hyperfocus Boredom Uncertainty	Lack of information Too much information
Social/relational	Isolation Loss of personal space	Being away from loved ones and friends
Spiritual	Challenge of faith Moral conflict Anger at God	Life doesnôt make sense like it used to

What is coping?

Coping is a change in our bodies, minds, or environments to adapt to stress. There are three main ways (tactics) to cope:

- Strengthen yourself
- Manage your environment and relationships
- Compartmentalize stress when necessary
-
- **Ways to Manage Stress**

Strengthen Yourself	
Physically	**Mentally**
Build strength	Embrace familiarity
Work on physical endurance	Be confident
Practice physical skillsô	Have a positive attitude
Stay fresh and well rested	Inoculate yourself from stress
Emotionally	**Spiritually**
Acknowledge feelings and reactions	Worship
Identify the source of feelings	Pray
Vent appropriately	Read your sacred texts
Avoid compacting and denying feelings	Challenge your values and beliefs

-

Manage Your Environment	
Physical Environment	**Relational Environment**
Wear protective equipment	Trust and support others
Take part in recreational activities	Be a team player
Be prepared for tasks	Strive for family cohesion
Reduce environmental stressors	Strive for team cohesion
Reduce unnecessary physical stressors	Be patient with others

-

Compartmentalize Stress	
Thinking	**Feeling**
Tune out dangers	Feeling numb to fear
Let go of horrors	Feeling numb to sorrow
Donôt dwell on negatives	Feeling numb to suffering
Avoid self-blame	

Stress Continuum

READY (Green)	REACTING (Yellow)	INJURED (Orange)	ILL (Red)
ÅGood to go ÅWell trained ÅPrepared ÅFit and focused ÅCohesive units & ready families	ÅDistress or impairment ÅMild and transient ÅAnxious, irritable, or sad ÅBehavior change	ÅMore severe or persistent distress or impairment ÅLeaves lasting memories, reactions, and expectations	• Stress injuries that don't heal without help ÅSymptoms and impairment persist over many weeks or get worse over time

Stressor

S

Most Important Distinction between Yellow Zone Reactions vs. Orange Zone Reactions

Stress Reaction	Stress Injury
Bending from stress	Damage from stress
Very common	Less common
Typical reaction in stressful situations	Risk for role and task failure
Always goes away	Risk for stress illness

Stress reactions are common and are a part of developing connectedness, competence, and confidence in facing life challenges. Most people have sufficient resources and skills to reset following a stress reaction.

Stress injuries cause damage to the mind and brain that result in functional impairment and typically require activation of additional resources to facilitate recovery and growth.

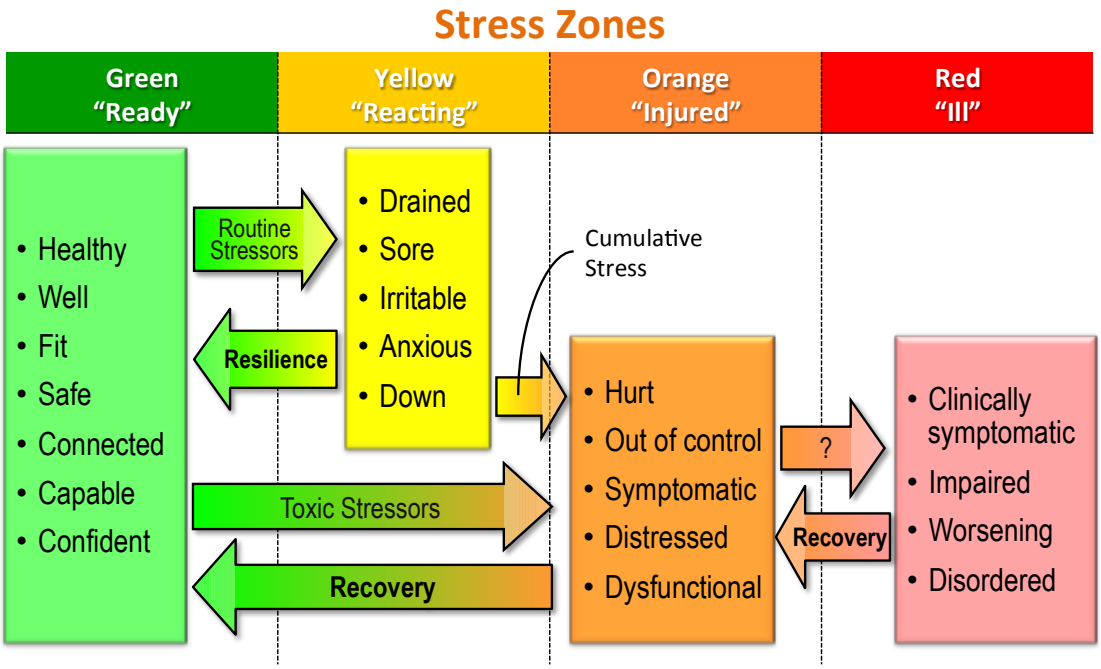
Yellow Zone Stressors Cause Yellow Zone Reactions

Lack of sleep	Physical injuries	Family separation
Harsh weather	Legal problems	Relationship problems
Hard work	Money problems	Loss of privacy
Minor illnesses	Limited resources	Conflicts with boss
Boredom	Lack of time	Peer conflicts

Orange Zone Stressors Cause Orange Zone Injuries

Life threat	Loss	Moral injury	Wear and tear
Safety	Friends/loved ones	Moral values	Concentration
Immortality	Possessions	Right and wrong	Decision making
Competence	Parts of oneself	God and country	Flexibility

Stress Continuum Transitions



Signs and Symptoms of Stress Injury

The following chart lists the signs and symptoms that would be present in the Operational Stress Continuum. Symptoms in the Reacting zone (yellow) are typical stress reactions. They do not necessarily warrant further action, unless they get worse or donôt go away.

READY	REACTING
Calm and steady	Anxious, irritable
Confident and competent	Worried
Getting the job done	Cutting corners on the job
In control	Short-tempered or mean
Sense of humor	Irritable or grouchy
Sleeping enough	Trouble sleeping
Eating the right amount	Eating too much or too little
Working, staying fit	Apathy, loss of interest
Playing well and often	Keeping to oneself
Socially and spiritually active	Negative, pessimistic

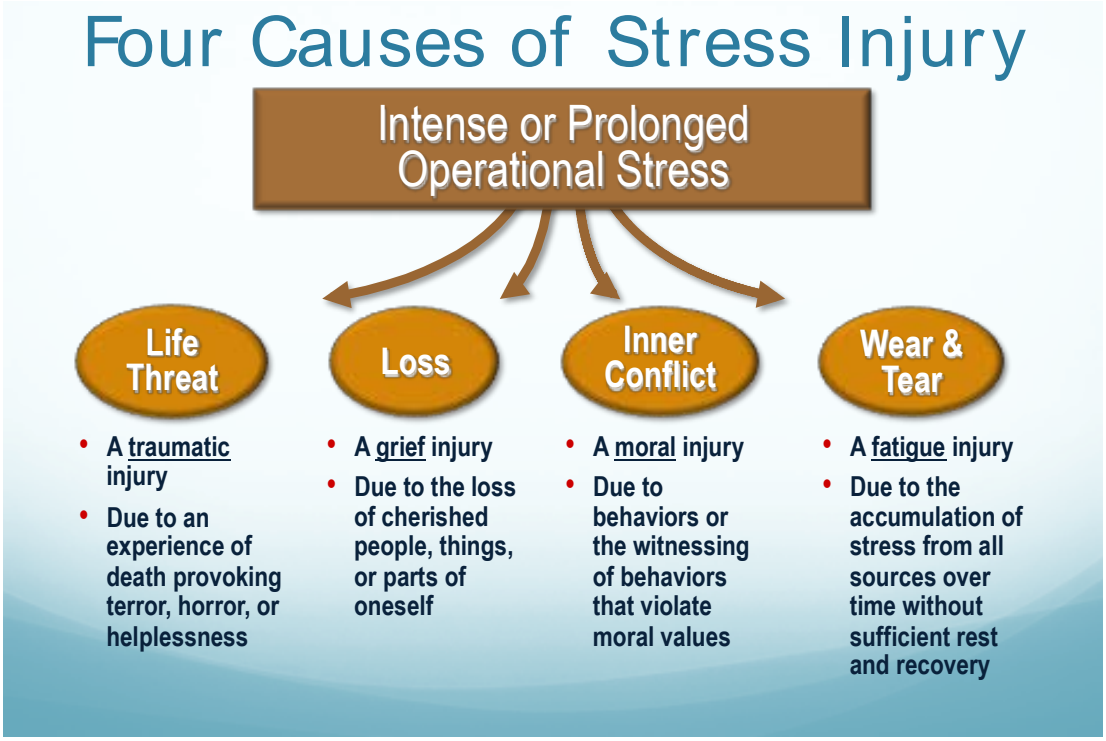
Signs and symptoms in the Injured and Ill zones are indicators that operational stress problems are persistent and serious. Stress injuries could be wounds to the mid or brain caused by intense or prolonged stress. Stress illnesses are diagnosable disorders that may arise if stress injuries donôt heal. These could include PTSD, depression, anxiety, substance abuse or dependence.

INJURED	ILL
Loss of control of body functions, emotions or thinking	Stress injury symptoms that last for several weeks after the stressors have ended or subsided
Canôt fall or stay asleep	Symptoms that get worse instead of better
Recurrent, vivid nightmares	Symptoms that get better for a while, then return even worse
Intense guilt or shame	
Panic or rage attacks	
Inability to enjoy activities	
Disruption of moral values	
Serious suicidal or homicidal thoughts	

Four Causes of Stress In jury

As shown in *Figure 3*, four classes of stressors place individuals at risk for stress injuries: life threat, loss, inner conflict, and wear and tear. The first three of these potential causes of stress injury — life threat, loss, and inner conflict — are usually discrete events that can be experienced either singly or in combination. The last cause of stress injury, wear and tear, is the accumulation of stressors from all life challenges, both large and small, over a long period of time. These four sources of stress injury often operate simultaneously and additively. Teams and families, like individuals, can also be damaged by experiences of life threat, loss, inner conflict, or wear and tear; therefore, units and families can also collectively benefit from the tools of OSFA adapted for use in such organizations.

Figure 3. Four sources of Orange Zone stress injury.



The Goal of OSFA is Indicated Prevention

The prevention of mental disorders caused by the stress of operations is one of the highest priorities of first responder agencies. ***Mental disorder prevention can occur on three different levels, defined by who is targeted*** by prevention interventions. *Table 1* below lists the three levels of prevention intervention developed by the Institute of Medicine Committee for Prevention of Mental Disorders.[1][2]

[1] Mrazek PJ, Haggerty RJ (Eds.). *Reducing Risks for Mental Disorders: Frontiers for Prevention Intervention Research; Institute of Medicine Report of the Committee for Prevention of Mental Disorders.* Washington, DC: National Academies Press; 1994.

Table 1. Three levels of prevention interventions defined by whom they target.

UNIVERSAL	SELECTIVE	INDICATED
Targets potentially everyone in a population	Targets subgroups of the population at increased risk	Targets individuals suffering subclinical distress or impairment

All three levels of prevention are essential to ensuring the readiness of teams and the psychological health and well-being of the individuals that comprise them.

Universal prevention is the goal of organization-wide stress control training and deployment-cycle stress control briefs and workshops. ***Selective*** prevention is one of the goals of team-level After Action Reviews (AARs), safety stand-downs, and post-deployment decompression periods. Both universal and selective prevention interventions are important, but the greatest benefits for health and readiness may result from ***indicated*** prevention interventions ð those that target individuals who are not only in high risk groups, but also who are already experiencing significant distress or changes in functioning due to stress. The difference between indicated prevention and clinical treatment is that in indicated prevention, the symptoms that are targeted are milder or of shorter duration and therefore subclinical ð below the threshold of severity and duration for the diagnosis of a mental disorder. OSFA is a set of indicated prevention interventions that target subclinical distress or impairment.
The goal of OSFA is to prevent subclinical stress injuries from becoming clinical stress illnesses.

OSFA is designed to reduce the risk for Red Zone stress illness through the following means:

- By continuously monitoring the stress zones of team and family members
- By recognizing quickly those individuals who have been injured by stress and are in need of interventions to promote healing
- By offering a spectrum of one-on-one interventions to ensure safety, reduce the risk for further stress injury, and to promote recovery
- By monitoring the progress of recovery to ensure return to full function and well- being
- By referring individuals for higher levels of care, and to coordinate care with other support services, whenever needed
- By monitoring the effect of Orange Zone stress on units and families
- By augmenting and promoting the repair of pre-existing support structures that may have been damaged by Orange Zone stress
- By advising leaders and other members of chains of command regarding the effects of stress on individuals and teams, and how to mitigate them
- By teaching others on teams and families how to use the tools of OSFA.
- By reporting lessons learned from the use of OSFA to sponsoring agencies so OSFA will adapt and improve over time

OSFA is Guided By a Set of Core Principles

Leadership and team cohesion are potentially the most powerful forces for healing and recovery available to team members ð more powerful than the clinical skills of counselors or therapists, and more powerful than the medications prescribed by physicians.

OSFA promotes recovery and healing by augmenting, restoring, and leveraging leadership and cohesion on teams.

OSFA augments not only existing leadership, but also medical care, religious ministry, and other intrinsic social support resources; it never supplants or competes with them.

OSFA occurs in natural work, field, and home contexts, wherever and whenever it is needed.

OSFA is individualized to meet the needs of each individual in each context; there are no one-size-fits-all OSFA solutions.

OSFA is never a one-shot intervention, but rather an ongoing process of promoting healing, monitoring progress, and adjusting, as needed over time.

Assessment and reassessment ð first, last, and always ð is central to OSFA.

Continuum Model, the cornerstone of OSFA care.

As a first-line treatment for stress injuries, OSFA will sometimes serve as a stop- gap until more definitive care can be provided, but even after clinical care becomes available, OSFA is continued as a bridge between leadership and clinical care.

In more mild instances of Orange Zone stress injury, OSFA may be the only intervention needed to promote recovery and reintegration.

OSFA requires a collaborative team effort to be most effective.

OSFA Supports Five Core Leader Functions

Leaders are responsible for five core stress control functions: strengthen, mitigate, identify, treat, and reintegrate. The first two of these functions, strengthen and mitigate, have been served by leadership, training, and team cohesion since long before scientific concepts of stress management were introduce. The last three leader functions of OSFA ð identify, treat, and reintegrate ð require skills and concepts that may be newer to leaders and their intrinsic social and spiritual support personnel. OSFA is designed to provide teachable and practical tools to meet these challenges for leaders to identify, treat, and reintegrate stress injuries.

OSFA OVERVIEW[3]

The most fundamental of these concepts is at the heart of all public health programs. It is the principle that effective health promotion in a population can only be carried out as a collaboration between stakeholders and across disciplines, with members of the community actively engaged in the process under the direction of their organic leaders.

How best to promote the psychological health, in particular, of teams has been the subject of considerable dispute in the past. Contested issues have included not only which particular prevention and early intervention practices might be most effective, but what exactly is the nature of adverse stress states in crisis settings.

Advancements in research on severe stress in both humans and animals have brought increasing clarity to the nature of adverse stress outcomes; they are undeniably based on changes in functioning, if not structure, in ***every*** dimension of human existence, including the biological, psychological, social, and spiritual domains. It no longer makes sense to conceive of the impacts of severe stress in only one or two of these dimensions. To be optimally effective, prevention interventions and treatments should target all of these dimensions of human existence. Viewed multi-dimensionally, stress states clearly lie along a spectrum of severity and type ð they are neither all normal, transient, and self-limiting, nor all harbingers of chronic mental illness.

The Stress Continuum Model, *Figure 1*, was developed by military leaders in collaboration with mental health and religious ministry personnel as a tool for conceptualizing the spectrum of stress states, and for operational stress risk management.
Enlarging the Green Zone of readiness and wellness is the goal of universal prevention activities. Returning to Green from Yellow Zone stress reactions is the goal of leader-driven stress mitigation functions. But the stress zone in which the risk for failure of role performance and future mental disorders becomes significant is the Orange Zone of stress injuries. That is why indicated prevention interventions may yield the greatest benefit in this zone. As leaders have been educated in recent years about the stress continuum and the bio-psycho-social-spiritual nature of stress injuries, a common question has been, "Okay, if stress can injure my team, then where do we get training in first aid for these injuries?"

Until recently, a common practice for caregivers to respond to potentially traumatic events in both military and civilian settings has been a form of group psychological debriefing, such as Critical Incident Stress Debriefing (CISD)[2]. Partly to replace CISD, a different set of concepts and practices known as Psychological First Aid (PFA) were developed jointly by the National Child Traumatic Stress Network and the Veterans Administration NCPTSD for use in civilian

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[3] OSFA was developed through a long-term collaboration between Marine Corps and Navy line leaders, the Navy Bureau of Medicine and Surgery (BUMED), the Navy Chaplain Corps, the Department of Veterans Affairs National Center for Posttraumatic Stress Disorder (NCPTSD), and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE).

disaster and terrorism settings.[3] PFA is a set of principles and unobtrusive, flexible procedures designed to help survivors and first responders achieve five goals: (1) regain a sense of safety, (2) reduce intense physiological arousal and negative emotions, (3) increase self-confidence and self-efficacy, (4) feel connected to sources of social support, and (5) experience hope that help is available, needs will be met, and suffering will abate. These five goals of PFA have strong support in the research literature.[4]

In the OSFA framework, a key assumption is that for many individuals, the most enduring resources for resisting Yellow Zone stress reactions and recovering from Orange Zone stress injuries are relationships with leaders and peers. Team leaders are critical resources for building resilience through training and fostering cohesion (*strengthening*), ensuring that Yellow Zone reactions are short-lived (*mitigation*), identifying Orange Zone injuries and Red Zone illnesses so that proper care can be provided (*identification* and *treating*), and facilitating recovery of functional capabilities (*reintegration*).[5] Leaders at all levels must be engaged in OSFA at every step.

[2] For a critical review of the efficacy of CISD, see Bisson, J. I., McFarlane, A. C., Rose, S., Ruzek, J. I., & Watson, P. J. Psychological debriefing for adults. In E. B. Foa, T. M. Keane, M. J. Friedman, & J. A. Cohen (Eds.), *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford Press.

[3] Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., et al. (2006). Psychological First Aid: Field Operations Guide, 2nd Edition. Available on www.nctsn.org and www.ncptsd.va.gov.

[4] See Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry 70(4),* 283-315.

[5] US Marine Corps & US Navy. (in press). *Combat and Operational Stress Control*, MCRP 6-11C/NTTP 1-15M. Quantico, VA: Marine Corps Combat Development Command.

Three Levels and Seven Core Actions of OSFA

As shown in *Figure 4* below**,** OSFA consists of ***seven core actions*** grouped on ***three levels***. The seven core actions are ***Check, Coordinate, Cover, Calm, Connect, Competence,*** and ***Confidence***. The three levels of OSFA into which these actions are grouped are called ***Continuous Aid***, ***Primary Aid***, and ***Secondary Aid***. *Table 2*, on the next page, gives an overview of the seven core actions and three levels, and shows how they fit together. In the rest of this manual, these seven actions of OSFA will be described in detail.

Figure 4. Operational Stress First Aid (OSFA).

Continuous Aid ï facilitates a series of checks and coordination activities to monitor stress responses, expedite care efforts and match needs to available resources

- Check
- Coordinate

Primary Aid ï focuses on safety, calming and preventing further harm

- Cover
- Calm

Secondary Aid ï guides individuals, peers, leaders, and caregivers to work together to promote recovery or facilitate appropriate referral for further evaluation or treatment

- Connect
- Competence
- Confidence

Table 2. Overview of Three Levels and Seven Core Actions of OSFA.

LEVEL		CORE ACTION		
Continuous Aid	***Ongoing*** OSFA actions, performed throughout deployment cycles Overlaps significantly with good small unit leadership Always individualized (one-on-one)	**1.**	**Check**	Assess current level of distress and functioning (stress zone) Assess immediate risks Assess need for additional OSFA interventions or higher levels of care Reassess progress
		2.	**Coordinate**	Call for help, if needed Decide who else should be informed of situation (e.g., commanding officer) Refer for further evaluation or higher levels of care, if indicated Facilitate access to other needed care
Primary Aid	***Acute*** OSFA actions performed for a short time in response to intense distress or loss of function Crisis management Life-saving and health-saving Often one-on-one	**3.**	**Cover**	Ensure immediate physical safety of stress-injured person and others Foster a psychological sense of safety and comfort Protect from additional stress (ensure respite)
		4.	**Calm**	Reduce physiological arousal (slow heart rate and breathing, relax) Reduce intensity of negative emotions, such as fear or anger Listen empathically to individual talk about experiences
Secondary Aid	***Delayed*** OSFA actions performed after the crisis has passed Longer term procedures to promote healing, recovery, and return to full function Often requires active participation by small unit leaders	**5.**	**Connect**	Facilitate access to primary support persons, such as trusted unit or family members Help problem-solve to remove obstacles to social support Foster positive unit social activities
		6.	**Competence**	Help mentor back to full functioning Collaborate with leaders to facilitate rewarding work roles and retraining, if necessary Encourage gradual re-exposure to feared situations
		7.	**Confidence**	Mentor back to full confidence in self, leadership, mission, and core values Foster the trust of unit members and family members in the individual Instill hope

CORE OSFA ACTIONS: CONTINUOUS AID TO SECONDARY AID

For caregivers, OSFA entails a continuum of assessment and intervention strategies designed to catch the early warning signs of crisis and risk, evaluate needs, ensure needed assistance and support, and maximize intrinsic healing resources of many organizations. In the ideal case, caregivers will have an enduring presence and ongoing relationships with team members under their care. This kind of care context allows for what we call Continuous Aid. Continuous aid entails ongoing assessments of needs, using leader and peer resources to facilitate resolution of Yellow Zone reactions, and coordinating care for Orange and Red Zone responses over time, ensuring continuity and follow-up towards the goal of complete reintegration of team members, and reestablishing team cohesion.

Primary Aid promotes safety and the resolution of toxic physiological and psychological states compromised by sustained Yellow Zone stress reactions (wear and tear) or exposure to life threat, loss, or potentially morally injurious experiences. Secondary Aid begins, if feasible, during an initial contact with a team member in crisis, and only after Primary Aid needs are met, if they are needed. Primary Aid is an immediate crisis response *in the moment*, while Secondary Aid usually provides more enduring support of healing *moving forward,* leveraging other resources to promote wellness and connection, and return to Green Zone effective functioning *over time*.

CONTINUOUS AID: Check and Coordinate

Unlike the other components of OSFA, which are intended to be used only in specific situations and only for a limited period of time, the two actions that comprise **Continuous Aid must be performed continuously to be effective**. These two actions are **Check** and **Coordinate**, and they must be fully integrated into the normal day-to-day work of caregivers on behalf of all team members under their care, throughout deployment cycles ð before, during, and after exposures to stressor events. Check and Coordinate are the portals through which individual members receive the other preventive interventions of OSFA, or higher levels of care, if needed. They are also the means by which other support systems are mobilized, leaders are informed of what they need to know, the effectiveness of interventions are assessed, and continual progress toward recovery is ensured.

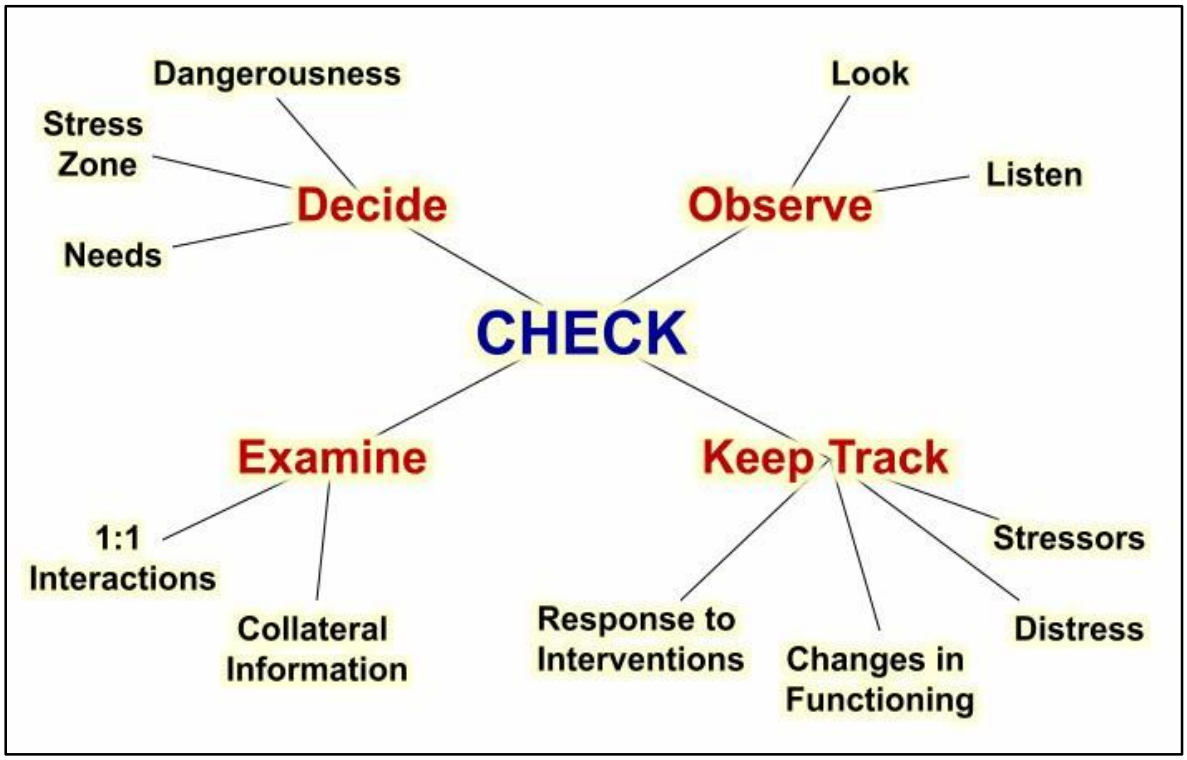
These first two core actions of OSFA are similar to the first two steps of Basic Life Support (BLS), also known as cardiopulmonary resuscitation (CPR), as taught by the American Heart Association. When learning to perform BLS on a manikin named Annie, many of us were taught to first check the stricken individual to determine if they were really in need of emergency life support. "Annie, Annie, are you okay?" we said as we shook her shoulders. After checking for an open airway, breathing, and a pulse, but finding none, we were taught to next call for help before beginning rescue breaths. We were taught to shout, "Activate the emergency medical system!" to someone nearby so they would know to dial 911 to summon paramedics. Check, coordinate, and then provide life-saving assistance. A major difference between initial BLS procedures and the Continuous AID functions of Check and Coordinate lies in the ongoing, recurrent nature of assessment and recruitment of other help and resources in OSFA. In OSFA, after providing lifesaving Primary Aid, we would recurrently check back with the stress-injured person to assess current status and needs. We would continuously monitor the effectiveness of whatever first aid or definitive treatment interventions were offered, and we would return again and again, long after the need for emergency care had passed. If practicing OSFA with a manikin, we might perform regular checks by touching her shoulder and asking, "Annie, are you **still** okay?"

CHECK

What Is It? *Figure 5* graphically depicts the major components of the Check function of OSFA. The first and most important component is to **observe** ð to look and listen for direct or indirect indications that someone may have been injured by stress and be in need of aid. While observing, OSFA caregivers must also **keep track**, at least mentally, of the current and recent stressors impacting team members, and of the course over time for any distress or alterations in functioning they have shown. Of course, observation and tracking from a distance are not sufficient. If indications of a possible stress injury arise (as will be described below), individuals must be **examined** for more information, both directly, through one-on-one interactions, and indirectly, through

collateral sources. Finally, based on the flow of information obtained, OSFA caregivers must **decide** what needs to be done based on assessments of dangerousness and current stress zone.

Figure 5. Conceptual components of Check function of OSFA.



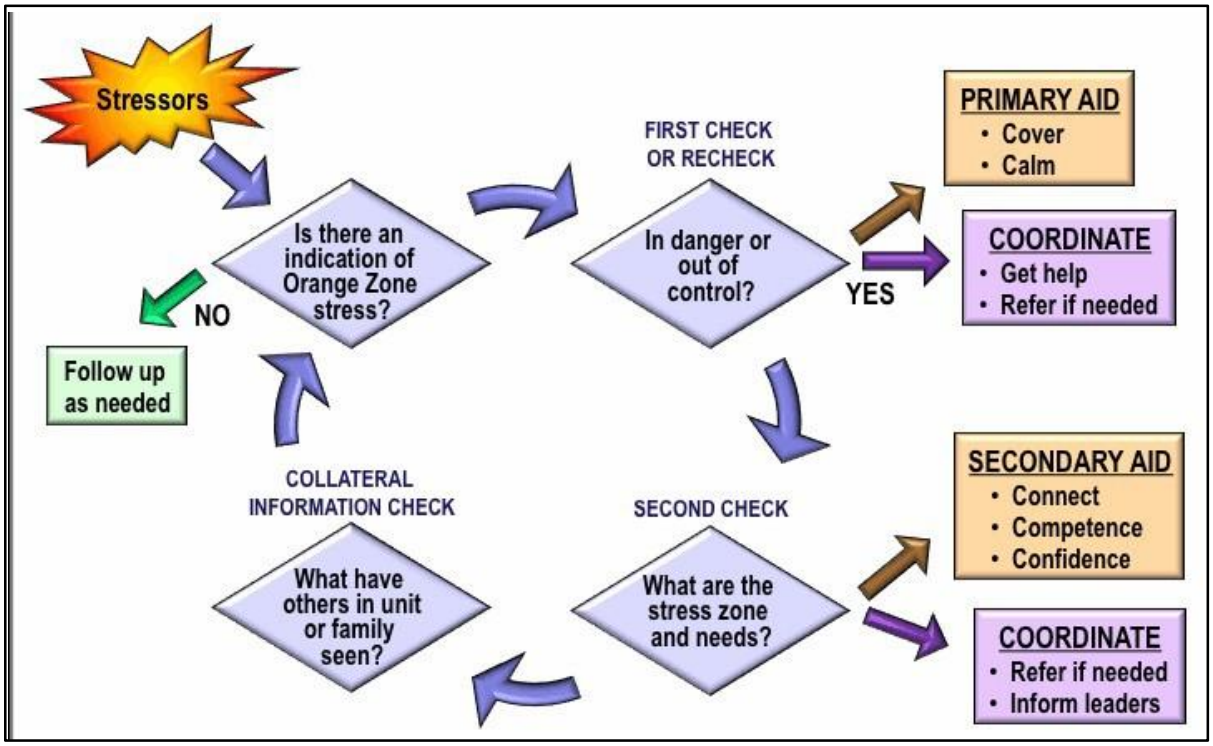
Why Is It Needed? Individuals exposed to intense and prolonged stress need OSFA caregivers to monitor continually and assess them for possible Orange Zone stress for several reasons:

- Those who are injured by stress may be the last to know it.
- Stigma is an obstacle to asking for help.
- Matching needs to available resources requires careful, ongoing assessment.
- Stress zones and needs change over time.
- Risks from stress injuries may last a long time after the event.

The Check Cycle. Each application of the Check function of OSFA passes through a sequence of steps known as the Check Cycle, depicted in *Figure 6*. Each step in this cycle will be described in detail below, but the following is a brief overview of the steps in the cycle.

The Check Cycle is initiated by awareness that one or more individuals have been exposed to one or more potential Orange Zone stressors, such as loss of life in the unit. In the aftermath of such stressors, individuals are repeatedly monitored for evidence of Orange Zone stress, such as significant and persistent distress (guilt, shame, anger, and anxiety) or alterations in physical, mental, social, or spiritual functioning. If no indications of Orange Zone stress are present, nothing more need be done except continued monitoring. If **Orange Zone Indicators** are present, however, the next step ð First Check ð is immediately undertaken.

Figure 6. The Check Cycle.



First Check is analogous to the ' primary survey in physical trauma triage ð a quick once-over to assess for immediate threats to life, such the ABCs of airway, breathing, and circulation. The First Check in OSFA is a quick **crisis assessment,** looking for indications of dangerousness to self or others, or significant loss of physical, mental, or emotional control. Primary Aid, to be described in the next chapter, is a set of crisis responses to dangerousness or loss of control. The next step in the Check Cycle, undertaken once it is clear that no crisis exists, is Second Check.

Second Check, like the ' secondary survey in physical trauma triage, is a more deliberate and thorough assessment. The goals of Second Check are to determine the individualós current stress zone and needs for the Secondary Aid functions, to be described later.

Collateral Information Check is the final step in the Check Cycle, which is obtaining information about the individual by questions from others familiar with him or her, such as immediate superiors, peers, chaplains, medical personnel, or family members.

The Check process cycles through these three steps repeatedly for as long as individuals are at risk for Orange Zone stress. Not every step will prompt action each time through the Check cycle, but to make sure all necessary actions are taken, all three steps should be mentally considered each time through.

How To Recognize Who Needs Help: Orange Zone Indicators. The sequence of decisions and actions that comprise OSFA usually begin with an awareness on the part of a OSFA caregiver that someone might have suffered an Orange Zone stress injury, and therefore may be in need of help and preventive interventions. These hints suggesting the

possibility of Orange Zone stress are called **Orange Zone Indicators**, and they come in **three forms**, all of which are important:

- **Recent Stressor Events:** recent exposure to stressors with a high potential to cause stress injury, especially situations involving life threat, loss of someone or something cherished, or violations of moral codes
- **Internal Distress:** significant and persistently troubling feelings, such as fear, anger, anxiety, sadness, guilt, or shame
- **Changes in Functioning:** significant and persistent alterations in physical, mental, social, or spiritual functioning that seem outside personal control

Monitoring for Orange Zone Indicators is one of the most basic and crucial tasks for OSFA. Being able to recognize Orange Zone Indicators is the most important OSFA skill to learn and practice.

A caregiver on a team can become aware of Orange Zone Indicators in a team member in several possible ways:

- The caregiver may personally witness an abrupt change in the behavior of a team member under severe stress.
- A team member might confide in the caregiver that he or she has experienced a significant increase in internal distress or alarming alterations in functioning.
- A member of the chain of command, medical department, or other responsible person in the agency may seek the caregiver's assistance with an individual with Orange Zone stress indicators.
- A peer or team member might tell the caregiver about the changes in behavior that were witnessed or heard about in a team member.
- The team or part of it may be exposed to an intense stressor event with a high risk for producing Orange Zone stress.

Table 3 below gives examples of Orange Zone indicators that might prompt the Check function of OSFA. Note that the ***key indicator*** of a possible Orange Zone stress injury is not an event, but rather an individual's response to events, in particular, ***a recent, significant change in level of distress or personal functioning.***

Table 3. Examples of Orange Zone Indicators.

	Look for:	Listen for:
Current Stressors	Close brush with death during operational deployment or training The loss of friends, peers, or leaders by death or serious injury Events in which actions or failures to act may violate deeply held beliefs or moral values Yellow Zone stress reactions that continue, day after day, for many months	I almost got killed in a motorcycle crash yesterday." "My son is very sick and may not pull through." "My mom just died." "I can't believe my wife cheated on me while we were deployed!" "My wife left me, taking the kids and all our stuff."
Level of Distress	Pacing or persistent agitation Uncharacteristic outbursts of anger, anxiety, or fear Uncharacteristic fighting, alcohol abuse or misconduct Persistent sadness or absence of normal emotions Loss of interest in work, hobbies, or socializing Persistent withdrawal from interactions with others	"I can't stop seeing the same scene replayed over and over again in my mind." "I keep waking up from the same nightmare." "I don't have any energy anymore." "It was all my fault." "I don't trust anyone in this unit any longer."
Changes in Functioning	Significant and persistent changes in personality Uncharacteristically poor hygiene or grooming Sudden drop in job performance Persistent forgetfulness Uncharacteristic loss of control of emotions	"I can't slow down my heart rate." "I haven't slept in weeks." "My appetite is gone, and I have lost a lot of weight." "I am afraid I might lose it and hurt someone."

Figure 7, below, lists the 15 items of the Peritraumatic Behavior Questionnaire (PBQ), an additional tool for caregivers or leaders to recognize changes in behavior in the immediate aftermath of severe stressors that might be indicators of Orange Zone stress.

Figure 7. Peritraumatic Behavior Questionnaire (PBQ) ð Observer Rated

INSTRUCTIONS: Please complete the items below by filling in the circle under the answer that best describes the reactions YOU OBSERVED IN THE INDIVIUDAL BEING RATED DURING AND/OR IMMEDIATELY AFTER A RECENT STRESSFUL EVENT. To apply to the person being rated, these reactions must have been UNUSUAL FOR THEM, NOT THE WAY THEY NORMALLY BEHAVE. If an item does not describe an observed change in behavior for the rated individual during or after a stressful event, please fill in the circle for "Not at all true."

		NOT AT ALL TRUE	SLIGHTLY TRUE	SOMEWHAT TRUE	VERY TRUE	EXTREMELY TRUE
1	For a period of time, the individual did not act like their normal self.	○	○	○	○	○
2	For a period of time, the individual seemed to feel fearless and invulnerable, as if nothing could harm them	○	○	○	○	○
3	For a period of time, the individual seemed not to care about their own or othersô welfare or safety.	○	○	○	○	○
4	For a period of time, the individual seemed to feel no remorse for doing things that would have bothered them in the past.	○	○	○	○	○
5	For a period of time, the individual seemed to be determined to get revenge.	○	○	○	○	○
6	For a period of time, the individual seemed unable to stop laughing, crying, or screaming.	○	○	○	○	○
7	For a period of time, the individuals seemed helpless and unable to look out for their own welfare.	○	○	○	○	○
8	For a period of time, the individual appeared to be confused, as if having difficulty making sense of what was happening.	○	○	○	○	○
9	For a period of time, the individual appeared to be disoriented, as if uncertain about where they or what day or time it was.	○	○	○	○	○
10	For a period of time, the individual could not move parts of their body.	○	○	○	○	○
11	For a period of time, the individual froze or appeared to be moving very slowly, such that they could not do everything they wanted to do.	○	○	○	○	○
12	For a period of time, the individualôs speech changed (such as stuttering, repeating words or phrases, or having a shaky or squeaky voice).	○	○	○	○	○
13	For a period of time, the individual was not able to fully carry out their duties (during or immediately after the event).	○	○	○	○	○
14	For a period of time, the individual expressed the belief that they were going to die.	○	○	○	○	○
15	For a period of time, the individual had an intense physical reaction, such as sweating, shaking, or heart pounding.	○	○	○	○	○

We now turn to a more detailed description of the three major steps in the Check Cycle as depicted in *Figure 6* ð First Check, Second Check, and Collateral Information Check.

First Check: Safety and Crisis Assessment

What is First Check?

Safety assessment of an individual with Orange Zone indicators

When does First Check happen?

As soon as possible after learning of an Orange Zone indicator

May be during direct observation of Orange Zone behaviors

What are the goals of First Check?

Assess for dangerousness to self or others ð need for Cover

Assess for physiological arousal or emotions ð need for Calm

Determine whether immediate outside help or referral is indicated

How do you perform First Check?

Look and listen

Assess ability of the individual to recognize and respond to threats

Assess level of self-control and physical and emotional calmness

If indicated, ask about impulses or thoughts of suicide or homicide

The primary ***goal of First Check is to assess dangerousness and the need for immediate Primary Aid*** or emergent referral. Dangerousness may take any of the following forms in an Orange Zone crisis situation:

In a potentially lethal environment, acute mental confusion or loss of mental focus and decision-making ability

In a potentially lethal environment, acute loss of control of physical self-control, such as freezing, fleeing, or blindly striking out

In a potentially lethal environment, intense and uncontrollable emotions, such as rage or panic

In any environment, an inability to respond to commands or direction

Suicidal thoughts, fantasies, impulses, mental images, plans, or recent attempts or gestures

Homicidal or assault thoughts, fantasies, impulses, mental images, plans, or recent attempts or gestures

Signs of dangerousness may be obvious or they may be subtle, but every attempt must be made to assess for dangerousness because safety ð the Cover function of OSFA ð trumps everything else. If dangerousness is suspected, immediate use of the Primary Aid action of Cover is clearly indicated, followed or accompanied by a call for help (Coordination).

The other goal of the First Check ð after safety is addressed ð is to determine whether immediate calming is required because of intense negative emotions or

physiological hyper arousal. The ***need for the Calm function of Primary Aid*** OSFA may be indicated by any of the following:

- Uncontrollable yelling, crying, or other vocalization
- Excessively rapid and shallow breathing while at rest
- Excessively rapid heart rate while at rest
- Shaking or trembling of hands or voice
- Speech that is excessively rapid or illogical
- Intense negative emotions, such as rage or fear
- Inability to keep attention focused on tasks at hand

Second Check: Thorough Assessment. After the First Check has been completed and either the Primary Aid actions of Cover and Calm were successfully taken or they were not needed at all, then it is time to move on to the more deliberate and thorough Second Check.

What is Second Check?

Detailed assessment of an individual with Orange Zone indicators

When does Second Check happen?

As soon as possible after crisis has passed (if a crisis existed)

May occur after obtaining collateral information from other sources

What are the goals of Second Check?

Identify current stress zone, especially whether Yellow or Orange

Determine needs for Secondary Aid: Connect, Competence, and Confidence

Look for indicators of ability to function in operational role

Determine needs for other physical, emotional, social, or spiritual support or care

Determine who else needs to know, and who else can help

Compared to the First Check, the Second Check is more conversational and collaborative. This is because current stress zone, needs for further assistance, and functional capacity in many important spheres cannot be assessed merely by observing an individual ð you need their active participation in the Second Check to acquire this information.

Establishing that collaboration in the Second Check sets the tone for all future OSFA interventions, for good or ill; therefore, it is crucial at this point to **establish rapport through empathic listening,** compassion, and gentleness, while also establishing a working alliance by informing the individual exactly why you are talking to them, and what information you have that makes you concerned about them. A useful tool in the collaborative conversation of the Second Check and beyond is ***OSCAR communication***, defined by these features:

Observe: Actively observe behaviors; look for patterns.

State Observations: Focus attention to the behaviors; state just the facts without interpretations or judgments.

Clarify Role: State why you are concerned about the behavior; validate why you are addressing the issue.

Ask Why: Seek clarification; try to understand the other person's perception of the behaviors.

Respond: Clarify concern if indicated; discuss desired behaviors; state options in behavioral terms.

In the Second Check, the OSFA caregiver covers the same three Orange Zone indicators as in the First Check ð current stressors, level of distress, and impairment of functioning ð using the same two senses, looking and listening (see *Table 3*). But in the Second Check, all three areas must be explored in much more depth. *Table 4* summarizes the information sought during the Second Check.

Table 4. Orange Zone indicators surveyed during the Second Check.

Current and Recent Stressors	Life threat events experienced during current and past deployments, or while at home Losses of friends, family members, leaders, or of significant objects to which the individual was strongly attached Inner conflict events in which the individual either felt betrayed by someone else, or violated, through action or inaction, of their own moral code Sum total of all wear-and-tear life stressors, including those involving personal health, finances, family and other relationships, and career
Increases in Level of Distress	Increased fear, anxiety, or worry that interferes with the individual's well-being Increased sadness, depressed mood, hopelessness, or inability to experience pleasure in situations where he or she once did Increased anger or irritability that interferes with the individual's ability to get along with others Recurrent distressing thoughts, images, impulses, or dreams that difficult to push out of awareness and that provoke painful emotions or physiological arousal Persistent and distressing feelings of guilt or shame Loss of self-confidence Loss of trust in peers, leaders, equipment, or mission

Table 4. Orange Zone indicators surveyed during the Second Check.

Decreases in Normal Changes in Functioning	A significant change in personality, such as becoming uncharacteristically harsh, cruel, indifferent, or cold Withdrawal from peers, family, or others sources of social support Loss of faith in God or participation in prayer or other religious practice Loss of mental focus and sharpness of memory or problem-solving abilities Gaps or lapses in memory Uncharacteristic outbursts of temper Uncharacteristic attacks of panic Persistent changes in physical functioning, such as changes in bowel function, loss of physical strength or fine muscle control, or unusual pain

By surveying all the above areas, the CSFA caregiver should have enough information to make several important decisions:

1. What stress zone is the individual currently in, and why?
2. Would the individual benefit from the Secondary Aid functions of OSFA to Connect socially, restore personal Competence, or enhance self-Confidence?
3. Is referral for further medical or mental health evaluation warranted?

Collateral Sources of Information. At many points during the assessment process ð and the reassessment process that follows ð it may be very helpful to gather additional information about the individual in question from collateral sources, such as members of the chain of command, chaplains, medical officers, counselors, EMTs, peers, and family members. When asking such sources about the individual being assessed, cover the same three Orange Zone indicators that guided the First and Second Check: (1) current and recent stressors, (2) indications of internal distress, and (3) evidence of loss of previous functional capacity or changes in functioning. The information acquired from these collateral sources will either support or conflict with the information obtained directly from the individual.

Either way, it will be helpful to make accurate assessments and sound intervention decisions.

Recheck. As stated earlier, the Check action of OSFA is never a one-shot effort. Even if an individual who has been assessed seems perfectly fine with no evidence of being in the Orange Zone, the initial indicator that prompted the assessment might increase the risk for the development of Orange Zone stress in the future. Rechecking must follow up the effect over time of Primary Aid or Secondary Aid. At each re-encounter with the individual, the same sequence of First, Second, and Collateral Checks are followed.

COORDINATE

The second Continuous Aid action of OSFA, which always flows from and follows the Check function, is Coordinate. There are two broad goals for the Coordinate function:

1. Who needs to know about this individual's stress?
2. Who else can help?

What Is It? *Figure 8* graphically depicts the major components of the Coordinate function of OSFA. There are four actions that follow from answering the above questions. The first component is to **get help** ð the lone rescuer in any first-aid situation is often at risk for injury or being overwhelmed by the immediate demands. In basic life support (BLS), the second step after assessment is to call for help. Getting help can be as simple as at least one other person knowing that there are stress concerns and that you are trying to help by activating the duress alarm. The next action is **collaborate** ï this action is a form of partnership with the stress-injured person and is intended to expand resources and options that may have been depleted by the stress injury source. Collaboration is about getting the person to the next level of immediately available support, such as, a mentor, trusted leader, base resources, and so forth. The **inform** action is intended to engage key others who have a need to know or the ability to help organizationally or emotionally. Informing others is part of breaking the code of silence that is required to reduce self-isolation, negative automatic thoughts, and self-loathing. This action is most effective when it is done in collaboration with the injured person and focuses on those who have a need to know or are supportive resources. Some stress injuries cause significant impairment in functioning or may require more formal intervention. The **refer** action is used to ensure that the individual is engaged with appropriate organizational supports and resources that extend beyond peers, family, and good intentions.

Figure 8. Conceptual components of the Coordinate function of OSFA.

Coordinate with leaders. The decision to inform leaders or members of their chains of command about an individual experiencing significant stress is not always an easy one to make. Because of the stigma attached to stress and mental health problems, those who are informed may unnecessarily lose some of their respect for or trust in the stressed individual. The individual's future in that agency, and in service in general, may be affected. Furthermore, the individual may feel ashamed or embarrassed to have others told about his or her stress responses. The individual may even feel betrayed by the caregiver who informed the leader. The following are factors to consider in deciding whether and how much to tell leaders.

- How great is the risk to the individual in question, or other members of the team, if the leaders are unaware of the individual's stress?
- How great is the chance that the individual will be unable to perform important duties in the future?
- Might the individual benefit from a temporary change in duty assignment or a period of rest?
- Does the individual warrant further evaluation and possible treatment from a medical or mental health professional, and does the commanding officer need to know about such a referral?

The challenge of deciding how much to tell leaders is another important reason for the OSFA caregiver to develop and maintain a collaborative working alliance with the individual being helped. That individual deserves to know what future actions are being considered and to have input in decision-making processes. Often, an individual who is reluctant to have his or her commanding officer informed of the situation can be convinced of the potential rightness of that decision as well as its potential benefits to him or her directly.

Leaders and their chains of command are invaluable allies in applying the core actions of OSFA. Supervisors and small team leaders, if respected and trusted by a subordinate, can be far more effective than a caregiver alone at the Secondary Aid actions of Competence and Confidence. If not included in the OSFA action plan, members of the chain of command may unwittingly undermine the efforts of the caregiver. OSFA works best as a collaborative effort.

Coordinate with other sources of care and support. An equally important decision that OSFA caregivers must make at every turn is whether and to whom to refer an individual for a higher level of care. Factors to consider when making that decision include the following:

- How confident is the OSFA caregiver in the assessment of the individual, especially of stress zone and dangerousness?
- Is there evidence that something is missing from the picture ð some way in which the facts do not add up?
- How solid is the working alliance between OSFA caregiver and the individual?
- Would the individual possibly benefit from a form of care or treatment that the OSFA caregiver is unable to provide?
- How has the individual progressed over time: is he or she getting better, staying the same, or getting worse?

When in doubt, getting another opinion is almost always helpful, whether you agree with that opinion or not. If a formal referral is not clearly indicated, other options include consulting with another OSFA caregiver to get a second opinion, or consulting with a medical or mental health professional informally, as a "hallway consult." Getting others' input in this way is almost always the right thing to do, even if there are no doubts about the assessment and plan or unanswered questions.

Coordination with other sources of care and support does not end with a referral or request for help. If higher levels of treatment are prescribed, OSFA caregivers assume a case-management role in the unit to ensure that treatment recommendations are followed and that follow-up appointments are kept. Accomplishing these goals always requires collaboration with the chain of command.

PRIMARY AID:
Cover and Calm

Primary Aid in OSFA includes two basic stress first-aid functions, Cover and Calm, for the **short-term management of crisis situations** brought on by Orange Zone stress. Primary Aid is analogous in some ways to basic life support (cardiopulmonary resuscitation, or CPR) in physical first aid in that Primary Aid can be life saving when it is needed, and it can prevent further harm from occurring until other forms of help can be obtained. Compared to CPR, though, Primary Aid is much simpler, more intuitive, and requires less training and skill. Since Primary Aid is designed for use in crisis situations, which occur rarely, the Primary Aid functions of Cover and Calm are used only rarely. But when they are needed, they are needed immediately, with little time to bring in others with training in Primary Aid. For this reason, every member of the team should be familiar with the basics of Primary Aid functions of Cover and Calm.

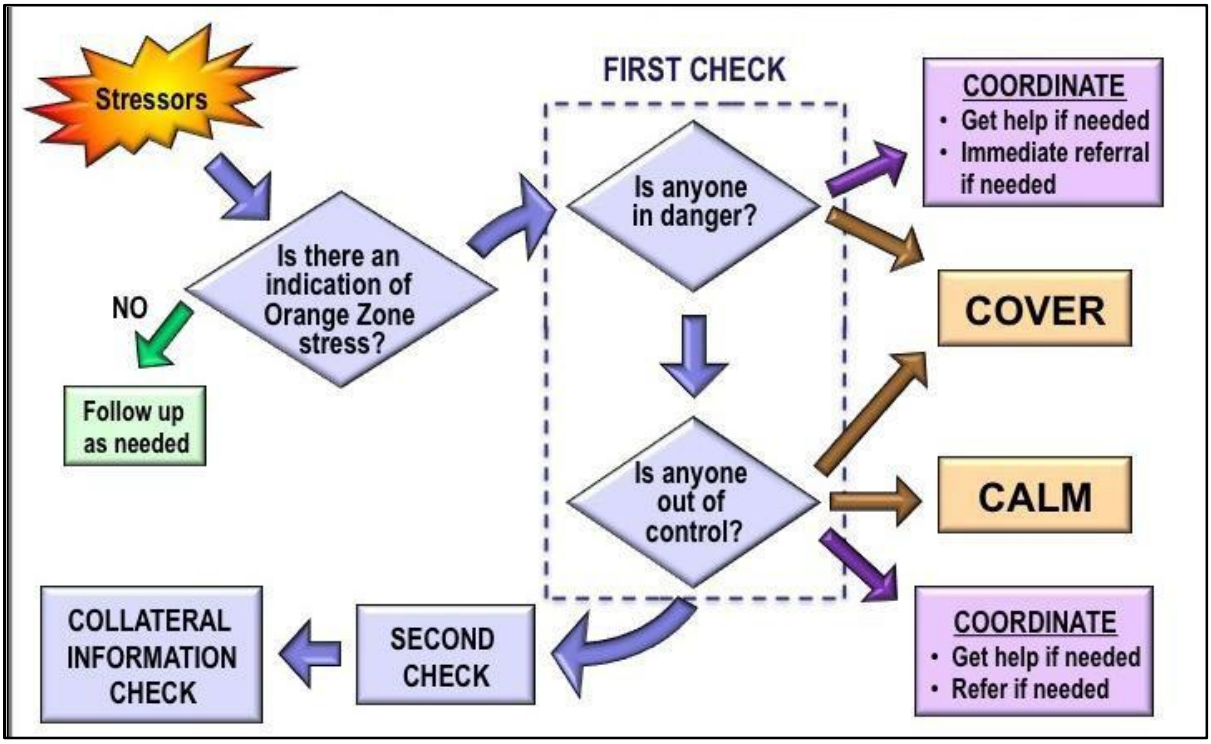
Figure 9 below reviews the Check Cycle presented in the last chapter with emphasis on the relationship between First Check and Primary Aid. As previously stated, the Check Cycle is initiated by the recognition of an Orange Zone Indicator ï significant and persistent distress or alterations in functioning in the aftermath of one or more Orange Zone stressors. A stressor event may alert the OSFA caregiver to the possibility of Orange Zone stress, but it is always the distress and changes in functioning that signal the presence of a stress injury. If these are not present, no matter how awful and potentially overwhelming the stressor may be, no further OSFA actions are needed except occasional follow-up.

If Orange Zone Indicators <u>are</u> present, the First Check is then begun as soon as possible to determine, first of all, whether anyone is in danger due to the distress and functional impairment caused by the stress injury. If anyone is in danger, the Cover function is performed to bring him or her to safety. Coordination is done, as needed, to enlist the help of others or to refer for othersó evaluation and treatment of dangerousness.

The next part of First Check ï performed simultaneously with the dangerousness check rather than after it ï is to assess whether anyone is unable to subdue his or her own physiological, mental, or emotional arousal levels; in other words, to determine whether anyone is out of control. If so, the Calm function is used along with Covering actions to restore self-control and promote a sense of safety. As always, Coordination is done as needed to ensure needed additional help is obtained.

Once these two crisis issues (safety and calmness) are addressed, Second Check and the rest of OSFA can follow.

Figure 9. Cover and Calm, the focus of First Check.



COVER

What Is It? *Figure 10* below shows a conceptual tree linking the major components of Cover as a OSFA function. Starting in the top right quadrant, the first and most basic component of Cover is to **make the stress-injured person safe** ï in any way you can. At the same time, or in rapid sequence, Cover also encompasses **making all others safe** from the stress-injured person, if that is an issue. Cover is more than physical safety, though; It also includes the **perception of safety** that follows from both a reduced real danger surrounding a person and greater quiet and order. To the extent necessary to ensure continued safety, Cover also means **standing by** the person who is acutely in the Orange Zone, remaining available and ready to assist further, as needed.

Figure 10. Major components of the Cover function of OSFA.

When Is It Needed? Cover is needed when Orange Zone situations create a threat to the safety of one or more people. There are three main categories of situations that require Cover: (1) external danger to a stress-injured person, (2) danger to others from the stress- injured personós functional impairment, and (3) internal danger to a stress-injured person caused by extreme levels of distress. Below are examples of these categories of danger situations.

Danger situation: Orange Zone person is in <u>external danger</u>

- Person in immediate life-threat situation is not thinking clearly or making good decisions because of stress.
- Person has frozen or panicked in a life-threat situation.
- Person has an intense flashback to a previous life-threat situation that impairs current functioning.
- Person puts self in harmós way due to need for revenge or anger.

Danger situation: <u>Others in danger</u> from person in Orange Zone

- Person not thinking clearly due to stress while holding a lethal weapon.
- Person has frozen or panicked while operating a vehicle with other passengers.
- Person has threatened others.

Danger situation: Orange Zone person in <u>internal danger</u>

- Person has expressed serious thoughts of suicide.
- Person has serious health threat related to Orange Zone stress (for example, continuing to work when seriously injured or experiencing heart attack symptoms).

How Does It Work? The way the Cover function of OSFA promotes safety is through the following mechanisms:

- Make decisions on behalf of someone who is not thinking clearly
- Take action on behalf of someone who is not behaving in a safe manner
- Get control of someone who is out of control
- Provide authoritative (parent-like) presence to gain control
- Warn and protect others who may not be aware of a danger
- Create an environment of safety to promote recovery

How Is It Done? The possible non-verbal and verbal techniques for Cover are almost limitless in number and variety. Any action that quickly makes those in danger safe can be a Cover procedure. When choosing a Cover technique, the priorities are: (1) **ensure safety quickly** and (2) **take no more autonomy away from others than is necessary** for safety ð in other words, intrude on others as little as possible and for as short a duration as possible. The following are possible non-verbal and verbal Cover procedures arranged from <u>least</u> to <u>most</u> intrusive. Most of these procedures are intuitive and what many people would do in danger situations if without training.

Non-verbal Cover procedures (from least to most intrusive)

- Make eye contact.
- Hold up your own hands in a ' stop gesture.
- Apply gentle pressure on the neck or arm with one hand.
- Shake or nudge the person to get his or her attention.
- Block a personós way with your own body.
- Pull or drag to safety; physical restraint.
- Take physical control of the personós body in any way possible.

Verbal Cover procedures (from least to most intrusive)

- Ask the person if he or she is okay.
- Ask the person if he or she needs help
- Tell the person what you observe and suggest an alternate, safer course of action.
- Yell a warning to the person about impending danger.
- Forcefully command the person to stop.

What Are Potential Obstacles and How Are They Overcome? Because applying the Cover function of OSFA can be difficult in certain situations, it is useful to consider in advance how specific obstacles to their use can be overcome. *Table 5* below lists a few possible obstacles and ways to mobilize resources to overcome them.

Table 5. Potential obstacles to Cover, and how to overcome them.

Potential Obstacles to Cover	Mobilize Resources to Overcome Them
You are not thinking clearly or behaving safely, either.	Get help.
You are fully occupied responding to your own threats.	Get yourself safe first, then attend to others.
You do not have sufficient physical strength to get control of another person.	Get help.
You cannot acquire or hold the Orange Zone personós attention and trust.	Involve leaders, peers, medical chaplains, or family members.
The Orange Zone person remains dangerously agitated even after being Covered.	Consider medications, such as antipsychotic or tranquilizing medications.

CALM

What Is It? *Figure 11* below shows a conceptual tree linking the major components of Calm as a OSFA function. Calming slows down and reduces the intensity of activation of both the body and the mind, both to promote the recovery of normal mental and physical functioning and to put a halt to potential damage being caused to the brain and mind by excessive physiological arousal and high levels of circulating stress chemicals. Calm **quiets** the body by slowing down or stopping major muscle activity and slowing down heart rate and the level of alertness. It **soothes** intense and distressing emotions, such as fear, anger, guilt, or shame. Calm helps **compose** scattered mental focus by redirecting attention outwardly, away from distressing internal states of distress. Providing **rest** also helps promote recovery and healing.

Figure 11. The conceptual components of the Calm function of OSFA.

When Is It Needed? Calm is only needed when Orange Zone stress has interfered with the ability of individuals to reduce their own physiological activity level or emotional intensity. There are three main categories of situations that require Calm: (1) when physiological arousal level is stuck too high, (2) when cognitive mental functioning is disorganized or scattered, and (3) when distressing negative emotions are out of control.

Below are examples of these categories of situations that requiring Calming.

When physiological arousal level is stuck too high:

- Loss of physical control: fleeing, flailing, or blindly striking out
- Pacing or other persistent, excessive major motor activity
- Hyperventilating
- Shaking
- Rocking or other repetitive self-soothing activity

When cognitive functioning is disorganized:

- Rapid, pressured speech (talking too fast)
- Flight of ideas (thoughts flit from one topic to another)
- Not responding appropriately to commands or questions
- Freezing

When negative emotions are out of control:

- Poorly controlled fear or panic
- Poorly controlled anger or rage
- Intense guilt or shame

How Does It Work? The Calm function of OSFA depends on the interconnectedness of the mind, brain, and body to work. Certain life-sustaining functions, such as breathing and heart rate, are normally controlled by the autonomic nervous system, entirely outside the conscious awareness and control of the individual. These functions have to be automatic so they do not cease as soon as you stop paying attention to them. But in addition to being controlled by the autonomic nervous system, these life-sustaining functions can also be controlled, to some extent, through conscious focus and effort, such as through deep breathing.

The Calm function of OSFA promotes recovery and healing through the following mechanisms:

- Reduce muscular activity
- Reduce mental and emotional effort
- Slow down heart rate
- Reduce levels of stress chemicals in the blood and brain
- Reduce intensity of negative emotions, such as fear and anger
- Increase positive emotions, such as safety and trust

- Increase ability of the individual for self-control
- Restore mental clarity and focus

How Do You Do It? Similar to the Cover function of OSFA, Calm is performed through any of a number of non-verbal or verbal procedures that can be of almost limitless variety, but should always be tailored for the specific situation and person being aided.

Unlike Cover, the Calm function does not take away autonomy (that is, you usually do not need to obstruct a personós actions to Calm them), so preserving autonomy is usually not an issue. Conversely, the trust and engagement of the individual to be Calmed is more crucial than in Cover. In applying the Calm function, non-verbal procedures are usually performed first, with verbal procedures added as needed. The following are a few possible non-verbal and verbal Calm procedures.

Non-verbal Calm procedures

- Calm, authoritative physical presence
- Eye contact
- Staying with the person
- Not showing fear, anger, impatience, or disgust
- Touching or holding, if appropriate and not threatening

Verbal Calm procedures

- Repetitive, soothing phrases, such as 'Easy nowé or 'Itós okayé
- Reassurances of current safety and/or support, such as 'Youóre safe nowé or 'Iómhere with youé
- Encouragement, such as 'You can do ité or 'There you goé
- Calming directive, such as 'Calm down! or 'Relax! Attention-getting, such as 'Look at me! or 'Listen to my voice!
- Distraction, such as encouraging thinking about something else
- Coaching in deep-breathing or grounding exercises
- Empathic listening to distressing thoughts, feelings, or memories
- Deep breathing and grounding are specific procedures that can be easily learned and coached. Appendix P lists the procedures for deep diaphragmatic breathing as a Calming tactic.

What Are Potential Obstacles and How Are They Overcome? Although the Calm function of OSFA usually offers fewer challenges than the Cover function, obstacles may still be encountered. It can therefore be useful to consider in advance how specific obstacles to the application of Calm procedures can be overcome. *Table 6* below lists a few possible obstacles to Calm and ways to mobilize resources to overcome them.

Table 6. Potential obstacles to Calm, and how to overcome them.

Potential Obstacles to Calm	Mobilize Resources to Overcome Them
You are not yet calm yourself.	Use calming techniques on yourself and others at the same time, such as by self-talk or by demonstrating slow, deep breathing.
You are too distracted or busy to attend to the person in need.	Get help.
You are surrounded by too much noise and chaos.	Find and get to a safer, quieter place.
Someone else is agitating the person by their loud or frantic behavior.	Direct others away from the Orange Zone person if they are not helping.
You cannot acquire and hold the Orange Zone personós trust or attention.	Engage and involve supportive leaders, peers, or others.
The Orange Zone person fails to Calm down even after the use of non-verbal and verbal techniques.	Consider medications, such as antipsychotic or tranquilizing medications.

SECONDARY AID:

Building Bridges to Connect, Competence, and Confidence

Secondary Aid includes the last three stress first-aid actions of ***Connect***, ***Competence***, and ***Confidence***. These Secondary Aid actions are not intended to respond to crisis situations involving immediate danger or loss of control, as are the Primary Aid actions of Cover and Calm. Rather, Secondary Aid focuses on promoting recovery from Orange Zone stress by augmenting and maximizing the healing forces already intrinsic to teams ð those based on leadership principles, such as vertical trust and communication, and on unit cohesion principles, such as horizontal trust and support. Secondary Aid is thus an extension of the leadership and the social and spiritual structure of the unit rather than a set of one-on-one interventions undertaken in isolation.

Table 7 below gives an overview of the three Secondary Aid actions of Connect, Competence, and Confidence. Compared to Primary Aid, Secondary Aid is a more gradual process of promoting recovery and well-being that must be sustained over a longer period of time. As functions of leadership, Secondary Aid actions require greater skill and ability to communicate and influence others than do the Primary Aid actions of Cover and Calm, which can be used by anyone as self- or buddy-aid.

Table 7. Overview of Secondary Aid.

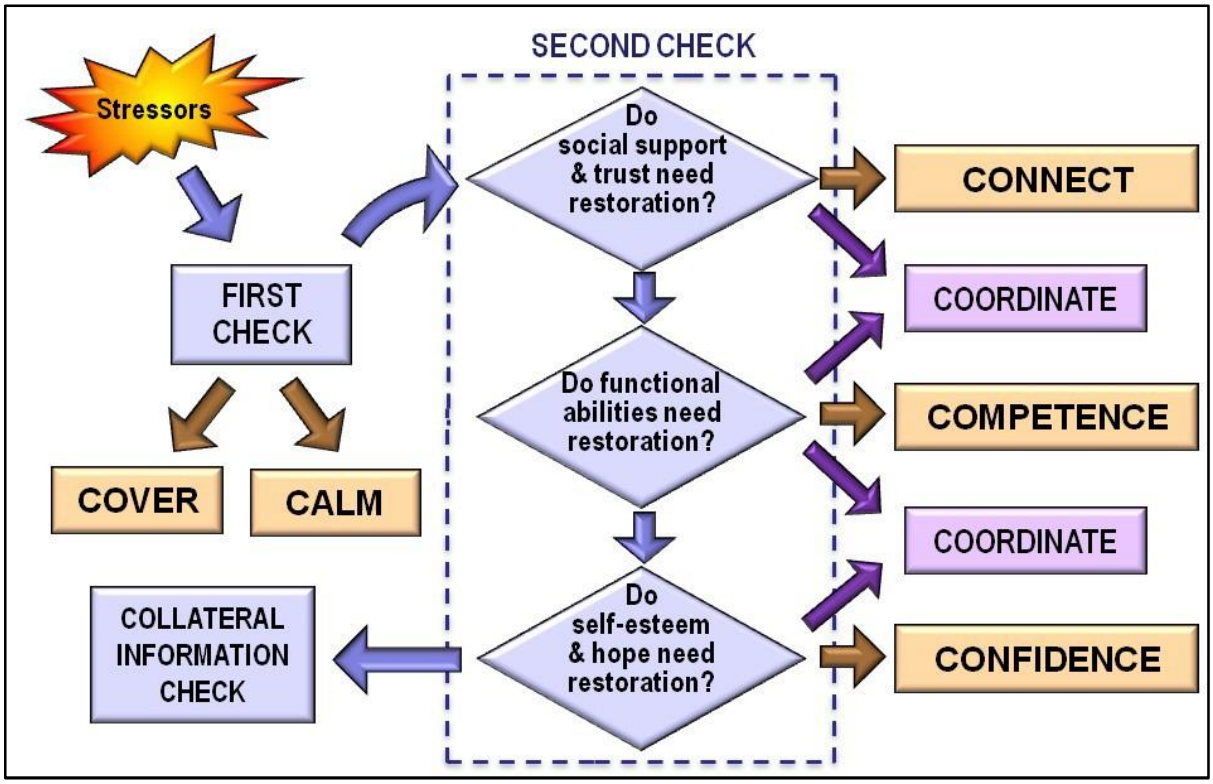
LEVEL		CORE ACTION	
Secondary Aid	***Delayed*** OSFA actions performed after the crisis has passed Longer term procedures to promote healing, recovery, and return to full function Often requires active participation by small unit leaders	**Connect**	Facilitate access to primary support persons, such as trusted unit or family members Help problem-solve to remove obstacles to social support Foster positive unit social activities
		Competence	Help mentor back to full functioning Collaborate with leaders to facilitate rewarding work roles and retraining, if necessary Encourage gradual re-exposure to feared situations
		Confidence	Mentor back to full confidence in self, leadership, mission, and core values Foster the trust of unit members and family members in the individual Instill hope

Secondary Aid normally begins after an Orange Zone crisis has passed and the Primary Aid actions of Cover and Calm are no longer needed, if they were needed. As Secondary Aid is undertaken, however, the need for Primary Aid may reappear at any point, if only briefly; for example, as persons with Orange Zone are exposed to reminders of their original experiences of life threat or loss. Although the three Secondary Aid actions are presented in a particular order, their application on behalf of Orange Zone individuals is more simultaneous than sequential. Each of these actions can be performed in many gradations of intensity and depth, depending on the needs of individuals and the abilities and resources of the OSFA leader or caregiver.

Connect, Competence, and Confidence: The Focus of Second Check

Figure 12 below illustrates the components of the Check Cycle that are the portals of entry for Secondary Aid. As with Primary Aid, these steps are not a linear sequence that is gone through only once for each individual in the Orange Zone, but a cycle that is repeated over and over again for as long as it is needed.

Figure 12. Second Check and Secondary Aid.



Just as the crisis responses of Primary Aid follow from the assessments and decision-making of the First Check, Secondary Aid is the result of the more detailed assessments of Second Check. The Second Check in OSFA answers the questions: (1) which stress zone is this person in right now? and (2) what are their physical, mental, social, and spiritual needs and resources? The three actions of Secondary Aid are not intended to meet all possible needs of an individual recovering from Orange Zone stress, but they are designed to address three common and basic psycho-social-spiritual needs of such individuals:

- The need for peer and family social support (Connect)
- The need for the capacities necessary to function competently in personal, occupational, and social spheres (Competence)
- The need for a positive self-image and hope for the future (Confidence)

As with First Check and Primary Aid, Second Check and Secondary Aid must always be accompanied by Coordination to answer the two questions: (1) who needs to know about this personós current status? and (2) who else can help? Before returning to the starting point of the Check Cycle after each passage through it, Collateral Information must be obtained from all available sources to ensure that decisions are based on the best possible information.

The three Secondary Aid actions are seeds that can be slow to sprout, and even longer to bear fruit. The provider of Secondary Aid has a unique opportunity to plant seeds with individuals who may be open to intervention because of the acute nature of Orange Zone Stress, versus later when they may be less open and amenable to support or influence. Patience and persistence are crucial.

CONNECT

What Is It? Research has shown that positive social support with others who are trusted and valued builds resilience and is crucial for adapting to the entire spectrum of life challenges, from daily hassles to experiences of trauma, loss, and personal failure. Social and spiritual supports also shape expectations for ethical and moral behavior and help provide crucial meaning for life experiences. In the aftermath of Orange Zone stress injuries, everyone needs to Connect with trusted others to feel safe, to communicate personal experiences and perceptions, to affirm personal worth, and to restore understanding and predictability. The Connect function of OSFA facilitates the meeting of those needs, either directly or indirectly.

The Connect function targets all **three types of social and spiritual support**:

Instrumental support: the provision of material aid (for example, financial assistance or help with daily tasks)

Informational support: the provision of relevant information intended to help the individual cope with current difficulties (for example, advice or guidance)

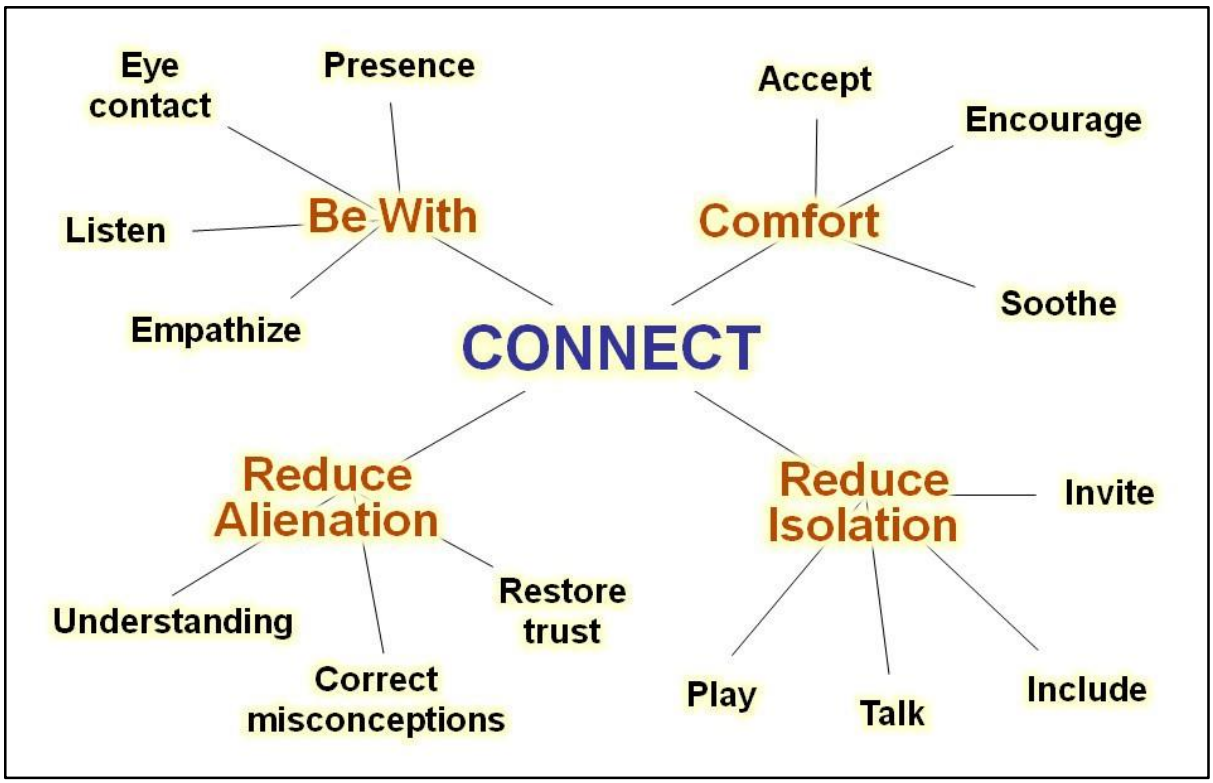
Emotional support: the expression of empathy, caring, and reassurance, and providing opportunities for positive forms of social involvement and/or distraction, emotional expression, and venting

If teams always functioned perfectly, there would never be a need for the OSFA Connect function, but individuals and teams under severe stress do not always have optimal, or even adequate, social and spiritual functioning. Yellow Zone stress can create social friction on teams, and Orange Zone stress can generate persistent alienation and loss of trust. The Connect function of OSFA troubleshoots these challenges to social and spiritual support, and attempts to correct them.

Figure 13 graphically defines the four broad conceptual components of the Connect function of OSFA. Although overlapping to some degree, each of these four areas is a separate domain of social and spiritual support. Each area deserves to be considered in every

case. The first and most basic component of Connect is to **be with** the stress-injured person, in any way you can, by maintaining a steady presence and eye contact and by listening, and/or empathizing. At the same time, Connect also encompasses **comforting** the stress-injured person, if needed, by encouraging or soothing him or her, or by accepting what the individual is going through. Cover is more than being available and comforting the person; it also includes the actions of **reducing the alienation and isolation** that can follow from Orange Zone stress. This might be by working with others in the command to improve their understanding of the stress-injured individualós circumstances, to correct misperceptions and/or restore trust in the individual, to assure that others are inviting the stress-injured individual to be a part of activities, or by making an effort to talk with the person in a more concerted way.

Figure 13. The conceptual components of the Connect function of OSFA.



When Is It Needed? The Connect action of OSFA is closely related to **unit cohesion,** which is a state of mutual trust, respect, and communication within the team. The Connect action of OSFA can be thought of as intentionally using unit cohesion for the benefit of one or more stress-injured individuals on the team, and repairing unit cohesion to the extent it is decremented by Orange Zone stress on the team. Stress-injured individuals almost always withdraw from those around them and lose some of the trust and camaraderie they previously enjoyed. Leaders in the Orange Zone may also be less effective at promoting trust and communication on a team. The Connect action of OSFA is, therefore, **needed whenever Orange Zone stress causes a relative loss of cohesion on a team**, or social isolation or alienation in an individual. In the examples of behaviors or feelings below, a person injured by Orange Zone stress:

- No longer feels like his or her normal self, and feels uncertain and awkward around others.
- Feels ashamed of his or her acute Orange Zone crisis, and fears others on the team have lost trust in him or her.
- Cannot stop thinking about the vivid details of the death of a team member, but is afraid to talk with others on the team about it.
- Is emotionally numb and detached, and cannot seem to feel interest in interacting with peers like he or she used to.
- Fears that talking with others in the unit will trigger painful memories about events they lived through together.
- Cannot stop feeling intensely angry all the time and thus avoids being around others.
- Blames leaders or peers in the unit for the death of fellow team members or another troubling event.
- Is blamed by other members of the team for the death or injury of a peer or some other troubling event.
- Feels exhausted and overwhelmed
- Does not have sufficient energy to socialize with others.

How Does It Work? The Connect function of OSFA works by reducing isolation and alienation to promote within individuals and the unit:

- A common identity through shared experiences, values, and modes of behavior.
  Common experiences through sharing of perceptions, thoughts, and feelings.
- Common understanding of the meaning of events.
- Shared responsibility.
- Shared suffering.
- Reduced feelings of guilt, shame, or blame.
  Greater forgiveness.
- More hope.

How Is It Performed? As summarized in *Table 8* below, the Connect function of OSFA progresses through the **three general steps** of (1) assessing resources for social support, (2) assessing obstacles to social support, and (3) intervening to remove those obstacles.

Table 8. Steps to perform the Connect function of OSFA.

Connect Step	Why Do It	How to Do It
i. Assess social resources	Identify the best possible sources of social support for an individual	Identify who in the unit is most trusted by the individual (this could be you). Identify who in the unit has a positive attachment to the individual. Identify members of the chain of command whom the individual most trusts. Identify individuals outside the unit (e.g., family members) trusted by the individual.
ii. Assess obstacles to social support	Understand why an individual is not using all available social resources	Ask the individual about how he or she perceives his or her own level of social involvement and connectedness. Ask the individual about his or her level of satisfaction with the social support he or she is getting. Find out what has changed in the individual that has led to isolation or alienation. Observe the individual interacting with others, looking for patterns of poor communication, respect, or trust. Ask unit leaders their perceptions of an isolated individual, and how other unit members perceive that person.
iii. Intervene to remove obstacles to social support	Overcome obstacles in the individual or in others to better social connectedness	Listen empathically and compassionately, especially to experiences of loss, trauma, or moral injury. Encourage and lead formal or informal group social activities. Encourage the isolated individual to seek out greater social connectedness. Provide a model for how to do that. Describe to the isolated individual the specific isolating behaviors you witness. Look for and confront distorted perceptions and conceptions in the individual that might interfere with two-way trust and respect. Confront and try to neutralize blame, guilt, and shame. If specific problems are identified that are interfering with social connectedness, encourage active problem solving. Lead group discussions of events (like an After Action Review) in order to promote common perceptions and understanding.

Leaders play a critical role in developing and maintaining social cohesion. OSFA caregivers should advise, encourage, and mentor leaders to enhance social support in the unit through the following actions:

Engage Chain of Command to:

Lead After Action Reviews after all significant events.

Show concern and caring consistently.

Reassure individuals with Orange Zone stress.

Build teamwork.

Be a good mentor or role model.

Reduce conflict, blaming, scapegoating, and rumors in the unit.

Honor the fallen.

What Are Potential Obstacles and How Are They Overcome? Because applying the Connect function of OSFA can be difficult at times, it can be useful to consider in advance how specific obstacles to their use can be overcome. *Table 9* below lists a few possible obstacles and ways to mobilize resources to overcome them.

Table 9. Potential obstacles to Connect, and how to overcome them.

Potential Obstacles to Connect	Mobilize Resources to Overcome Them
You are too distracted or busy to attend to the person in need.	Engage peers and leaders to help the person in need. Connect the stress-injured person with supportive family, friends, and others.
You cannot gain the trust and confidence of the person in need.	Recruit peers and leaders to engage the person in need.
The person in need has recently lost one or more of his close friends.	Encourage the communalizing of grief. Encourage the grieving person to develop other attachments.
The person in need has been ostracized by others in the unit.	Temporarily separate the Orange Zone person from negative influences. Engage leaders to address possible scapegoating.
You have negative feelings toward the person in need.	Talk to someone you trust about your feelings toward the person in need. Ask someone else to provide OSFA aid to that person.

For individuals who lack sufficient motivation to work on improving their own level of trust and connectedness with others in the unit, reviewing the following potential benefits for them of doing so may be helpful.

You need others because:

- They can you solve problems.
- They can provide resources when you run short.
- They can provide needed information.
- They can provide new perspectives for your problems.
- They listen and understand you.
- They can validate your experiences and feelings so you feel less alone.
- They can reassure you when you feel uncertain.
- They can help you feel like you belong and fit in.
- They can distract you from your worries.
- They can make you feel more valuable as a person.
- They can depend on you and make you feel needed.
- They can give you opportunities to be a better person by thinking of someone else's welfare.

COMPETENCE

What Is It? In OSFA, the Competence function focuses on **enhancing and restoring, when necessary, individual capacities to function and perform in all important life roles**, including occupational, personal, and social domains. The term ' Competence is really shorthand for ' help restore previous capabilities or ' cultivate personal competence. The need for the Competence action of OSFA is signaled by the loss of previous mental, emotional, or physical capabilities directly because of an Orange Zone stress injury or Red Zone stress illness. Which capabilities may be lost, and to what extent they may be lost, will depend greatly on the situation and the individual involved. For many individuals in many circumstances, Orange Zone stress may cause no discernible loss of mental or physical abilities. On the other hand, a severe life threat or loss injury may cause a brief period of significant mental confusion followed by a longer period of slightly decreased ability to think clearly and sharply, or to control intense emotions. Orange Zone stress also often presents new and significant challenges to individuals' capacities to cope and adapt, such as the challenge of managing reminders of life threat or loss. The intensity of Orange Zone experiences can strain the ability of individuals to maintain supportive connections with others.

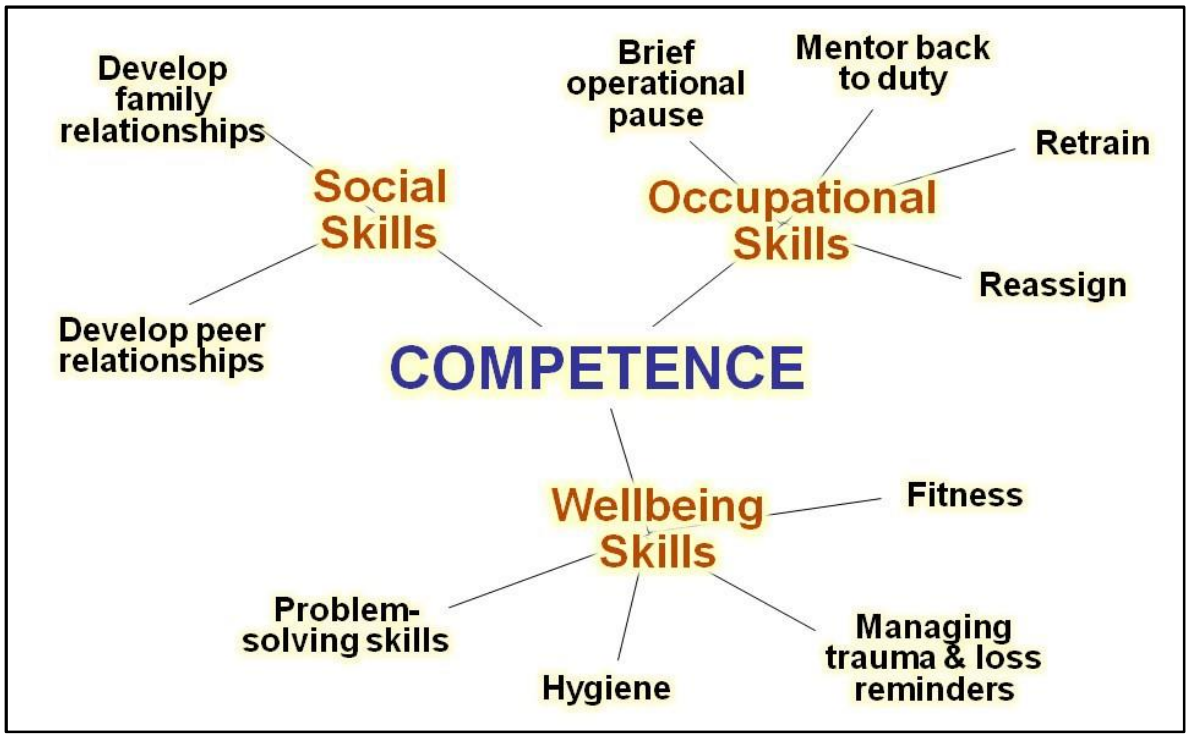
Figure 14 below graphically depicts the three conceptual components of the Competence function of OSFA: (1) occupational skills, (2) personal wellbeing and wellness skills, and (3) social skills. Occupational functioning is the first and most important target of the Competence function of OSFA. The risk of career harm that can be associated with Orange and Red Zone stress is strongly influenced by leader perceptions of competence[6].

Facilitating competence can help to mitigate the stigma associated with not being mission ready. Service members not only suffer the wounds of life-threat trauma, loss, inner conflict, and fatigue, they also experience a loss in the sources of resilience and good feeling that stem from being competent and excelling in their service and personal roles. This is a source of distress and an impediment to healing and recovery. The Competence action of stress first aid aims to restore previous mental and physical capabilities, and the

[6] Westphal, R. J. (2007). Navy Leaders' Attitudes about Mental Health Problems. *Military Medicine*. 172(11), 1138-1143.

confidence in those abilities, through practicing them and demonstrating effectiveness. The critical role caregivers play in this process is to encourage and support the re-establishment of important mental and physical capabilities and to foster learning or practicing the skill required to cope with Orange Zone symptoms.

Figure 14. The conceptual components of the Competence function of OSFA.



When Is It Needed? The two important signals for the need for the Competence function of OSFA are (1) the temporary or persistent loss of previous skills or abilities due to Orange Zone stress and (2) the emergence of new life challenges with which the individual has not yet developed the ability to cope, such as Orange Zone symptoms of distress. The following are examples of each category of need for Competence.

Orange Zone stress can cause the loss of previous skills or abilities:

- Temporary loss of mental focus or clarity during an Orange Zone crisis (for example, dissociative freezing and going blank)
- Temporary loss of emotional or behavioral self-control (for example, panic or rage responses under stress)
- Loss of ability to modulate physiological arousal due to Orange Zone stress (for example, shaking, trembling, pounding heart, or rapid and shallow breathing)
- More persistent changes in cognitive functioning due to wear-and-tear stress (for example, slowed memory recall or difficulty making decisions or solving problems)
- Loss of enthusiasm and motivation due to acute or chronic Orange Zone stress
- Decrease in social aptitude due to loss of sense of humor, changes in fluency of

speech, or decreased range of emotional responses

- Loss of ability to see the "big picture" due to moral injuries

Orange Zone stress can create new challenges to coping:

- Trauma or loss reminders causing feelings of dread, panic, or anger
- Disturbing memories of trauma, loss, or moral injury intruding into conscious awareness
- Difficulty relaxing, slowing down, or getting to sleep
- Difficulty maintaining an emotional even keel in the face of frustrations
- Dread and desire to avoid re-exposure to situations reminiscent of trauma or loss
- Stress-induced physical symptoms, such as low energy or changes in bowel functioning (for example, diarrhea)
- An inability to modulate emotional numbing and/or discuss intense experiences or emotions, which strains supportive connections with others

How Does It Work? The Competence function of OSFA lays the foundation not only for recovery and healing, but also for posttraumatic growth and development by ensuring that needed skills are obtained and practiced. It reduces the stigma associated with Orange or Red Zone stress by minimizing their career impact. It also reduces the potential social consequences of Orange and Red Zone stress by identifying social skills that are needed or have been decremented and restoring them as quickly as possible.

How Is It Done? The core process for the Competence function of OSFA is **taking one step backward in order to take two steps forward.** In other words, like an obstacle that suddenly appears on the road after we drive around a bend, Orange Zone stress can present a life challenge that sometimes cannot be circumvented without first stopping, backing up a bit, and then changing course. Thus, restoring or enhancing Competence in the face of Orange Zone stress can require the following sequence of actions: **(1) stop, (2) back up, and (3) move forward again.** *Table 10* below describes the elements of these three Competence steps.

Table 10. Steps to perform the Competence function of OSFA.

Competence Step	Specific Intent	How to Do It
1. Stop	Rest, take time to recover Identify challenges to functional capabilities Do not keep doing what is not working	With the concurrence of leaders and operational capability, take an operational pause for 24-72 hours. Assess functional capabilities and limitations, if any, in occupational, social, and personal well-being spheres.
2. Back up	Retrain and refresh old skills Learn new skills Explore new options	Provide refresher training. Provide leadership mentoring. Practice problem solving. Provide training in new occupational, social, or personal wellness skills. Enhance wellness through sleep, nutrition, exercise, meditation, prayer, etc.
3. Move forward again	Practice refreshed skills Practice and perfect new skills Find new directions and goals	Gradually increase responsibilities and duties. Set achievable goals. Explore and troubleshoot obstacles as they arise. Reinforce successes. Reinforce motivation to overcome challenges.

OSFA caregivers should become adept at teaching a variety of **stress-coping skills** that are relevant to Orange Zone stress. Examples of important well-being skill sets that should be considered as part of the Competence function of OSFA include the following:

- Sleep
- Hygiene
- Relaxation
- Meditation or prayer
- Anger management
- Goal setting
- Problem solving
- Nutrition
- Physical exercise and conditioning

What Are Potential Obstacles and How Are They Overcome? Restoring and enhancing Competence in all important life spheres for individuals in the Orange Zone can be challenging. Without full engagement by unit leaders and key family members, it is impossible.

Table 11 below lists a few possible obstacles to Competence and ways to mobilize resources to overcome them.

Table 11. Potential obstacles to Competence, and how to overcome them.

Potential Obstacles to Competence	Mobilize Resources to Overcome Them
You cannot engage unit leaders in the effort to restore Competence.	Coordinate with others in the unit to provide leaders with behavioral observations to support the need for Competence aid. Coordinate with other leaders to troubleshoot obstacles to Competence function. Refer the Orange Zone individual for evaluation by a mental health professional.
The Orange Zone individual does not recognize his or her need for Competence aid.	Repeatedly but tactfully describe to the Orange Zone individual your observations about his or her functional capabilities and performance. Coordinate with others to do the same.
The Orange Zone individual lacks motivation to retrain or develop new skills.	Appeal to the Orange Zone person's loyalty to peers, family members, and others who rely on him or her. Coordinate with other influential people in the Orange Zone individual's life to enhance motivation.
Resources are not available for retraining or training in new skills.	Engage leaders to address supply of needed resources.
You are not sure you have sufficient Competence to provide aid.	Consult with others; seek mentoring. Refer individual to other levels of care.

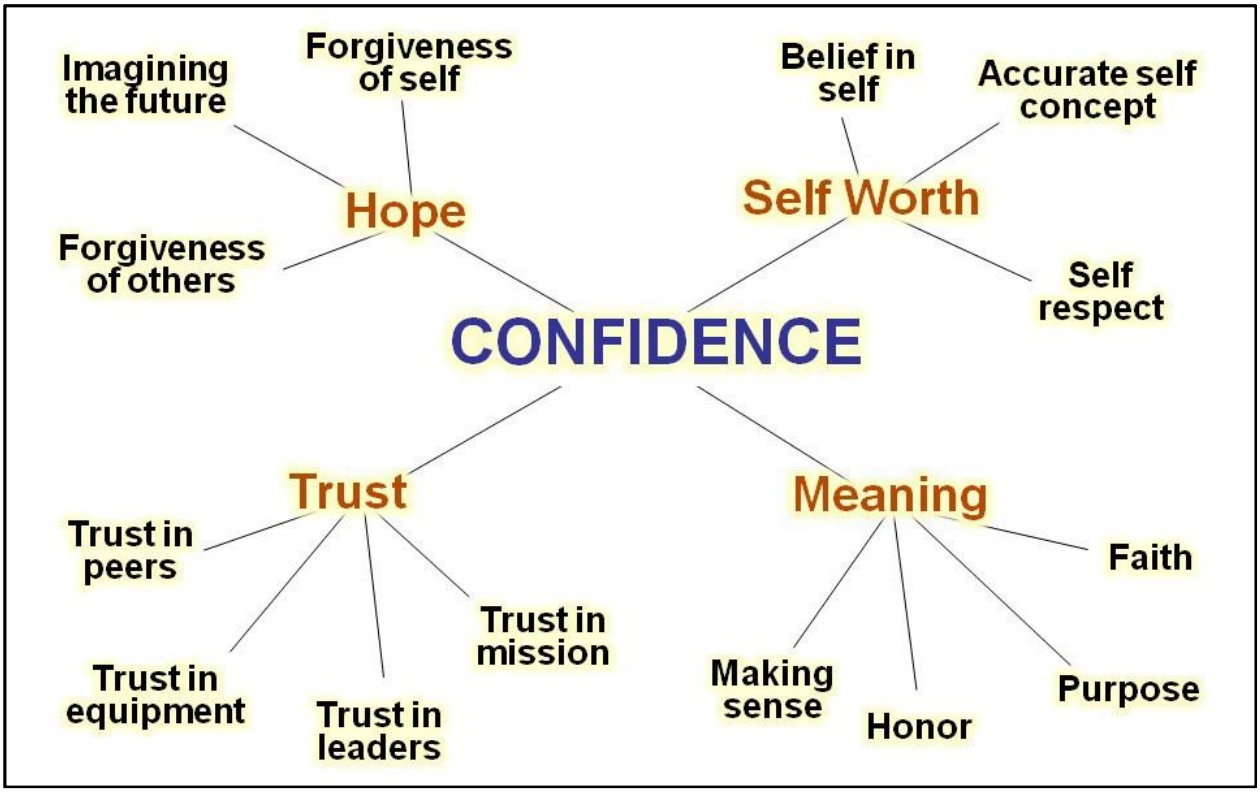
CONFIDENCE

What Is It? The final function in OSFA, Confidence, focuses on **building realistic self-esteem and restoring hope,** both of which are often diminished in the aftermath of Orange Zone stress. Confidence is the capstone of the process of recovering from a stress injury and of becoming stronger and more mature because of it. The acquisition of new strengths and capabilities in the aftermath of Orange Zone stress is sometimes called posttraumatic growth.

Realistic self-confidence and self-esteem are earned through mastering challenges and achieving goals, despite hardships and obstacles. The role caregivers play in this process is to support stress-injured individuals as they set realistic goals, work to achieve those goals, and maintain a positive but realistic self-image. **Restoring hope** comes through identifying obstacles to belief in self, mission, values, and faith, and helping to remove those obstacles and/or build meaning.

Figure 15 below graphically depicts the four conceptual components of the Confidence function of OSFA: (1) self-worth, (2) meaning, (3) trust, and (4) hope. Each of these components of Confidence is a key to living a constructive, creative, and fulfilling life ð as an individual, and in relation to important others, institutions, and spirituality. More than any other function in OSFA, Confidence depends on a firm social and spiritual base to be effective.

Figure 15. The conceptual components of the Confidence function of OSFA.



When Is It Needed? Each of the six OSFA actions discussed up to this point addresses a potential need of individuals experiencing Orange Zone stress. Each of these needs addressed by OSFA can be experienced by those in the Orange Zone as injurious to hope, trust, and meaning, as well as detrimental to their self-worth, especially in cultures, such as those in first responder agencies, that prize self-sufficiency and autonomy. The final OSFA function, Confidence, addresses these needs ð to restore trust, hope, meaning, and a positive and sustainable self-image based on a realistic self. It can be assumed that **everyone** who has developed significant and persistent distress or alterations in functioning due to experiences of life-threat, loss, inner moral conflict, or wear and tear faces a challenge to restore and maintain a sense of hope, meaning, trust, and positive self image in relation to the world.

Everyone who has ever sustained a stress injury needs the Confidence function of OSFA. The life challenges addressed by the Confidence function are common to all human beings on the planet throughout their lives. The challenges of Confidence are life-long challenges.

The urgency and importance of the Confidence function of OSFA is apparent from considering the alternatives to possessing its components: a positive self-worth, meaning, trust, and hope. The alternative to hope is despair, the alternative to trust is alienation, the alternative to meaning is emptiness, and the alternative to self-worth may be suicide.

Although much more research is needed in this area, the components of Confidence are likely central to the relationship between stress injury and suicide, aggression, and other destructive behaviors.

At the extreme end of the spectrum, the following attitudes and behaviors signal the most dire need for the Confidence function:

- Hopelessness
- Loss of faith
- Loss of belief in good in others and self
- Feeling betrayed by those who were once trusted
- Feeling betrayed by oneself
- Seeking revenge
- Feeling unforgivable or unredeemable
- Suicidal or homicidal thoughts

How Does It Work? Restoring Confidence in all its components is an inherently spiritual process that requires exceptional leadership and communication skills. It is only through the empathic but honest mirroring provided over time by a trusted other, such as a OSFA caregiver, that individuals recovering from Orange Zone stress can find sustainable self-worth, rational meaning and purpose, trust, and hope for the future. Each individual must be met where they are, without preconceptions or cookie-cutter solutions. During the course of recovering their Confidence, individuals must perform hard work ð to grieve losses, give up immature ways of seeing themselves and their relationship to the world, and forgive themselves and others for their failings.

How Do You Do It? More than in any other aspect of OSFA, the Confidence function requires an empathic and honest relationship evolving over time. There are no gimmicks or tricks. It also requires that the helping person be seen as an authority, or at least authoritative, so that distortions of thought and perception, once confronted, will be genuinely reconsidered. The power of respected religious organizations, their symbols, and their ceremonies, can be tapped into by OSFA caregivers.

Apart from such generalities, *Table 12* below lists possible procedures to develop Confidence.

Table 12. Steps to perform the Confidence function of OSFA.

Confidence Step	Specific Intent	How to Do It
Assess needs	Assess self image, understanding of meaning of life events, level of trust in self and others, and hope for the future	Listen empathically. Develop a trusting relationship. Ask questions and offer tentative observations and understandings.
Connect with resources	Restore depleted physical, psychological, and social resources Foster spiritual connections	Coordinate with all possible sources of needed resources, both inside and outside the agency. Address financial problems, family problems, occupational problems, health problems, etc.
Encourage growth	Remove excessive guilt or shame Promote forgiveness of self and others Establish new meaning and purpose Set new directions and goals	Listen for and confront distorted or overly negative and/or rigid conceptions or perceptions of self or others. Encourage the individual to put himself or herself in others' shoes, to see himself or herself through others' eyes, or to try more adaptive ways of seeing himself or herself, or the situation. Appeal to trusted authority or spiritual figures. Encourage making amends, or giving to others the same things one has lost, oneself. Encourage learning and education. Encourage establishing new relationships and strengthening old ones. Encourage setting realistic goals and setting a plan to achieve those goals in readily attainable steps.

What Are Potential Obstacles and How Are They Overcome? Restoring and enhancing Confidence is the greatest challenge of OSFA. *Table 13* below lists a few possible obstacles and ways to meet them by mobilizing resources.

Table 13. Potential obstacles to Confidence, and how to overcome them.

Potential Obstacles to Confidence	Mobilize Resources to Overcome Them
The individual is unable to grieve the loss of important, sustaining attachments.	Encourage the communal sharing of grief with others affected by the same loss. Search for and confront excessive self-blame or blame of others. Relentlessly point out the self-destructive nature of stalled grief. Encourage the individual to imagine how the deceased person would view his or her stalled grieving if they were present to comment on it. Invoke an inspiring social or spiritual image, teaching, or belief to promote acceptance and grieving. Encourage physical memorials and ceremonies.
The individual has lost portions of himself or herself that are viewed as essential.	Encourage supportive relationships with others who have sustained similar losses and found new hope. Search for and confront excessive self-blame or blame of others. Invoke an inspiring social or spiritual image, teaching, or belief to promote healing. Encourage the learning and mastery of new skills and abilities.
The individual feels unforgiveable.	Encourage the making of amends, even if that will be a life-long endeavor. Invoke an inspiring social or spiritual image, teaching, or belief to promote self-forgiveness. Relentlessly point out the self-destructive nature of self-blame.
The individual cannot forgive others.	Relentlessly point out the self-destructive nature of blame and revenge motives. Encourage the individual to learn more about and empathize with those who are blamed. Invoke an inspiring social or spiritual image, teaching, or belief to promote forgiveness. Appeal to Core Values.

In promoting Confidence, it is important for the OSFA caregiver to continuously monitor for possible dangerous thoughts or impulses, such as for suicide or homicide, and to take Primary Aid actions as needed to ensure safety. Referral for mental health evaluation and possible psychotherapy and/or medication treatment should also be continuously considered, especially when progress seems to be stalled or reversing direction.

Even under the best of circumstances, the components of Confidence are achieved only through concerted effort over a long period of time. Patience is required, as is the willingness to plant seeds now that may only sprout in the unforeseen future.

Leadership Functions:

OSFA is the senior leader's responsibility.

Leaders at all levels must take measures to prevent and reduce operational stressors that impact response readiness. Leaders must implement the five core leadership functions of OSFA:

5 Core Leadership Functions for OSFA

1. Strengthen your personnel Build toughness Create confidence and forewarn of stressors Inoculate to extreme stress Build physical and mental fitness Build unit cohesion Enforce ethical standards Foster family readiness Promote effective coping
2. Mitigate and remove unnecessary stressors Remove unnecessary stressors Balance competing priorities Ensure adequate sleep and rest Encourage self-care and buddy care Protect team members from unnecessary gore
3. Identify team members with stress problems Know your team and stress loads Understand the Stress Continuum and Stress Zones Recognize and identity stress reactions, injuries, and illnesses Recognize degradation to team cohesion Encourage team members to identify stress problems in themselves and others Use After-Action Reviews (AARs) to defuse stress and identify those who may need help
4. Treat and coordinate care Create an environment where it is okay to get help Utilize the Seven Cs of OSFA Refer to chaplain, medical care, mental health
5. Reintegrate back into the team Expect return to full function Keep person with team if possible Communicate both ways with treating professional Fight stigma and harassment Continually monitor fitness for service

- Leaders are responsible for making decisions about individuals and teams across the stress continuum
- Caregivers using the stress continuum and OSFA knowledge are potential tools for the leaders
- Caregivers provide both individual and team services

Operational Stress Assessment (OSA)

Leaders must watch for secondary traumatic stress and burnout as well as wear-and-tear stress injuries, which are more likely to occur after a period of time. All reactions must be anticipated, identified and appropriately managed.

Depending on the magnitude, intensity and exposure to a particular event, distress or impairment assessments may need to occur moment to moment, hourly, daily, monthly and in proximity to the anniversary of the stressor.

Ask:

- How big?
- How bad?
- How long?
- How close (location, time, relationship)?

Unless indicators suggest a need for more frequent checks, team members and caregivers should follow-up according to the following guidelines:

- Routinely while engaged in the response
- Release check prior to departing the response location
- First follow-up at 3-7 days post-release
- Second follow-up at 30 days pot release
- Follow-up near the anniversary of an event or stressor as people often revisit associated thoughts and emotions

Leaders should emphasize the following four aspects of self-care at each check:

- What is your current status on the Stress Continuum?
- If not Ready, what is your plan to move in that direction?
- What resources are available to support your plan?
- What can I do today to help you to move in a positive direction?

Follow-up with self-assessments below:

1. Spirituality

Creativity, order, connection

Okay	Needs Work	Needs Help
❑ Enjoy worship ❑ Happy with fellowship ❑ Happy with spiritual expression ❑ Able to give and receive love ❑ Appreciating beauty ❑ Creative ❑ Comfortable with your place in world ❑ Connected, peaceful	❑ Less tolerant of different beliefs ❑ Feeling distant from God; want to get closer ❑ Don't know how to love or feel loved ❑ Feeling distant from others ❑ Struggling to understand others ❑ Not sure where you fit in ❑ Something's missing	❑ No reverence for anything outside self ❑ Alone and wandering aimlessly ❑ Spiritually empty ❑ Don't care about others ❑ Nothing seems important ❑ Feel powerless to change life ❑ Out of touch ❑ Loss of purpose ❑ Lacking a "moral compass"

2. Emotional/Mental/Physical Health

Fitness, wellness, self-esteem, control

Okay	Needs Work	Needs Help
❑ Sleeping well ❑ No bad nightmares ❑ Working out regularly ❑ Good nutrition ❑ Good energy level ❑ Good emotional control ❑ Able to enjoy life ❑ Not troubled by memories ❑ Feeling good about self	❑ Trouble getting to sleep ❑ Keep waking up ❑ Out of shape ❑ Eating too much or too little ❑ Loss of interest in life ❑ Feeling anxious or worried ❑ Feeling irritable ❑ Painful memories ❑ Feeling guilty	❑ Can't sleep enough ❑ Repeated disturbing thoughts ❑ Trouble pushing memories out of mind ❑ Panic attacks (heart pounding, shaking) ❑ Rage outbursts ❑ Depressed mood ❑ Keep blaming self ❑ Thoughts of suicide or homicide

3. Relationships

Spouse, significant other, family, friends

Okay	Needs Work	Needs Help
❑ Good communication ❑ Feeling close ❑ Looking forward to seeing ❑ Cooperating well ❑ Playing well ❑ Good sex ❑ Good conversation ❑ Affection ❑ Openness ❑ Responsiveness	❑ Trouble communicating ❑ Occasional fights and disagreements ❑ Uncomfortable being together ❑ Not having fun ❑ Staying apart ❑ Difficult or rare sex ❑ Complaints from partner ❑ Ambivalence ❑ Guardedness	❑ Poor comm. ❑ Frequent fighting ❑ Dreading contact ❑ Emotional coldness ❑ No sex ❑ Irresolvable conflict ❑ Criticism ❑ Contempt ❑ Defensiveness ❑ Emotionally numb ❑ Thoughts of hurting others or self

4. Roles in Life

Leader, coach, parishioner, citizen, provider

Okay	Needs Work	Needs Help
❑ Comfortable in roles ❑ Meeting your own expectations in roles ❑ Able to balance competing demands ❑ Fulfilled ❑ Energized	❑ Some strain in roles ❑ Not meeting own expectations in roles ❑ Not able to fit the pieces together ❑ Out of balance ❑ Pressured ❑ Drained	❑ Pulled apart ❑ Too many demands ❑ Tension between roles ❑ Serious conflict with others over roles ❑ Exhausted

5. Public Behavior

Driving, waiting, dealing with public, patience

Okay	Needs Work	Needs Help
❑ Comfortable in public ❑ Appropriate in public ❑ Good and careful driver ❑ Patient in frustrating situations ❑ Calm, even with rude people ❑ Friendly ❑ No police involvement	❑ Avoiding going out in public ❑ Suspicious of strangers ❑ Absent minded ❑ Getting frustrated easily ❑ Impatient ❑ Occasionally angry or irritable ❑ Driving too fast ❑ Driving recklessly	❑ Paranoid in public ❑ Road rage ❑ Picking fights ❑ Rage outbursts in public ❑ Panic attacks in public ❑ Persistent hyperactive startle responses ❑ Arrests

6. Work Function

Shop, supervisors, goals, promotion, rewards

Okay	Needs Work	Needs Help
❑ Achieving ❑ Feeling like a team ❑ Mentoring subordinates ❑ Getting rewarded ❑ Career goals progressing ❑ Job satisfaction ❑ Enjoying going to work ❑ Respected by subordinates	❑ Cutting corners ❑ Needing a lot of supervision ❑ Animosity toward peers or leaders ❑ Being apathetic or unmotivated ❑ Unrewarding ❑ Stagnating ❑ Indifferent	❑ No respect for self or others ❑ Defying authority ❑ Being a tyrant to subordinates ❑ Hostile environment ❑ Disorganized/lack of leadership ❑ Held back ❑ Unsupported ❑ Abandoned ❑ Abused

7. Money and Finances

Budget, purchases, credit, bills, savings

Okay	Needs Work	Needs Help
❑ Saving money ❑ Bills paid up to date ❑ Keeping to budget ❑ Debt under control ❑ Working a financial plan ❑ Spending in sync with spouse	❑ Minimal savings ❑ Bills past due ❑ Financial worries ❑ Uncomfortable debt ❑ Vague financial plan ❑ Conflict with spouse over spending	❑ No savings ❑ Collection notices ❑ Major financial stress ❑ Large debt load ❑ Creditors contacting command ❑ Total disagreement over spending ❑ Financial trouble

8. Substance Use/Abuse

Tobacco, alcohol, drugs, sugars, fats

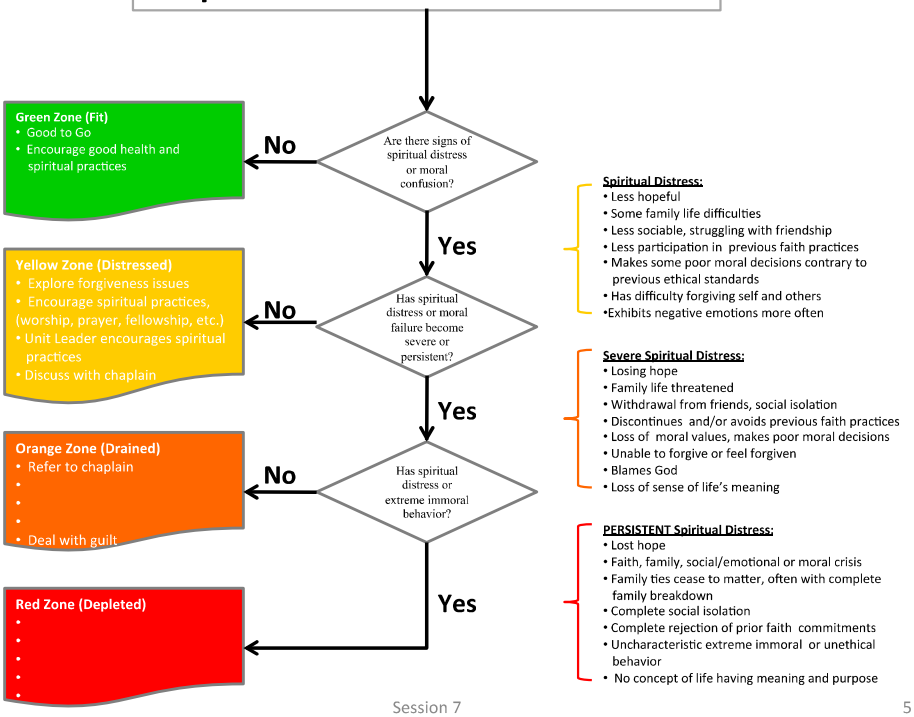
Okay	Needs Work	Needs Help
❑ Good control over intake of alcohol ❑ Not tempted to use drugs ❑ Not smoking chewing more ❑ Nobody who knows you thinks you are abusing	❑ Others express concern over drinking ❑ Got drunk when didn't intend to ❑ Use alcohol to get to sleep ❑ Drinking is getting in the way ❑ Smoking or chewing more	❑ Anger when others complain about drinking ❑ Lying to keep drinking ❑ Hiding drinking ❑ Harm to life from alcohol ❑ Using illegal drugs ❑ Blackouts ❑ Frequent drinking to intoxication

SPIRITUAL FITNESS GUIDE

This is a self-assessment tool to help persons consider their spiritual condition .
(This is a modified version of a model developed by the U. S. Navy Chaplain Corps)

Spiritually FIT	Spiritually DISTRESSED	Spiritually DRAINED	Spiritually DEPLETED
POTENTIAL INDICATORS	**POTENTIAL INDICATORS**	**POTENTIAL INDICATORS**	**POTENTIAL INDICATORS**
• Engaged in life's meaning/ purpose	• Neglecting life's meaning/purpose	• Loss sense of life's meaning/purpose	• Claims life has no meaning/ purpose
• Hopeful about life/future	• Less hopeful about life/ future	• Holds very little hope about life/future	• Holds no hope about life/ future
• Makes good moral decisions	• Makes some poor moral decisions	• Makes poor moral decisions routinely	• Extreme immoral behavior
• Able to forgive self and/or others	• Difficulty forgiving self and/or others	• Unable to forgive self and/ or others	• Forgiveness is not an option
• Routinely practices faith disciplines	• Infrequently practices faith disciplines	• Discounts practices of faith disciplines	• Abandons practices of faith disciplines
• Respectful to people of other faiths	• Less respectful to people of other faiths	• Strong disrespect to people of other faiths	• Complete disrespect to people of all faiths
• Engaged in core values/ beliefs	• Neglects core values/ beliefs	• Disregards core values/ beliefs	• Abandons core values/ beliefs
• Appropriately makes worldview adjustments	• Adequately makes worldview adjustments	• Inadequately makes worldview adjustments	• Inappropriately makes worldview adjustments

Spiritual Fitness Decision Matrix



STRESS MANAGEMENT

Basics of Stress[4]

Stress is a normal psychological and physical reaction to the demands of life. A small amount of stress can be good, motivating you to perform well. But multiple challenges daily, such as sitting in traffic, meeting deadlines and paying bills, can push you beyond your ability to cope. Your brain comes hard-wired with an alarm system for your protection. When your brain perceives a threat, it signals your body to release a burst of hormones that increase your heart rate and raise your blood pressure. This "fight-or-flight" response fuels you to deal with the threat. Once the threat is gone, your body is meant to return to a normal, relaxed state. Unfortunately, the nonstop complications of modern life mean that some people's alarm systems rarely shut off.

Stress management gives you a range of tools to reset your alarm system. It can help your mind and body adapt (resilience). Without it, your body might always be on high alert. Over time, chronic stress can lead to serious health problems. Don't wait until stress damages your health, relationships or quality of life. Start practicing stress management techniques today.

Stress Relief[5]

The pace and challenges of modern life make stress management necessary for everyone.

To monitor your stress, first identify your triggers. What makes you feel angry, tense, worried or irritable? Do you often get headaches or an upset stomach with no medical cause?

Some stressors, such as job pressures, relationship problems or financial concerns, are easy to identify. But daily hassles and demands, such as waiting in a long line or being late to a meeting, also contribute to your stress level.

Even essentially positive events, such as getting married or buying a house, can be stressful. Any change to your life can cause stress.

Once you've identified your stress triggers, think about strategies for dealing with them. Identifying what you can control is a good starting point. For example, if stress keeps you up at night, the solution may be as easy as removing the TV and computer from your bedroom and letting your mind wind down before bed.

Other times, such as when stress is based on high demands at work or a loved one's illness, you might be able to change only your reaction.

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[4] Mayoclinic.org

[5] Ibid

Don't feel like you have to figure it out on your own. Seek help and support from family and friends, whether you need someone to listen to you, help with childcare or a ride to work when your car's in the shop.

Many people benefit from practices such as deep breathing, tai chi, yoga, meditation or being in nature. Set aside time for yourself. Get a massage, soak in a bubble bath, dance, listen to music, watch a comedy ð whatever helps you relax.

Maintaining a healthy lifestyle will help you manage stress. Eat a healthy diet, exercise regularly and get enough sleep. Make a conscious effort to spend less time in front of a screen ð television, tablet, computer and phone ð and more time relaxing.

Stress won't disappear from your life. And stress management needs to be ongoing. But by paying attention to what causes your stress and practicing ways to relax, you can counter some of the bad effects of stress and increase your ability to cope with challenges.

Relaxation Techniques[6]

Relaxation techniques are an essential part of stress management. Because of your busy life, relaxation might be low on your priority list. Don't shortchange yourself. Everyone needs to relax and recharge to repair the toll stress takes on your mind and body.

Almost everyone can benefit from relaxation techniques, which can help slow your breathing and focus your attention. Common relaxation techniques include meditation, progressive muscle relaxation, tai chi and yoga. More-active ways of achieving relaxation include walking outdoors or participating in sports.

It doesn't matter which relaxation technique you choose. Select a technique that works for you and practice it regularly.

Basic Stress Management

God, grant me the serenity to accept the things I cannot change,
The courage to change the things I can,
And wisdom to know the difference.

Most persons impacted by distress will benefit from a balance approach to stress management. Physical, emotional, mental, and spiritual elements must be addressed. Victor Franklôs admonition to self-regulate is an essential element and other strategies could be added to provide the balanced approach.

- Minimize exposure to stressors
- Change appraisal of stressful situations

[6] Ibid

- Manage physical stress responses
    - Physical exercise
        - Walking, swimming, jogging, running, hiking, biking, sports
    - Rest
        - Regular bedtime, sleep, breaks, vacation, ñtime outò
    - Healthy nutrition, diet, hydration
    - Reducing environmental stressors
        - Temperature
        - Light/darkness
        - Noise/silence
        - Crowds
        - Traumatic visuals, smells

- Manage emotional stress responses
    - Catharsis
        - Talking it out, ñventing,ò counseling, therapy
        - Writing ï journal, poetry, etc.
    - Enjoyable activity
        - Art ï painting, sculpting, photography, etc.
        - Hobbies ï fishing, hunting, sewing, reading, crafting, collecting, etc.

- Manage mental stress responses
    - Diaphragmic breathing
    - Stress inoculation therapy (prepare in advance for stressful events)
    - Grounding techniques
    - Seek and appropriate sound information
    - Have a positive attitude
    - Consider other possibilities ï a ñplan Bò

- Manage spiritual stress responses
    - Meditation (mindfulness)
    - Prayer
    - Worship
    - Music
    - Connection, social support, community
    - Reading sacred texts

Controlling stress in our lives is sometimes a complicated and challenging task. Begin with awareness ï find out what causes stress in your life. Some events make the cause obvious ï death of a loved one or a major life change. Some stress sources are not easily identified.

Operational Stress First Aid – Ways to Manage Stress

Strengthen Yourself	
Physically	**Mentally**
Build strength	Embrace familiarity
Work on physical endurance	Be confident
Practice physical skills'	Have a positive attitude
Stay fresh and well rested	Inoculate yourself from stress
Emotionally	**Spiritually**
Acknowledge feelings and reactions	Worship
Identify the source of feelings	Pray
Vent appropriately	Read your sacred texts
Avoid compacting and denying feelings	Challenge your values and beliefs

Manage Your Environment	
Physical Environment	**Relational Environment**
Wear protective equipment	Trust and support others
Take part in recreational activities	Be a team player
Be prepared for tasks	Strive for family cohesion
Reduce environmental stressors	Strive for team cohesion
Reduce unnecessary physical stressors	Be patient with others

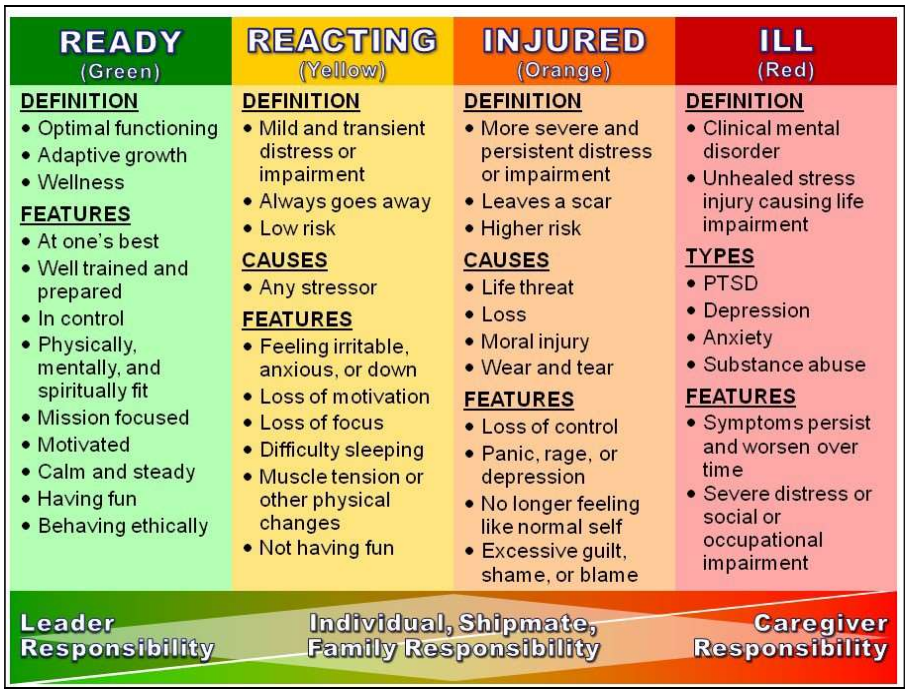
Compartmentalize Stress	
Thinking	**Feeling**
Tune out dangers	Feeling numb to fear
Let go of horrors	Feeling numb to sorrow
Don't dwell on negatives	Feeling numb to suffering
Avoid self-blame	

APPENDICES

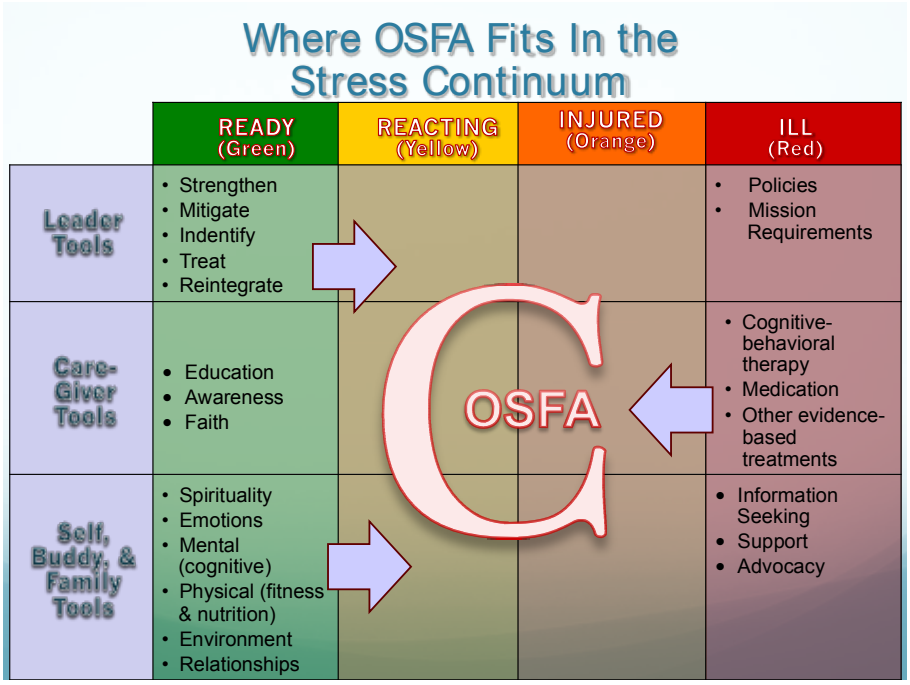
Appendix A: Operational Stress First Aid (OSFA) Overview

	Goals	When It Is Used	How You Do
CHECK	☐ Identify stress zone and need for stress first aid ☐ Assess effectiveness of stress first-aid actions ☐ Monitor recovery	☐ After every significant stressor ☐ After applying stress first aid ☐ After every deployment ☐ Whenever needed, repeatedly and often	Watch and listen for: ☐ Unusual stressors. ☐ Severe distress. ☐ Changes in normal functioning or behavior.
COORDINATE	☐ Inform others who need to know ☐ Refer for additional help ☐ Make sure help is received	☐ Every time significant stress problems are identified ☐ Whenever needed, repeatedly and often	☐ Inform chain of command (one level up). ☐ Refer to care provider, if indicated. ☐ Follow through.
COVER	☐ Get individual to safety as soon as possible ☐ Prevent others from being harmed	☐ When stressed persons are at risk or places others at risk ☐ Then only briefly, until mental focus and self-control return	☐ Recognize danger posed by or to a stressed person. ☐ Neutralize the danger. ☐ Keep person safe until they recover.
CALM	☐ Reduce heart rate ☐ Reduce emotional intensity ☐ Regain mental focus	☐ When a person's level of physical activation or emotions are too intense for a situation	☐ Stop activity and relax. ☐ Breathe slowly and deeply. ☐ Refocus thinking ("grounding").
CONNECT	☐ Promote peer support ☐ Prevent stressed individuals from isolating themselves	☐ When stressful events cause loss of trust, respect, and communication in team or family	☐ Spend time with stressed persons. ☐ Ask how they are doing. ☐ Encourage peer support.
COMPETENCE	☐ Restore mental and physical capabilities ☐ Restore role functioning	☐ Stress injury or illness causes loss or change in normal functioning and abilities	☐ Encourage and mentor back to full function, step by step. ☐ Retrain, if necessary.
CONFIDENCE	☐ Restore self-confidence ☐ Restore confidence in others, beliefs, values, and/or God ☐ Restore hope	☐ Any time an individual loses confidence in self, peers, leaders, mission, values, or God	☐ Provide increasing responsibility and experiences of mastery. ☐ Positive reframing and meaning-making. ☐ Help set and achieve goals.

Appendix B. OSFA Stress Continuum Model



In terms of the Stress Continuum, the goal of OSFA is simply to ***move towards green*** to restore health and readiness after an Orange Zone stress injury.



Although individuals in both the Yellow and Orange Zones may benefit from OSFA, it is most useful for the early and ongoing care of Orange Zone stress injuries. In Orange Zone stress injuries, leadership tools for stress mitigation are often inadequate, and clinical mental health treatment may be either unavailable or unnecessary.

Appendix C: Motivational Interviewing

Helping people to be agents in their healing and recovery and building self- efficacy are core OSFA principles. However, caregivers will face people who are not able or willing to acknowledge a given stress-related problem or not inclined to follow through on a secondary aid plan to promote Connection, Competence, and Confidence. Motivational interviewing (MI) is an approach aimed at enhancing an individual's motivation for behavior change and increasing the likelihood that the individual will engage in a plan of action to promote positive change. In the trauma field, MI is used with a variety of challenges, including: symptom management, medication and treatment compliance, relationship problems, wellness behaviors, anger management, and substance use. MI is a set of skills that transcend any specific problem or issue. Within OSFA, the objective is to increase the likelihood that a person will engage in steps towards being an active agent in a secondary aid plan to promote healing and recovery from operational stress.

The key MI principle is that a person is most likely to change his or her behavior when the individual generates the need, the decision, and the plan for change. MI is an approach that helps caregivers overcome their understandable inclination to tell persons what they need to do, and helps them shape the dialogue so that persons self-identify what needs to be addressed to improve their situation. Caregivers should be prepared for reluctance and ambivalence about change (for example, a "yes, but" kind of response). In the MI framework, ambivalence about change is an expected human experience. In MI, the caregiver avoids confrontation and avoids telling persons what to do; rather, MI entails providing reflective feedback to the person about his or her reluctance and ambivalence in a neutral but caring manner. It entails working with the ambivalence rather than against it. Sometimes this is called "meeting the person where they are."

MI requires that the caregiver develop a nonjudgmental collaborative relationship with the person. An important healing aspect of OSFA is developing a partnership, a mutuality of concern, where those with stress injury behaviors know they are not alone and that they are part of something greater than themselves. Caregivers need to avoid: *Arguing or disagreeing; udging, critici ing, or blaming; warning of negative conse uences; seeking to persuade; interpreting or analy ing defensiveness; being authoritative; or using sarcasm*. MI entails helping the person self-identify his or her wishes and intentions and to have them think about methods for positive change The four key MI strategies are: (1) expressing empathy; (2) asking questions that help the person identify a discrepancy between his or her current state and self-identified wishes, goals, and needs in the future; (3) *rolling with* resistance and avoiding argumentation; and (4) supporting self-efficacy. For caregivers, the first and last strategy should come easily.

1) *E pressing empathy* involves demonstrating warmth, accurate understanding, and positive regard. This can be accomplished by trying to be impartial as to the outcome of your conversation, demonstrating accurate understanding through reflection, using open questions that encourage elaboration, and seeking permission to ask questions and give advice.

2) *Identifying a discrepancy* is done by encouraging the person to articulate how his or her current state differs from his or her ideals and goals. Discrepancies often emerge when persons answer specific questions and become more aware of their

current state as compared to where they would like to be. The idea is that identifying a discrepancy increases motivation to work on reducing it. One strategy to help persons identify discrepancies and make a more informed decision about what they would like to see happen is to raise their awareness of the negative consequences of continuing without making changes.

***Example**:* Have the person consider the good things and the bad things that will come if he or she stays the same versus work towards changing the behavior. In other words, have the individual think about and share what he or she sees are the pros and cons of change. This process may help the person to:

- Clarify short-term and long-term consequences of changing vs. not changing
- Discover what is truly important to him or her and how the person can change so behavior reflects core values
- Identify the positive incentives for changing his or her behavior
- Be more motivated to work towards changing because the person realizes that the pros for change outweigh the cons

3) *Rolling with resistance and avoiding argumentation* entails learning how to recognize resistance, reluctance, or ambivalence, managing it without pushing against it, and how to invite but not impose new perspectives. It is important to recognize that caregivers who are using OSFA strategies are often a part of the team that is under duress and must be aware that their own frustrations about the environment will influence first reactions to resistance. The basic sequence entails reflective feedback about ambivalence and using open-ended questions to help the person generate ideas about the problem and what he or she needs to do to help solve it.

Example: If the person is isolating himself or herself for a variety of reasons, a caregiver might say:

- "Would you be willing to share what is going on with you when isolated from other people?"
- "What helps you by being isolating?"
- "What's negative about staying isolated?"
- "If you didn't isolate yourself, what do you think might happen, how would things be different?" and so forth.

4) *Supporting self sufficiency* involves eliciting suggestions for change from the person, supporting his or her choices, and closing the conversation with a discussion of plans and intentions in service of secondary aid goals. This includes summarizing the issues discussed and getting the person to share what he or she plans to do in the short-run in service of a secondary aid plan of action. For example, "It sounds like you feel that things can't stay the way they are now. What do you think you might do differently in the next few days and weeks? Is there anything I can help with?" Caregivers should shape this dialogue in terms of what the person needs to do differently to reconnect, regain competence and bolster confidence. Caregivers might also help the person clarify priorities, set "milestones" on the

way to achieving goals, help the person to develop multiple ways in which he or she might change, and create a menu of options. Finally, it may be helpful to suggest a 'trial run' of a plan. The person could agree to try out new behaviors for a short period of time, to see how he or she feels, without making a full commitment. The caregiver should follow up to see what the person learned from the experience and commit to further changes if it works.

Additional Resources:

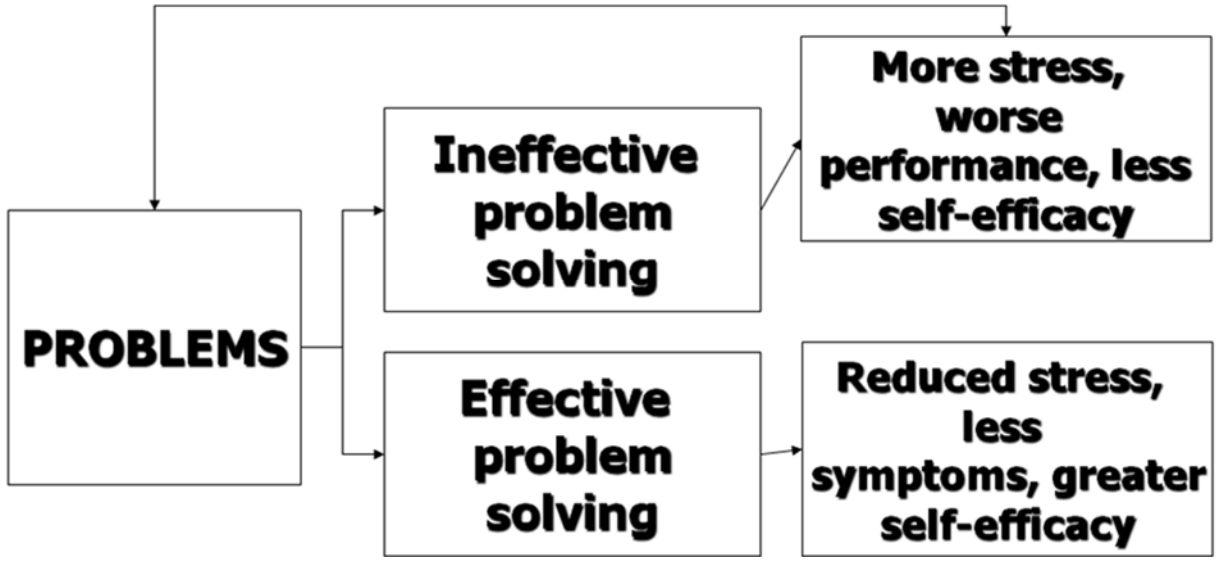
Miller, W. R., Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist 64:*527-537.

National Registry of Evidence-based Programs and Practices (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA). Keyword: Motivational Interviewing.

Appendix D: Problem-Solving Strategies to Promote Secondary Aid Goals

If left unaddressed, life problems, daily hassles, and acute conflicts pile up and drain personal and social resources. Conversely, people who employ strategies that resolve or successfully reframe life problems (problem solving) have higher degrees of self-efficacy and confidence, are resilient in the face of major demands, and are at reduced risk for mental health problems, particularly depression. For persons, unsettled and lingering life problems (for example, conflict with a spouse or financial strain) contribute to cumulative wear and tear, triggers or reveals orange zone injury, thwarts healing and recovery from operational stress injury and illness, and creates disconnection and reduced competence and confidence (the three targets of Secondary Aid). Conversely, Orange Zone stressors can leave an individual less able to solve his or her problems due to reduced creativity, cognitive flexibility, and energy to carry through with plans. Persons with Orange Zone Stress Injuries may have a very high burden of concurrent life problems and conflicts or a history of poor problem solving, or their exposure to operational stress and subsequent injury has made it difficult for them to engage in the step- by-step process of problem solving. Regardless of the origin of current difficulties, if stress- injured persons are not eventually engaged in the process of problem solving the actions to promote healing and recovery will have little lasting impact.

This Figure shows the relationship between life problems and outcomes. Notice that ineffective problem solving not only leads to more distress and impairment, but, in turn, this leads to worse problems, creating a vicious cycle.



Problem-solving training is a simple yet useful tool for caregivers working with persons to accomplish secondary aid goals. These strategies stem from *Problem-Solving Therapy*, a cognitive-behavioral therapy approach that treats mental health problems by teaching patients how to systematically solve psychosocial problems (e.g., D'Zurilla & Nezu, 2007). Regaining a sense of control over life's problems is probably the most important factor for resolving depressive symptoms, and the problem-solving intervention

has been found to be effective in treating depression (e.g., Areán, et al., 1993). The basic strategy entails helping people to have a "problem orientation," which entails a rational, positive, and constructive mindset toward problems in living and viewing problem solving as a means of coping with current stressors. Individuals are taught to see intense negative emotions as cues for identifying the existence of a problem, to inhibit the tendency to respond automatically to problems, and to engage instead in the problem-solving process. The component skills of problem solving involve teaching people to: (a) better define and formulate the nature of problems, (b) generate a wide range of alternative solutions, (c) systematically evaluate the potential consequences of a solution and select the good options to try-on, and (d) monitor and evaluate the solution outcome after its implementation.

In terms of OSFA provided by caregivers, problem solving will be useful to accomplish the three Secondary Aid goals, namely, *connect*, *competence,* and *confidence*. If the person is in crisis and his or her mental status is severely compromised, Primary Aid rather than problem solving is first indicated. By definition, if caregivers are discussing Secondary Aid goals with the person, the person will be in a mental state that will allow him or her to take advantage of a problem-solving intervention. Problem solving can help persons to (1) reduce sources of stress (that is, life demands and difficulties) as well as problems and conflicts with peers or leaders, (2) slow down quick- triggered, impulsive responses that can cause problems, (3) regulate emotions, (4) increase ownership and responsibility-taking (self-efficacy), (5) increase self-awareness and self- knowledge, and (6) generate self-satisfaction and hopefulness.

There are four key steps in problem solving: (1) identify and define the problem, (2) explore alternative solutions, (3) apply a good enough and workable solution, and (4) evaluate the impact of the action taken.

Identifying and defining the problem is the most important step because it helps the person organize his or her thoughts and think critically about the source of difficulties in a patient, objective, and rational manner (in the ideal case). This step can also help the person to take a step back and examine the source of distress or conflict (for example, the caregiver can say, "Let's take a look at what is going on…"). Caregivers should ask (and assist) the person to *break down large problems into smaller and more manageable parts*. They should also help the person to define the problem in concrete terms. Questions that will be helpful include:

- "What is bugging you about this?"
- "What would you like to see happen?"
- "What do you need, what do you want?"
- "How would things be different if you solved this problem?"
- "What makes this a problem?"
- "What have you already tried to solve the problem?"

The second step is called *brainstorming*. It entails asking persons to take a step back and examine what needs to happen to solve the problem identified. Brainstorming is a unique skill because it requires uncritical acceptance of *all* ideas. At this stage, persons are asked to generate a free-flowing set of potential solutions, independent of quality (quality/choice will come next). Remember, *withholding judgment may be very difficult, particularly for persons new to the process.* Caregivers should be patient and not get in the way; you want to empower the person rather than do the work for them (even though you will be tempted to do so!).

In the next stage of problem solving, the person is asked to select a solution among all the brainstormed options. The process involves helping persons: Weigh advantages and disadvantages for each viable solution, factor difficulties and obstacles to successful implementation, and select a potential solution that best meets the situation/context and the person's abilities. The selected option should be realistic and doable. You want to make sure the person agrees with the solution and is able and willing to try it out. Caregivers should get the person to agree to try out a selected solution. *Encourage the person to embrace the process and to be curious about whether the solution works.* The person should be clear on his or her goals; they should be specific to the problem at hand. Overreaching goals can lead to failure. At later stages, the person can choose another alternative solution, if that becomes necessary.

Finally, the last stage entails evaluating and learning from the process (the process should be as important as the outcome). This requires follow-up and checks. Persons need to learn from the experience. Caregivers should be enthusiastic and curious about how it went and what was learned. The goal is to get the person to *embrace and own the process.* Key questions are:

- What did the person learn about the situation that he or she did not know for sure before?
- Exactly what happened when the person tried to implement the solution?
- Should the goal be defined more clearly?
- Are the goals unrealistic?
- Have new obstacles arisen?
- Are the implementation steps difficult to achieve? If so, why?
- Is the person truly committed to working on the problem?

The answers to these questions will guide subsequent dialogues about problem solving and repetitions of the problem-solving stages.

Additional Resources:

Areán, P. A., Perri, M. G., Nezu, A. M., Schein, R. L., Christopher, F., & Joseph, T. X. (1993). Comparative effectiveness of social problem solving therapy and reminiscence therapy as treatments for depression in older adults. *Journal of Consulting and Clinical Psychology, 61*, 1003-1010.

D'Zurilla, T. J., & Nezu, A. M. (2007). *Problem-solving therapy: A positive approach to clinical interventions* (3rd ed.) NY: Springer Publishing Co.

D'Zurilla, T. J., & Nezu, A. M. (2001). Problem-solving therapies. In K. Dobson (Ed.), Handbook *of cognitnve-behavioral therapies* (2nd ed., pp 211-245). NY: Guilford.

Malouff, J. M., Thorsteinsson, E. B., Schutte, N. S. (2007). The efficacy of problem solving therapy in reducing mental and physical health problems: A meta-analysis. *Clinical Psychology Review, 27*, 46-57.

Nezu, A. M., & Nezu, C. M. (2001). Problem-solving therapy. *Journal of Psychotherapy Integration, 11*, 187-205.

Nezu, A. M., Nezu C.M. & Perri, M.G. (1989). *Problem-solving therapy for depression: Theory, research, and clinical guidelines*. NY: Wiley.

Nezu, A. M. (2004). Problem solving and behavior therapy revisited. *Behavior Therapy, 35*, 1-33.

Reynolds, C. F., Miller, M. D., Pasternak, R. D., Frank, E., Perel, J. M., & Cornes, C., (1999). Treatment of bereavement-related major depressive episodes in later life: A controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. *American Journal of Psychiatry, 156*, 202-208.

Scogin, F, Welsh, D., Hanson, A. Stump, J. & Coates, A. (2005). Evidence-based psychotherapies for depression in older adults. *Clinical Psychology: Science and Practice, 12*, 222-237

Appendix E: Guidelines and Strategies for Orange Zone Stress Injuries

Persons are at risk for exposure to frequent and sustained operational challenges, stressors, adversities, losses, and traumas. At a given point in time, the psychological, biological, social, and spiritual response to these challenges is a gestalt blend, reflecting the cumulative burdens and exposures that each person experienced and a host of additional risk (for example, family conflict, and financial strain) and resilience (for example, good social cohesion and support, good training, and leadership) factors. In this sense, no two persons will present caregivers with an identical Orange Zone Stress Injury or Red Zone Stress Illness. In addition, caregivers should bear in mind that adaptation to operational stress is an unfolding trajectory; what you see is not what you get over time. For example, some persons with Orange Zone Stress Injuries in the field will recover and heal, and some will develop chronic Red Zone Illnesses, such as PTSD. In contrast, some persons will be stunningly resilient early on and have a delayed Red Zone Illness.

Nevertheless, there are predictable types or forms of adaptation to the four different sources of operational stress injury, namely, *life threat*, *loss*, *inner conflict*, and *wear and tear*. Even if persons have been exposed to a number of events within each of these stressor categories, it is likely that at a given point they are suffering from a focal wound or they are consumed by a particular type of experience, for one reason or another. Consequently, caregivers need to appreciate the different behavioral indicators of a particular type of stressor, the relatively unique phenomenology and need states that define a particular type of injury, and the potentially unique targets for secondary aid associated with a specific form of Orange Zone Stress Injury. This will have the added value of enhancing caregivers' empathy and understanding.

What follows is a table that depicts four different classes of injurious experiences, their associated phenomenology, the need states that arise, and some unique targets for secondary aid.

Appendix E

Injury Type	Life-Threat	Loss	Inner Conflict	Wear and Tear
Injurious Elements	Terror, horror, helplessness, freezing/loss of functioning, perceived failure, perceived impotence	Abrupt attachment loss, horror, shock, vulnerability, aloneness, unfairness, meaninglessness	Witnessing morally repugnant behavior, betrayal, violence and degradation	Cumulative stress reactions, poor self-care, poor supports, not enough respite, fatigue, exhaustion
Phenomenology	Triggered intrusive memories, panic, dissociation, fear, hyper vigilance, jitteriness, withdrawal, numbing, avoidance	Sadness, purposelessness, lethargy, hopelessness, intrusive memories, numbing, detachment, avoidance, anger	Guilt, shame, demoralization, poor self-care, self-handicapping, self-harm, intrusive memories	Fatigue, withdrawal, mental status impairment, irritability
Needs	Comfort, safety, predictability and control, reassurance, unburdening	Comfort, empathy, restoration of enduring attachments	Forgiveness, absolution, meaning-making, unburdening, correction	Rest, respite
Secondary Aid Targets	Exposure to corrective (non-threat) experience, non-avoidance, regaining predictability and control, relaxation and self-care	Reconnection, reengagement in meaningful activities, support, acceptance of loss	Renewal from positive action, doing good, supporting others, religious and spiritual guidance and activity	Self-care and wellness training

Appendix F: Five Core Leader Functions

The Operational Stress Continuum model provides a framework for understanding and recognizing operational stress across its spectrum. The OSFA establishes the following five core leader functions for OSC across the Stress Continuum:

- Strengthen
- Mitigate
- Identify
- Treat
- Reintegrate

Strengthen

Strengthening individuals, teams, and families to enhance their resilience is the first core OSC function for responder leaders. Individuals enter responder service with a set of pre-existing strengths and vulnerabilities based on genetic makeup, prior life experiences, personality style, family supports, and a host of other factors. Centuries of experience in responder organizations and decades of scientific research have demonstrated that leaders of responders can do much to enhance the resilience of team members and their families, regardless of these pre-existing vulnerabilities. Activities available to leaders to strengthen their personnel fall into three main categories:
(1) training, (2) social cohesion, and (3) leadership.

Training. Tough, realistic training develops physical and mental strength and endurance, enhances persons' confidence in their ability as individuals and as members of teams to cope with the challenges they will face, and inoculates them to the stressors they will encounter. One challenge for team leaders is to find the "sweet spot" between training that is tough and realistic enough to really build resilience, and training that is so tough that it inflicts Orange Zone injuries during training.

Social cohesion. Social cohesion, defined broadly as mutual trust and support in a social group, is developed through the sharing of adversity over time in a group with a stable membership. Social cohesion is a protective factor against the toxic effects of operational stress in both responder teams and families. Effective leaders know how to build cohesive teams given enough time and team stability, but a too-common challenge is to maintain team cohesion in the face of rotations into and out of the team, including late joins, casualties, and deployment replacements. Individual augmentees and members of outside teams may be particularly disadvantaged regarding this important ingredient to resilience. Another challenge for team leaders with respect to social cohesion is how to forge mutual trust and peer support among families left behind; they are no less a part of the team than the active responders who deploy in cohesive teams, but they often have much less opportunity to develop social cohesion with other families.

Leadership. Although complex and multifaceted, leadership is an essential factor for the strengthening of team members and families. Team members are strengthened by leaders who teach and inspire them, keep them focused on mission essentials, instill confidence, and

provide a model of ethical and moral behavior. Another crucial way in which leaders enhance the resilience of their team members is by providing a resource of courage and fortitude on which team members can draw during times of challenge. The influence leaders have over those they lead is a sword that can cut both ways — leaders who, themselves, are in the Yellow, Orange, or Red Zones may become detriments to their teams unless the leaders' own stress is recognized and effectively managed.

Mitigate

Since no person is immune to stress, no matter how strong and well prepared, the prevention of stress injuries and illnesses requires continuous monitoring and alleviation of the stressors to which individuals and teams are exposed. Optimal mitigation of stress requires the balancing of competing priorities. On one side is the need to intentionally subject persons to stress in order to train and toughen them, and to accomplish assigned tasks while deployed. On the other side are the imperatives to reduce or eliminate stressors that are not essential to training or mission accomplishment, and to ensure adequate sleep, rest, and restoration to allow recovery from stress between periods of challenge. Resilience, courage, and fortitude can be likened to leaky buckets that are constantly being drained by stress. To keep them from running dry, these buckets must be frequently refilled through sleep, rest, recreation, and spiritual renewal. Continuing this metaphor, the leader function of mitigation is crucial to preventing more holes from being punched in these leaky buckets than are absolutely necessary.

Mitigation is a preventive activity, aimed at keeping team members in the Green Ready Zone in the face of operational challenges, and to return them to the green zone after yellow zone reactions. Specific tactics and procedures for team leaders to mitigate operational stress are discussed in Chapter 3.

Identify

Since even the best preventive efforts cannot eliminate all stress reactions and injuries that might impact occupational functioning or health, effective force preservation requires continuous monitoring of stressors and stress outcomes. Operational leaders must know the individuals in their teams, including their specific strengths and weaknesses, and the nature of the challenges they face, both in the team and in their home lives. Leaders must recognize when individuals' confidence in themselves or their peers or leaders is shaken, or when teams have lost cohesion because of casualties, changes in leadership, or challenges to the team. Most important, every team leader must know which stress zone each team member is in at every moment, day to day. Persons cannot be depended upon to recognize their own stress reactions, injuries, and illnesses, particularly while deployed to operational settings. The external focus of attention and denial of discomfort necessary to thrive in an arduous environment also make it harder to recognize a stress problem in oneself. Stigma can be an insurmountable barrier to admitting to someone else stress problems that have been recognized; therefore, the best and most reliable method of ensuring that everyone who needs help gets it is for small team leaders to continually watch out for those they lead, and for peers to watch out for each other.

Treat

Available tools for the treatment of stress injuries and illnesses exist along a broad spectrum, including:

- Operational Stress First Aid (OSFA)
- Self aid or buddy aid
- Support from a small team leader or spiritual care provider (chaplain)
- Definitive medical or psychological treatment.

Although some forms of treatment can only be delivered by trained medical or mental health providers, many others require a little special training and can be applied very effectively by anyone in almost any setting, such as OSFA.

Regardless of what level or type of treatment is available and indicated for any given person, the overall responsibility for ensuring that appropriate and timely care is delivered rests with team leaders and their leaders. To increase the likelihood that needed care will be accepted by the individuals who need it, leaders must also attack stigma in their teams and organizations, in all its forms.

Reintegrate

The normal course for a stress injury, as for a physical injury, is to heal over time. The vast majority heals, with or without treatment. Similarly, the normal course for a stress illness, especially if properly treated, is to improve significantly over time, if not completely remit. Hence, operational leaders face one final challenge in their management of persons treated for stress injuries or illnesses — that of continually monitoring their fitness for duty, including worldwide deployment, and mentoring them back to full duty as they recover. This is the challenge of reintegration. For stress casualties to be effectively reintegrated in their teams, stigma must be continuously addressed, and the confidence of the stress-injured person, their peers, and small team leaders must be restored. This process may take months to bring to successful conclusion because recovery from a stress injury or illness is often a slow process. In those cases in which substantial recovery and return to full duty is not anticipated, the challenge for team leaders is to assist persons as they transition to non-deployed civilian life and private care.

Appendix G: Suicidal Ideation

Suicide is a preventable personnel loss that impacts team readiness, morale, and mission effectiveness. Relationship disruption, substance abuse, financial problems, legal problems, and mental health problems (such as depression) can interfere with individual efficiency and team effectiveness and also increase a person's suicide risk. Factors including positive attitude, solid spirituality, good problem solving skills, and healthy stress control can increase individual efficiency and team effectiveness, and reduce risk of intentional self-harm. As such, preventing suicide begins with promotion of health and wellness consistent with keeping persons ready to accomplish the mission. Basic suicide prevention programs consist of four elements:

- Training – increasing awareness of suicide concerns, improving wellness, and ensuring personnel know how to intervene when someone needs help; recognizing risk factors
- Intervention – ensuring timely access to needed services and having a plan of action for crisis response
- Response – assisting families, teams, and persons affected by suicide behaviors
- Reporting – reporting incidents of suicide and suicide-related behaviors

Caregivers support local leaders with information in their areas of expertise, intervention services, and assistance in crisis management. Suicidal risk factors and suicidal thinking can be part of stress injury related behaviors. Additional factors for caregivers to consider when concerns about suicidal thinking are identified during the CHECK.

Guidance for Caregivers: Responder SAFE-T[7]

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge. Assessment needs to consider are risk factors, protective factors, suicide inquiry, risk level and possible interventions, and documentation.

1. RISK FACTORS

- **Suicidal behavior:** History of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- **Current/past psychiatric disorders:** Especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity); *co-morbidity* and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (for example, civil or responder legal charges/investigation, loss of relationship, or financial or health status—real or anticipated); ongoing medical illness (especially CNS disorders and pain); intoxication; family turmoil/chaos;

[1] Defense Centers of Excellence. (2009). Responder SAFE-T: Suicide Assessment Five-step Evaluation and Triage. http://www.dcoe.health.mil/ForHealthPros/Resources.aspx

history of physical or sexual abuse; social isolation; recent or pending deployment; career setbacks or transitions (retirement, PCS, or discharge). Lingering deployment injuries or work-related guilt/triggers

- **Change in treatment:** discharge from psychiatric hospital, provider, or treatment change
- **Access to firearms, explosives, or other lethal means/devices/materials**

2. **PROTECTIVE FACTORS:** Protective factors, even if present, may not counteract significant acute risk.

- **Internal:** ability to cope with stress, cultural/religious beliefs, and frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports (for example, team cohesion, caring leadership, and connection with fellow team mates)

3. **SUICIDE INQUIRY:** Suicide inquiry includes specific questioning about thoughts, plans, behaviors, and intent.

- **Ideation:** frequency, intensity, and duration (for example, in last 48 hours, past month, and worst ever)
- **Plan:** timing, location, lethality, availability, and preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (for example, tying noose or loading gun) vs. non-suicidal, self-injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; explore ambivalence: reasons to die vs. reasons to live

4. **RISK LEVEL/INTERVENTION**

- **Assessment:** of risk level is based on clinical judgment after completing steps 1-3
- **Reassess:** as patient or environmental circumstances change

Risk Level/Intervention Considerations

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission is generally indicated unless a significant change reduces risk; suicide precautions.
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers.
Low	Modifiable risk factors, strong protective factors	Thoughts of death; no plan, intent, or behavior	Outpatient referral, symptom reduction; give emergency/crisis numbers.

5. **DOCUMENT:** Risk level and rationale; treatment plan to address/reduce current risk (for example, setting, medication, psychotherapy, E.C.T., contact with significant others, and consultation); firearm instructions, if relevant; follow-up plan; treatment plan should include roles for command.

Suicidal Inquiry Questions

When the caregiver identifies that a focused suicidal thought inquiry is indicated during the CHECK process, there are questions that may be helpful in inquiring about specific aspects of suicidal thoughts, plans, and behaviors.[8]

Begin with questions that address the patient's feelings about living

- Have you ever felt that life was not worth living?
- Did you ever wish you could go to sleep and just not wake up?

Follow up with specific questions that ask about thoughts of death, self-harm, or suicide

- Is death something you've thought about recently?
- Have things ever reached the point that you've thought of harming yourself?

For individuals who have thoughts of self-harm or suicide

- When did you first notice such thoughts?
- What led up to the thoughts (for example, interpersonal and psychosocial precipitants, including real or imagined losses; specific symptoms, such as mood changes, anhedonia, hopelessness, anxiety, agitation, or psychosis)?
- How often have those thoughts occurred (including frequency, obsessional quality, and controllability)?
- How close have you come to acting on those thoughts?
- How likely do you think it is that you will act on them in the future?
- Have you ever started to harm (or kill) yourself but stopped before doing something (for example,, holding a knife or gun to your body but stopping before acting, or going to the edge of bridge but not jumping)?
- What do you envision happening if you actually killed yourself (for example, escape, reunion with significant other, rebirth, or reactions of others)?
- Have you made a specific plan to harm or kill yourself? (If so, what does the plan include?)
- Do you have guns or other weapons available to you?
- Have you made any particular preparations (for example, purchasing specific items, writing a note or a will, making financial arrangements, taking steps to avoid discovery, or rehearsing the plan)?
- Have you spoken to anyone about your plans?
- How does the future look to you?
- What things would lead you to feel more (or less) hopeful about the future (for example, treatment, reconciliation of relationship, or resolution of stressors)?

[2] *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors.* (2003). American Psychiatric Association (APA) Practice Guidelines.
www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx

- What things would make it more (or less) likely that you would try to kill yourself?
- What things in your life would lead you to want to escape from life or be dead?
- What things in your life make you want to go on living?
- If you began to have thoughts of harming or killing yourself again, what would you do?

For individuals who have attempted suicide or engaged in self-damaging action(s), parallel questions to those in the previous section can address the prior attempt(s). Additional questions can be asked in general terms or can refer to the specific method used and may include:

- Can you describe what happened (for example, circumstances, precipitants, view of future, use of alcohol or other substances, method, intent, and seriousness of injury)?
- What thoughts were you having beforehand that led up to the attempt?
- What did you think would happen (for example, dying versus going to sleep, unconsciousness, getting attention of significant others)?

Supervisor Advisement

Responder leaders are required to provide support for those who seek help with personal problems. Access must be provided to prevention, counseling, and treatment programs and to services supporting the early resolution of mental health and the family for personal problems that underlie suicidal behavior. Caregivers need to be familiar with the IS PATH WARM and AID LIFE mnemonics that may be used to guide decisions and actions. Leaders will use organic resources or consult with the nearest medical personnel, chaplains, or counselors to assess requirements for supportive interventions for teams and affected persons. Caregivers need to be familiar with local resources to coordinate interventions when needed.

IS PATH WARM

I **IDEATION:** thoughts of suicide expressed, threatened, written, or otherwise hinted at by efforts to find means to suicide
S **SUBSTANCE USE:** increased or excessive alcohol or drug use

P **PURPOSELESSNESS:** seeing no reason for living or having no sense of meaning or purpose in life
A **ANXIETY:** feeling anxious, agitated, or unable to sleep (or sleeping all the time)
T **TRAPPED:** feeling trapped, like there is no way out
H **HOPELESSNESS:** feeling hopeless about self, others, and the future

W **WITHDRAWAL:** withdrawing from family, friends, usual activities, and society
A **ANGER:** feeling rage or uncontrolled anger; seeking revenge for perceived wrongs
R **RECKLESSNESS:** acting without regard for consequences; excessively risky behavior, seemingly without thinking
M **MOOD CHANGES:** experiencing dramatic changes in mood

AID LIFE

A **Ask.** Do not be afraid to ask, "Are you thinking about killing yourself?" or "Are you thinking about suicide?"

I **Intervene immediately.** Take action. Listen and let the person know he or she is not alone.

D **Do not keep it a secret**. Let someone know that you think there may be a risk.

L **Locate help.** Seek out the help of a chaplain, Marine and Family Service Center, corpsman, doctor, friend, family member, or emergency room staff.

I **Inform the chain of command** of the situation. The chain of command can secure necessary assistance resources for the long term.

F **Find someone to stay with the person now.** Never leave a suicidal person alone.

E **Expedite.** Get help now! An at-risk person needs immediate attention from professional caregivers.

Additional Resources

- http://www.usmc-mccs.org/suicideprevent/index.cfm?sid=ml
- Instructions and policies: OPNAVINST 6100.2A, (b) SECNAVINST 6320.24A, MILPERSMAN 1770, and OPNAVINST F3100.6H (NOTAL)
- www.suicide.navy.mil
- Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- www.nmcphc.med.navy.mil/LGuide/index.htm
- www.responderonesource.com
- www.respondermentalhealth.org (Funded by Department of Defense Office of Health Affairs) provides anonymous online mental health screenings
- www.usmc-mccs.org/leadersguide
- www.dcoe.health.mil

Appendix H: Caregiver Occupational Stress

Background

The current demands and challenges that responder medical personnel face today are dramatically different from the challenges of only a few years ago. Caregivers rarely deploy as a cohesive team and do not have the protective factors associated with intensive realistic team training. The restorative dwell time between deployments that is so critical to responder teams is not part of the caregiver culture. The skills, knowledge, and role expectations that caregivers use in a field or humanitarian environment are the same ones used in medical centers and clinics. Consequences of untreated cumulative stress can result in:

- Caregiver errors and increased number of near misses
- Somatic complaints, such as changes in eating habits, gastrointestinal distress, headache, fatigue, and sleep disorders
- Change in work habits, such as tardiness, presenteeism, and absenteeism
- Mental and emotional difficulties, such as memory disturbances, anger, self-doubt, isolation, and impaired judgment
- Accidents

The Challenges of Caregiver Stress Control

There is mounting evidence that caregivers are not meeting their own mental health needs or using existing mental health resources before serious consequences occur to self or others. The caregiver's code of silence (both moral and professional), dedication to caring for injured persons, and passion to ease suffering increases the need for leaders of caregivers to be vigilant for early stress behaviors.

The dominant stress response paradigm in civilian literature has several common elements: know the sources of job stress, know the signs and symptoms of stress, take care of yourself, and seek help when you begin to experience impairment in daily life. There are several significant barriers to self-help focused coping for healthcare personnel. First, endemic job stress produces some level of stress symptoms in all workers so that moderate and high stress look "normal". Second, early stress symptoms, such as fatigue, impaired sleep, and confusion decrease self-awareness and ability to engage in self-care. Third, caregivers are "other" focused and receive intrinsic rewards from self-sacrifice in the service of others. Finally, there are perceived barriers (stigma) to use of mental health services that are designed for mental illness treatment versus mental health promotion.

Caregiver Occupational Stress Control

The OSFA principles can also be used to recognize and address caregiver occupational stress injuries that stem from trauma exposure, loss, inner conflict, and fatigue. The three fundamental principles – early recognition, peer intervention, and connection with services as needed – need to be integrated into the caregiver role and work settings.

Leader Functions for Caregivers

A review of operational lessons learned and After Action Reviews highlight the importance of effective leadership in enhancing the mission capabilities of caregivers.

Leaders cannot assume that caregivers are not impacted by exposure to operational and garrison duties. Leaders who are responsible for caregivers need to consider the following adaptations of the five core OSC Leadership Functions to maintain caregiver mission readiness:

Strengthen. Caregiver training typically will focus on the "just in time" elements of the mission or the clinical environment. The responder-healer duality of the caregiver role needs to be acknowledged and practiced in the training. Training evolutions need to include After Action Reviews that incorporate the usual who, what, where, and how of the exercise and a discussion of the meaning of that event to the caregiver role or expectations. Pay particular attention to building cohesion. Caregivers rarely participate in the full cycle of pre-deployment training and may need overt leader support to be welcomed into an established cohesive team.

Mitigate. Caregivers are often considered "containers of resources" in the leaky bucket stress metaphor. As a "resource," there is a risk that they may not be meeting their own physical, social, mental, and spiritual needs. Include caregivers in the practices to conserve physical health and well-being. Consider having caregivers from other teams engage each other in a process of mutual assessment and support.

Identify. Caregivers are very adept at avoiding or minimizing responses to screening questionnaires and other early warning assessment tools. Leaders need to trust your gut instinct when you think a caregiver has a stress injury. Use the OSCAR approach to address your concerns. **O**bserve the behavior. **S**tate your observation clearly, **C**larify your role and why you are concerned. **A**sk for clarification to understand their point of view. **R**espond with guided options to get the caregiver to engage with available resources.

Treat. The stress first-aid strategies are as effective for caregivers as they are for other Sailors and Marines. The caveat is that caregivers are usually engaged in their roles and may not show symptoms of stress injury until after the last patient is treated or until they have turned over their responsibilities to the next shift. Watch for the period of quiet and solitude following intense caregiver activity or during prolonged and fatiguing care experiences. Connectedness and competence are critical interventions to support caregivers.

Reintegrate. Post-deployment reintegration is particularly challenging for caregivers. Caregivers often deploy as individual augmentees from their parent teams and became part of a cohesive team. They leave the cohesive team and return to their parent team, where they must become part of a new team. The caregivers in the parent command have had their own stressors and may place more emphasis on getting "back to work" rather than a purposeful reintegration. Operational deployment experiences in particular change a caregiver's tolerance for "unimportant issues". Administrative processes or rules that do not appear to improve patient care are generally not well tolerated. Consider phased-in work schedules and delaying collateral duty assignments as part of a caregiver post-deployment or post-stress injury reintegration.

Additional Resources

Figley, Charles R. and Nash, William P. (2007). Combat Stress Injury: Theory, Research, and Management. Routledge: New York.

Kraft, Heidi S. (2007). Rule Number 2: Lessons I learned in a Combat Hospital. Little, Brown, and Company: New York

Litz, Brett T. (2004). Early Intervention for Trauma and Traumatic Loss. Guilford Press: New York.

Stamm, B. Hudnall, 1999. Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators. Sidran Press: Lutherville, MD

Tubesing, Nancy L. and Tubesing, Donald A. 1994. Structures Exercises in Stress Management Volumes 1-5 and Structured Exercises in Wellness Promotion Volumes 1-5. Whole Person Associates: Duluth, MN.

Appendix I: Traumatic Stress Injuries

Overview

Traumatic stress injuries are literal damage to the brain and mind due to an experience involving real or threatened death or serious injury, or its aftermath. Not everyone who is exposed to real or threatened death or its aftermath is damaged by that experience; most people are not. But everyone is susceptible to experiencing intense terror, horror, or helplessness when confronted with his or her own or the mortality of peers, and each person's susceptibility varies over time due to the accumulation of stress from other causes. No one knows how common traumatic stress injuries are among persons engaged in combat operations because most are minor — more like bruises than fractures — and most heal quickly on their own without help from others. Even more serious traumatic stress injuries tend to be disabling for a short time, although completely normal functioning may not be regained for days, weeks, or months. The major challenges of managing traumatic stress injuries in persons include:

- Like other stress injuries, they are invisible, so leaders can easily overlook them.
- Like other stress injuries, they can provoke feelings of shame in persons, who may therefore be reluctant to admit, even to themselves, that they "lost it" because of a terrifying or horrible experience.
- It is hard to know the severity of any given traumatic stress injury except by waiting to see how quickly and completely it heals over time.
- Sometimes, the disabling effects of traumatic stress injuries may be delayed in their onset until weeks or months after returning from operational deployment.

To meet these challenges, leaders must closely monitor their people for traumatic stress injuries during and long after deployment, make it okay for their persons to ask for help when it is needed, and ensure that traumatic stress injuries that are still troubling or disabling after several weeks get professional care.

What to Look For

Successful identification and management of traumatic stress injuries require leaders to be aware of three possible indicators: (1) events that have a high potential for inflicting traumatic stress injuries — known as potentially traumatic events (PTEs), (2) the immediate symptoms and behaviors that most commonly accompany these injuries in their acute stages, and (3) the symptoms and behaviors that most commonly arise later in unhealed traumatic stress injuries.

Potentially traumatic events: are situations that place persons at risk for traumatic stress injuries. These situations vary in their toxic effect on persons, and each person's vulnerability to various PTEs is unique. PTEs in current operations include:

- Multi-casualty events, such as disasters, terrorism, homicides.
- Accidentally causing casualties.
- Death or maiming of women and children.

Appendix I

- Handling bodies and body parts.
- Casualties that are perceived as “avoidable” for any reason.
- Witnessed or committed infractions of ethics and the rules of engagement.
- Witnessed death or serious injury of a close friend or valued leader.
- Killing non-combatants or civilians.
- Being helpless to defend oneself.
- Physical injuries or near misses.
- Killing someone up close.

Immediate traumatic stress injury symptoms and behaviors: are those that appear instantaneously or soon after the impact on the mind and brain by a PTE if it is sufficiently intense for that person at that moment. Immediate symptoms and behaviors all involve a *temporary and partial loss of control*, lasting from a few seconds to several hours, but rarely continuing after a period of sleep. Immediate traumatic stress injury symptoms and behaviors include:

- Loss of control of emotions — intense terror, rage, horror, or helplessness.
- Loss of control of bodily functions — heart pounding much faster than normal, shaking, urinating, defecating, paralysis, or loss of vision or hearing.
- Loss of control of behavior — reflex freezing, fleeing, or striking back when these are neither intended nor appropriate.
- Loss of control of rational thinking — disorganized speech or behavior, or difficulty understanding or making sense of what is happening.
- Loss of control of memory — amnesia for traumatic events, yet fragments of unwanted memories intrude on awareness

Appendix J: Fatigue Stress Injuries

Overview

Fatigue stress injuries are potentially irreversible changes in the brain and mind due to the accumulation of stress from many sources over the duration of very long or repeated interactions. Whereas traumatic stress injuries occur abruptly as a result of one or more specific incidents involving terror or horror, fatigue stress injuries occur gradually due to the wear and tear of smaller stressors over time. Everyone is familiar with the stressors that can contribute to fatigue stress injuries, for they are commonplace in operational and training environments, and everyone is familiar with the early symptoms of fatigue stress, for they are likewise common during extremely busy or highly demanding periods. However, what characterizes a fatigue stress injury is not only the severity of stress symptoms that accompany it, but also the fact that these symptoms may not completely disappear on their own once sources of stress are no longer present. That is what makes fatigue stress a literal injury in some cases — the potential irreversibility of fatigue stress symptoms after the stressful interactions, primarily in the form of persistent clinical depression or anxiety symptoms. That is why the prevention and early recognition of fatigue stress injuries are so crucial for the health and well-being of your persons — and yourself. In contrast to traumatic stress injuries, to which younger persons are often most vulnerable, older persons tend to be more vulnerable to the wear-and-tear damage of fatigue stress injuries.

What to Look For

Successful identification and management of fatigue stress injuries require person leaders to be aware of two possible indicators: (1) stressors that have a high potential for contributing to fatigue stress and (2) the symptoms and behaviors that most commonly accompany fatigue stress injuries.

Stressors that can contribute to fatigue stress

Any and every stress experienced by a person can contribute to fatigue because stress from any cause depletes internal coping resources, both in the brain and mind. However, certain specific stressors seem to be uniquely toxic in their ability to contribute to or worsen fatigue stress injuries. They include:

- Sleep deprivation (less than 6-8 hours per day, every day)
- Deployment to a disaster or crisis environment for more than 6 continuous months
- High injury or casualty rates in the team
- The loss of sustaining friendships in the team due to death or injury
- The loss of sustaining relationships back home due to divorce or breakup
- Unresolved interpersonal conflicts with leaders or peers
- Physical illness or injury
- Unsolvable home front worries, such as relationship, health, or money problems
- Prolonged boredom
- The lack of opportunities for occasional recreation and enjoyment
- Lack of or infrequent breaks and rest periods

Fatigue stress injury symptoms and behaviors:

Fatigue Stress injuries appear gradually, usually over many months, from the depletion of internal biological and psychological resources without sufficient opportunities to replenish these resources. Physical changes in the brain, in its attempt to compensate for depleted resources, produce further symptoms that may persist long after sources of stress are removed. Common fatigue stress injury symptoms and behaviors include:

- Uncharacteristic irritability - having a "short fuse," being frequently sarcastic or mean, or criticizing others for no reason
- Uncharacteristic worrying or fearfulness — becoming fearful and concerned about dangers or potential problems that cannot be controlled, perhaps leading to increased fear and concern in others in the team
- Difficulty falling asleep or staying asleep — lying awake for hours without sleep, even though tired, or waking up tired after only a few hours of sleep and being unable to fall back asleep
- Feeling persistently "keyed up" - inability to relax, calm down, and slow down, even when there is time to do so
- Loss of interest or ability to feel pleasure in activities that used to be enjoyable
- Difficulty concentrating or sustaining mental focus
- Excessive and persistent feelings of guilt, hopelessness, or loss of faith
- Thoughts or impulses to harm oneself, peers, or leaders
- Unsolvable home front worries, such as relationship, health, or money problems

What to Do

The most important leader action for fatigue stress injuries is prevention through keeping operational tours short and ensuring that persons receive adequate sleep, rest, and recreation while deployed. Once persons develop symptoms and behaviors suggesting fatigue stress, appropriate leader actions include: (1) applying psychological first aid, (2) assessing the need for professional care, and (3) mentoring back to full duty and function.

- Enforce sleep – Allow for at least 6-8 hours per day, and longer, if possible.
- Rest - have the person take a break from operational challenges for 24-72 hours, if at all possible.
- Recreate - have the person engage in sports or games with others in the team, if at all possible.
- Ensure that the person is engaging in daily physical exercise, including aerobic endurance training, to help restore depleted resources.
- Reassure the person that his or her symptoms and behaviors will be temporary.
- Keep the person connected with his or her team, if at all possible.

Assess the need for professional care

- Indications for *immediate* professional care include:

- Person cannot get to sleep or stay asleep for at least 6 hours every day.
- Person threatens harm to self or others in the team.
- Person's behavior or speech is confused, irrational, or disorganized.
- Person's anger or fearfulness disrupts team integrity and threatens mission accomplishment

Professional care may be needed *later* if any of the following fatigue stress injury symptoms and behaviors either *worsen* or *fail to improve* after 30 days:

- Inability to get to sleep because of worrying
- Uncharacteristic anger outbursts
- Panic attacks (heart pounding, shortness of breath, and shakiness while at rest)
- Significant and unintended loss or gain of weight
- Difficulties concentrating and focusing thoughts
- Loss of interest in peers, family, friends, and normal activities
- Persistent feelings of hopelessness or guilt

Monitor and mentor back to health and full duty

- Ask the person about the stress injury symptoms listed above, and *listen* to his or her answers.
- If symptoms resolve without professional care, monitor the person carefully for persistent but unreported symptoms.
- If professional evaluation and treatment are indicated, encourage your person to receive and comply with such treatment.
- Do not allow your person to be criticized or punished for having experienced a fatigue stress injury - such injuries are *not* a sign of moral weakness.
- Assign a trusted leader to mentor the person gradually back to full duty.
- Encourage counseling with the team chaplain, if desired by the person.
- Anticipate damage to self-confidence after a fatigue stress injury, and help self-confidence to be regained through gradual but increasing mastery and success.
- Determine fitness for duty based on an ongoing assessment of the risk to the person and other team members of him or her remaining in the team, balanced against the risk to the person and other team members of him or her leaving the team
- Consider reassignment to less risky but still operationally useful duty if return to full combat duties is not feasible.

What to Avoid

- Getting angry with the person (It is natural to feel frustrated with someone who seems not to be coping as well as expected, especially in an operational situation, but expressing anger or frustration *never* helps.)
- Trying to convince a stress-injured person that he or she is fine, that nothing has happened to him or her, or that symptoms can be controlled if he or she tries harder.

- Blaming the person for being "weak" - everyone has his or her breaking point, including you.
- Not giving the person a chance to recover and restore self-confidence by returning to his or her operational duties when able.
- Delaying professional care for fatigue stress injury symptoms or behaviors that are severe or that persist longer than 30 days.
- Not trusting persons to perform just because he or she has had professional treatment for fatigue stress injuries, including possibly medication treatment.

What to Expect after Taking Action

- Most persons who experience a fatigue stress injury will recover if given adequate sleep, rest, and recuperation.
- Most (more than 95%) will remain with the team to complete the operational deployment.
- Many will require no professional medical or mental health help other than psychological first aid and crisis counseling with the team chaplain and support from their peers and leaders.
- Some will require medication to help them sleep or to fight persistent symptoms of depression or anxiety.
- You should be kept informed by treating professionals of the care your persons receive, and of how they respond to treatment.
- Of those few persons who are diagnosed and treated for stress disorders, such as clinical depression or anxiety, more than 90% will remain medically fit for full duty — getting needed treatment very rarely ends careers.
- If you make it okay for persons in your team to ask for help when they need it, more of your persons may ask for help. That is good for your team, your persons, and their families.

Troubleshooting Suggestions for Leaders

A Person you know is having problems but denies it.

Remember that most people are ashamed of having emotional problems of any kind, especially in operational situations in which everyone is stressed. To admit to themselves or anyone else that they need help, stress-injured persons have to believe that asking for help is not an admission of failure or weakness, and that they will be better off in the long run if they ask for help. You can make it more okay for a person with stress problems to admit to them if you disclose stress problems that you, yourself, or that other respected persons have experienced. Remind the person that although there is a small chance that getting help for a stress injury will hurt his or her career or future employability, there is a much greater chance that not getting help when needed will hurt his or her health or safety, as well as the safety of fellow persons. If a person with fatigue stress injury symptoms refuses to talk about them or to consider getting help, honor that decision unless the person’s potential risk to himself or herself or to others requires the person to submit to a mental health evaluation in accordance with DoDD 6490.1.

A Person asks for help, but you think they are faking.

Because stress injury symptoms are invisible, it is certainly possible to fake them in an attempt to get out of trouble or to avoid doing something a person does not want to do. Faking illness or injury for such purposes is malingering, of course – unethical. However, malingering of operational stress problems, such as depression, anxiety, or other fatigue stress symptoms, is exceedingly rare. Most persons who go through the hassle and potential humiliation of reporting stress injury problems truly have them. In cases in which possible malingering of stress injury symptoms is suspected, remember that although a person getting away with deception is an injustice, so also is a person being denied help for a real stress injury. Resist the urge to jump to conclusions, but always refer such persons for an in-depth mental health evaluation. Detailed interviews almost always uncover blatant lying because few malingerers are able to correctly guess all the symptoms they should have experienced, in the right order and in as great detail as they should easily recall if they were telling the truth. When asked enough questions, the consistency of malingerers' stories eventually breaks down. Collateral input from others who knew the person well before the stress injury is also helpful. Then, with all information available, make a judgment based on reason and fact, not suspicion and "gut feeling."

You send a person for help, but you are not sure they are getting the right kind of help.

Although chaplains, counselors, physicians, psychologists, and psychiatrists all have skills to help persons recover from traumatic stress injuries, not all helping professionals are equally trained and experienced in providing such help. There is a great deal about crisis-related stress injuries that has only recently been learned or developed. If one of your persons seeks care from a professional who seems not to be helping as much as expected or desired, you have a few options. First, talk to the helping professional and express your concerns or questions about his or her plan of care. Tell him or her what is desired. Second, if direct liaison with the helping professional does not help, seek help for your person through another of the many available portals of care. Third, contact one of the leaders of a helping professional community or service for further assistance and guidance.

Appendix K. Loss Stress Injuries

Overview

Grief encompasses all changes in mental function and behavior resulting from the loss of someone or something that is deeply cared about. In other responder operations, losses can result from casualties within the team, or from a death or relationship break-up back home. The physical and mental components of grief have, in the past, usually been considered typical responses to losses because they occur in some form in everyone who experiences a significant loss, and significant losses are inevitable in life. However, there is accumulating evidence that the changes in the brain, body, and mind that accompany grief can be virtually identical to those that accompany stress injuries due to trauma or fatigue, and that the long-term health consequences of unhealed grief can be as significant. As with other stress injuries, the wounds of grief can also impair mental functioning in a number of ways that may impact performance during other responder operations, and long- term health. Grief is a stress injury that deserves great respect and care.

What to Look For

Everyone experiences and expresses grief differently. There is no “right way” or “wrong way” to grieve and heal from a loss. However, successful identification and management of grief requires leaders to be aware of two possible indicators: (1) losses that may have a high potential for producing more severe and persistent grief symptoms and behaviors, known as “complicated grief” and (2) the symptoms and behaviors that most commonly accompany grief.

Losses that can lead to complicated grief:

- The death of a close friend or family member
- The death of a valued leader or mentor
- The death of someone with whom the person closely identified
- The death of someone for whom the person felt personally responsible
- A death that is believed to have been preventable
- A particularly violent or gruesome death

Grief symptoms and behaviors:

- Shock and disbelief
- Feeling or acting dazed or as if in a trance
- Temporary loss of control of emotions and behavior (especially anger and aggression)
- Persistent numbness or detachment and withdrawal from others
- Difficulty sleeping
- Persistent feelings of guilt for surviving, or for not preventing the death
- Persistent urges to get revenge (“payback”) for the death
- Recurrent nightmares or frequent painful remembrances about the death
- Loss of interest or ability to feel pleasure in activities that used to be enjoyable

- Difficulty concentrating or sustaining mental focus
- Thoughts or impulses to harm oneself, peers, or leaders

What to Do

Leaders should always keep in mind the fact that deaths or serious injuries in the team affect *everyone* in the team, although persons closest to the lost team member (closest to the center of impact of the loss) will likely be more deeply wounded by the loss. Furthermore, the community impacted by the loss almost always shares typical processes of healing from grief. Grief is a biological and psychological healing process in each individual, but it is also a social healing process within a group of affected individuals; therefore, leaders must attend to the individuals who appear to be the most affected by grief at the same time as they attend to the team as a whole. Leader actions for grief include: (1) applying psychological first aid for individuals, (2) applying psychological first aid for teams,
(3) assessing the need for professional care, and (4) mentoring back to full duty and function.

Individual Actions

- If the person loses control, keep positive physical control of the person until his
  - or her internal controls return.
- Calm, soothe, and support emotionally - be gentle but firm.
- Keep the person occupied and productive, but away from severe operational challenges for at least 24-72 hours, if possible.
- Enforce sleep - at least 6-8 hours per day, and longer, if possible.
- Listen to the person if he or she wishes to talk about the loss.
- Keep the person connected to peers and other leaders.

Team Actions

Team-level interventions after losses are the responsibility of team leadership, at all levels — including team chaplains and medical personnel — with assistance and support of mental health personnel outside the team as needed. The following are OSFA interventions for teams affected by losses:

- Get the team to safety as soon as possible.
- Rest the team for 24-72 hours, if at all possible.
- Encourage discussions in small group After Action Reviews of what happened, why it happened, what will be done to prevent it from happening again (if possible).
- Honor those who have died through memorial services, physical memorials, and other celebrations as appropriate culturally in the context.

Assess the need for professional care

It is unusual for persons to require or ask for professional care because of grief, and most people never seek any assistance for healing from a loss, except from a trusted minister, friend, or family member. Grief normally becomes less troubling over time as the individual mourns the loss. However, the following are indications of grief that is not healing fully, and may benefit from professional care:

- Persistent feelings of intense guilt
- Frequent painful or troubling recollections of the death or the deceased
- Recurrent nightmares about the death that interfere with sleep
- Loss of interest or pleasure in normally enjoyable activities
- Emotional and social withdrawal from friends or family
- Thoughts of suicide or homicide

Monitor and mentor back to health and full duty

- Ask your persons about their reactions to the loss and its meaning for them, then *listen* to their answers.
- Use every opportunity to honor the fallen through physical memorials (for example, by erecting small monuments or naming buildings, fields, or other structures after fallen persons).
- Remember that you are the leader of your persons *for life*; you must continue to mentor them through the healing and readjustment process long after the deployment ends.
- Be alert for inappropriate or excessive self-blame for failing to protect fellow persons from harm.
- Fight guilt and shame by pointing out realistically but compassionately how self-blame may be unfair and unhelpful.
- Watch for delayed signs of grief later on, after the deployment is over.
- If professional evaluation and treatment are indicated, encourage your person to receive and comply with such treatment.
- Do not allow your persons to be criticized or punished for receiving counseling or other treatment – getting help is *not* a sign of moral weakness.
- Encourage counseling with the team chaplain, if desired by the person.

What to Avoid

- Trivializing the loss or its impact on your persons
- Expecting everyone in the team to react the same way to a loss, especially in the middle of an operational deployment, when it is normal for many persons to be emotionally numb to losses, while others will feel grief more acutely
- Blaming any person for the death of another — it is rare for any single individual to bear responsibility for casualties in combat operations, and most casualties cannot be prevented.
- Openly addressing potential criticisms of you, as a leader, for any responsibility you may bear, yourself, for the loss (If there are reasons for your persons to blame you or anyone else in the chain of command for what happened, it is best to address this proactively during confidential After Action Reviews with team members so they know what really happened and why.)
- Not holding memorial services because of operational demands
- Delegating to your team chaplain the entire responsibility for grief leadership in your team; leading your persons through the process of healing from losses is your responsibility, and it cannot be delegated

What to Expect after Taking Action

- Although losses of close comrades are never forgotten, most persons heal quickly and well from grief.
- Very few persons will have long-term mental health problems from unhealed grief.
- The most common problem experienced by persons due to unhealed grief is survivor guilt, which may last a long time.
- Vigorous reinforcement of rules of engagement, the Law of War, and battlefield ethics throughout the chain of command should prevent your persons from acting on their wishes for revenge.

Troubleshooting

A Person you know is having problems but denies it.

Remember that most people are ashamed of having emotional problems of any kind, especially in combat or operational situations in which everyone is stressed. To admit to themselves or anyone else that they need help, stress-injured persons have to believe that asking for help is not an admission of failure or weakness, and that they will be better off in the long run if they ask for help. You can make it more okay for a person with stress problems to admit to him or her if you disclose stress problems that you, yourself, or that other respected persons have experienced. Remind the person that although there is a small chance that getting help for a stress injury will hurt his or her career or future employability, there is a much greater chance that not getting help when needed will hurt his or her health or safety as well as the safety of their fellow persons. If a person with stress injury symptoms refuses to talk about them or to consider getting help, honor that decision unless the person's potential risk to himself or herself or to others requires the person to submit to a mental health evaluation in accordance with DoDD 6490.1.

You send a person for help, but you are not sure they are getting the right kind of help.

Although chaplains, counselors, physicians, psychologists, and psychiatrists all have skills to help persons recover from stress injuries of all kinds, not all helping professionals are equally trained and experienced in identifying such problems and providing help for them. The last time our country was in a sustained conflict, not as much was known about complicated grief and its effects on the body and mind; there is a great deal about caring for operational stress injuries that has only recently been learned or developed. If one of your persons seeks care from a professional who seems not to be helping as much as expected or desired, you have a few options. First, talk to the helping professional and express your concerns or questions about his or her plan of care. Tell the professional what is desired. Second, if direct liaison with the helping professional does not help, seek help for your person through another of the many available portals of care (listed elsewhere in this guide). Third, contact one of the leaders of a helping professional commteamy or service for further assistance and guidance.

Appendix L: Inner Conflict Stress Injuries

Overview

Throughout history, warriors have been confronted with moral and ethical challenges, and modern unconventional and guerilla wars amplify these challenges. Potentially morally injurious experiences in war, such as perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held beliefs and expectations can be deleterious emotionally, socially, psychologically, behaviorally, and spiritually (e.g., Litz et al., 2009). In addition, although violence and killing are prescribed in war and encounters with the grotesque aftermath of battle are timeless and expected aspects of a warrior's experience, the actions, sights, smells, and images of violence and its aftermath may produce considerable lasting distress and inner turmoil comparable to the consequences of direct life threat. Most persons are able to assimilate what they do and see in war because of training and preparation, the warrior culture, the exigencies of various missions, rules of engagement and other contextual demands, the messages and behavior of peers and leaders, and the acceptance (and recognition of sacrifices) by families and the culture at large. However, once redeployed and separated from the responder culture and context (for example, with family or after retirement), some persons may have difficulty accommodating various morally conflicting experiences.

What to Look For

Inner conflict stress injury or “moral injury” requires an act of transgression that contradicts a person's personal or shared expectation about the rules or the code of conduct, either during the event or at some point afterwards. The event can be an act of wrongdoing, failing to prevent serious unethical behavior, witnessing or learning about such an event, or betrayal by trusted others.

If the person feels remorse about various behaviors, he or she will experience guilt; if the person blames himself or herself because of perceived personal inadequacy and flaw, he or she will experience shame. The more time passes without guidance, intervention, and peer and leader feedback, the more persons will be convinced and confident that not only their actions, but they are unforgiveable. In other words, persons will fail to forgive themselves and experience self-condemnation. If the person experiences betrayal, his or her confidence in leaders and mission readiness can be compromised as well.

Orange Zone Signs of Moral injury:

Persons with moral injury will experience distress, such as being haunted by intrusive thoughts and images of the morally injurious experience. Moral injury may also lead to emotional numbing (detachment, disinterest, and difficulty experiencing pleasure). Individuals who have been betrayed may be stuck on anger and disappointment at leaders. Persons who condemn themselves will experience intense guilt and shame.

What to Do

Moral injury requires a sustained plan for secondary aid. Caregivers need to think of ways of helping persons repair and renew. For many persons, repair and renewal require an initial dialogue about the moral transgression(s), its meaning and significance, and the implication for the person moving forward in his or her life. Because of shame, guilt, and the expectation of condemnation and rejection, the person needs to share and disclose what

haunts him or her. Persons need to articulate their thoughts about what the event means about who they are now, their role in the responder, their role in their families, and so forth.

Then, the caregiver needs to help the person think about what might happen if he or she sticks to these judgments, moving forward in his or her life.
Persons need support and guidance to consider an alternative repair and renewal plan over time, which will entail exposure to corrective experience within the responder and outside the responder (for example, with family).
The person needs to increase positive judgments about himself or herself by doing good deeds, and increase positive judgments about the world by seeing others do good deeds. They also need to experience others giving and receiving caring feelings and receiving goodness and care (and love) as well. This counters self-expectations of moral inadequacy and the experience of being tainted by various acts.

Individual Actions

- Provide nonjudgmental presence when a person is talking about moral transgressions and the personal meaning and significance.
- Resist inserting your beliefs into the dialog.
- Calm, soothe, and support emotionally - be gentle but firm.
- Ask how the person's experiences have changed his or her beliefs about himself or
- herself and what is meaningful in his or her life.

Team Actions

Team-level interventions are the responsibility of team leadership at all levels - including team chaplains and medical personnel - with assistance and support of mental health personnel outside the team as needed. In the case of moral injury, persons need support and mentoring. They need to be provided experience that will counteract their experience of self-condemnation and shame. Ostensibly, leaders need to help the person accept their transgression (not deny it) and reclaim good feelings about themselves as competent and confident decision makers and team members. Leaders also need to promote self-care, leisure activities, and positive connections.

Assess the need for professional care

It is unusual for persons to require or ask for professional care and most people never seek any assistance for healing from a moral transgression. The trajectory of moral injury is unknown. Clinical work with veterans diagnosed with PTSD indicates that the moral injury components associated with shame and guilt may persist for years. However, the following are indications of Red Zone moral injury that may require professional care:

- *Self-harming behaviors*, such as poor self-care, alcohol and drug abuse, severe recklessness, and para-suicidal behavior
- *Self-handicapping behaviors*, such as retreating in the face of success or good feelings and undermining efforts by others to help
- *Demoralization*, which may entail confusion, bewilderment, futility, hopelessness, and self-loathing

Monitor and mentor back to health and full duty

- Ask your persons about their reactions to the events associated with the moral injury and its meaning for them, then listen to their answers.

- Mitigate unrealistic guilt and shame in individuals when external factors significantly contributed to the troubling events.
- Support members where guilt and shame are realistic, and help them work through the loss of connectedness, competence, and confidence that occurs with moral injury.

What to Avoid

- Trivializing the event or its impact on your persons
- Blaming any person for the moral transgression associated with vague rules of engagement, confusing stimuli, or extreme fatigue (It is rare for any single individual to bear responsibility for adverse outcomes during inherently dangerous operations.)

What to Expect after Taking Action

- Painful life lessons are never forgotten; however, members should be able to develop a redefined meaning in life and begin to incorporate the experience into a positive worldview.
- Look for signs where the person uses the moral transgression experience to mentor and teach others.
    - Watch for signs of self-handicapping behavior or the member being shunned by the team. Sometimes the member can begin to work through the moral transgression while members of the team are trying to reconcile their own roles and expectations around the events.

Troubleshooting

A person you know is having problems but denies it.

Remember that most people are ashamed of having emotional problems of any kind, especially in crisis or operational situations in which everyone is stressed. To admit to themselves or anyone else that they need help, stress-injured persons have to believe that asking for help is not an admission of failure or weakness, and that they will be better off in the long run if they ask for help. You can make it more okay for a person with stress problems to admit to him or her if you disclose stress problems that you, yourself, or that other respected persons have experienced. Remind the person that although there is a small chance that getting help for a stress injury will hurt his or her career or future employability, there is a much greater chance that not getting help when needed will hurt his or her health or safety as well as the safety of fellow persons. If a person with stress injury symptoms refuses to talk about them or to consider getting help, honor that decision unless the person's potential risk to himself or herself, or to others requires the person to submit to an appropriate mental health evaluation.

Appendix M: Group-Administered OSFA

The model for applying OSFA in a group setting draws from a number of bodies of literature and expert opinion on group application of therapeutic principles, including the evidence for group psychotherapy in general, the principles of change that have been distilled from group studies, the trauma-focused and bereavement-focused group therapy literature, and the study of early group interventions after traumatic stress.

The current literature on group psychotherapy provides consistent evidence that, regardless of the type, this modality is associated with favorable outcomes across a number of symptoms (Foy et al, 2000). Although the data for group treatments initially appear promising, no single treatment emerges as the obvious choice. Very few studies have compared two or more active treatments, and those that do fail to find compelling differences. Additionally, a number of methodological issues have been noted, including random assignment of participants, assurance of adequate statistical power, and use of standardized manuals. Group psychotherapy typically lasts ten to fifteen weekly sessions, numerous exclusion criteria govern group constitution, and most studies have been conducted with female survivors of childhood or adult sexual abuse. Very few published reports include male survivors. The best controlled study to date using male participants was the VA cooperative study with Vietnam veterans (Schnurr et al, 2003), which found that a trauma-focused group treatment (including psycho-education about PTSD, coping and relapse prevention skills, personal autobiography, prolonged exposure, cognitive restructuring, and group cohesion) did not perform better than a present-centered group treatment that avoided trauma focus, cognitive restructuring, and other trauma-focused group treatment elements. While both treatments decreased PTSD symptoms, it is not clear what the active mechanism for change was.

General “active ingredients” in groups that produce change have been identified as: a) carefully structuring the tasks and activities of the group (that is, groups with early structure are more cohesive and have increased levels of helpful self-disclosure) and b) facilitating member-to-member interactions within the group (that is, positive feedback should be emphasized, and corrective feedback is most helpful when it is focused on specific and observable behaviors) (Davies, Burlingame & Layne, 2006).

In contrast to this long-term approach to group psychotherapy, over the last few decades, group intervention for the prevention and treatment of acute initial stress reactions has focused primarily on group debriefing models, such as Critical Incident Stress Debriefing (CISD), a structured group model designed to explore facts, thoughts, reactions, and coping strategies following trauma. Experts have completed a number of reviews on CISD but not one has yielded any evidence that CISD prevents long-term negative outcomes.

While civilian and military contexts are different, three recent randomized controlled trials (RCTs) also reported a lack of positive findings for debriefing interventions. In a large-scale RCT of a group debriefing intervention with active duty personnel, Adler et al., 2008 found no differences among Army personnel in CISD, stress education, and survey-only conditions on any behavioral health outcome, including PTSD, depression, general wellbeing, aggressive behavior, marital satisfaction, perceived organizational support, and morale. Findings included the following: heart rate and blood pressure readings before and after the sessions did not indicate a change in physiological stress; subjective ratings of distress did not change from pre- to post-session; soldiers rated their satisfaction with CISD

as high; and behavioral health outcomes at follow-up did not worsen as a result of CISD.

It is possible that future research will demonstrate that CISD may be useful under some conditions, or has subtle positive effects, such as perceived social support. Raphael, in a recent review of early interventions for civilians, recommends an intervention rationale that promotes safety and security, provision of information about the event or about coping principles, sharing of experience about what has happened, providing support for one another, practice of coping actions to prevent longer-term problems, problem solving, and determining future actions (Raphael et al, 2006). In research on educational groups to build resilience, the educational approach most likely to result in behavior change was designed to tailor the information to the individual's specific situation as well as offering for practice and mastery (Beardslee et al., 1999).

Potential difficulties with the group format should always be considered before making the decision to implement group OSFA, so as to reduce potential harm. These difficulties center around providing the right balance between the needs of individual members and the needs of the group as a whole, as there will be significantly less individualization, and less attention given to individuals generally. Potential risks of *any* group-delivered early intervention include:

1. Retraumatization through exposure to other participant's experiences. Some members may dominate with a "forceful drive" to either express their experience or to prove the superiority of their coping strategies. Some affected persons may be so acutely distressed that they are unable to tolerate or benefit from group interventions and should not be expected to participate in the early phases.
2. Inappropriate timing in terms of reactive trajectory of participants so that natural healthy denial is challenged or grief is pathologized. Some people rely strongly on denial in the initial phase, and their coping styles make them both unwilling to accept either individual or group intervention, or to benefit form them. It may be inappropriate to challenge these strategies. The group may split or scapegoat members, or may not be sensitive to the different needs or timelines of recovery of participants. There may be a subtle pressure to disclose what is distressing to members who are either highly distressed or withdrawn.
3. Creation of expectations of pathological outcomes. Many group protocols make the mistake of providing lists of possible reactions in order to prepare individuals for what may seem like alarming reactions. However, they fail to provide possible neutral or positive reactions to balance out expectations of what to expect, thereby inadvertently priming participants to expect primarily negative reactions.
4. Leading people to believe that the group is all that will be required to deal with their experience, so that individuals do not seek further care.
5. Inappropriate application in settings where physical survival is a greater priority.
6. In situations of loss, worse outcomes associated with group interventions. Schut, et al (2001) found that participation in bereavement groups tended to worsen outcomes, and hypothesized that this may be because they interfere with resolution of grief, or focus the person on ruminating about his or her grief experience.
7. Finally, that the group application may be very stressful for the leader early on after a highly stressful incident.

Raphael (2006) suggests that, to alleviate some of these potential risks, early intervention groups should provide structure, tasks, and information as well as focus on strengths, have clear goals, provide mutual support, and plan actions to address needs.

Using OSFA In a Group Format

If the potential negative effects or early group intervention are addressed as described above, there are several potential benefits of delivering OSFA in a group setting (see table below). First, providing information about different OSFA actions after a critical event is more efficient in a group format. When individual OSFA is difficult to deliver (for example, due to large numbers of affected persons, lack of availability of mental health providers, or cost-constraints), groups provide a potentially cost- and resource-effective way of serving persons. Second, social support is an important aspect of coping with operational stress, and a group provides a practical setting in which to ask for and give mutual support. Some may believe they are alone in their experiences, and meeting and sharing stories with others can reduce feelings of isolation. Third, a group setting provides a helpful way for participants to learn about the way others deal with similar situations. For example, input from other group members may assist an individual in challenging common distressing thoughts. Groups can be especially effective in "normalizing" the experience of the person, in that other persons are seen to be coping with similar difficulties. Group-administered OSFA should ideally differ from After Action Reviews in that it provides education about the OSFA principles as well as a forum for participants to share support and ideas for coping. This type of group is likely to lead to longer-term patterns of mutual support.

Potential Advantages of OSFA Offered in Group Format	**Potential Disadvantages of OSFA in Group Format**	**OSFA Group Adaptations to Address Potential Disadvantages**

▪ A group format gives an opportunity to provide accurate and timely information regarding the nature of the unfolding situation.
▪ Groups provide a potentially cost- and resource-effective way of serving persons.
▪ A group provides a practical setting in which to ask for and give mutual support, and sharing coping stories with others can reduce feelings of isolation.
▪ A group setting provides a helpful way for participants to learn about the way others deal with similar situations.
▪ Groups can be especially effective in "normalizing" the experience of the person, in that other persons are seen to be coping with similar difficulties.
▪ A OSFA group can offer an efficient way to provide information to help survivors:
  ▪ Better understand a range of OZ reactions.
  ▪ View their OZ reactions as expectable and understandable.
  ▪ Increase use of social supports and other adaptive ways of coping.
	▪ Offering a group shortly after a critical incident is an inappropriate application in settings where physical survival is a greater priority.
	▪ Operational tempo may not make groups feasible or necessary after every critical incident if they are happening frequently.
	▪ Focusing on emotional processing during immediate period may increase arousal, which is associated with long-term negative outcomes.
	▪ Distress can result from exposure to other participants' experiences.
	▪ Discussion of potential negative effects of the event can create expectations of pathological outcomes.
	▪ Offering a group after a critical incident can lead people to believe that:
	  □ Their own strategies are not enough to handle the event.
	  □ The group is all that will be required to deal with their experience, so that they do not seek further care.
	▪ In situations of loss, worse outcomes have been associated with group interventions. (i.e., they may interfere with resolution of grief, or
		▪ Early after critical incidents, offer only impromptu informational sessions and After Action Reviews, whereas more structured educational groups should be offered only when practical and possible.
		▪ Do not focus on processing of thoughts or reactions related to the events, but rather provide education about the OSFA principles as well as a forum for participants to share support and ideas for coping.
		▪ Rather than just providing lists of possible symptoms, which runs the risk of implanting expectations of pathology and dysfunction, instead offer constructive information that proactively encourages an expectation of resilience and, if necessary, help-seeking.
		▪ Have clear goals.
		▪ Tailor group actions to address specific group members' needs, while not in any way making participants feel that they need to share their experiences.
		▪ Carefully structure the tasks and activities of the group to focus on promoting helpful coping strategies.

Potential Advantages of OSFA Offered in Group Format	**Potential Disadvantages of OSFA in Group Format**	**OSFA Group Adaptations to Address Potential Disadvantages**
▪ Decrease use of problematic forms of coping. ▪ Recognize the circumstances under which they should consider seeking further help. ▪ Know how and where to access additional help.	focus the person on ruminating about his or her grief experience). ▪ A group may be very stressful for the leader early on after a highly stressful incident.	▪ Focus on team members' strengths. ▪ Facilitate member-to-member feedback within the group so that it is focused on positive coping strategies and mutual support, rather than sharing of complaints or exposure to stressors. ▪ Offer opportunities for practice and mastery of positive coping strategies. ▪ Make group as homogeneous as possible (i.e., in terms of exposure type, other stressors that impact reactions, or timeline of recovery).

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Appendix N: Applying the Connect Action

You can help your fellow persons cope with operational stress by spending time with them and listening carefully and persistently. Most people recover better when they feel connected to others who care about them. Some people choose not to talk about their experiences very much, and others may need to discuss their experiences. For some, talking about things that happened can help those things seem less overwhelming. For others, just spending time with people one feels close to and accepted by, without having to talk, can feel best. Here is some information about giving social support to other people.

Reasons Why People May Avoid Social Support

- Not knowing what they need
- Feeling embarrassed or "weak"
- Feeling they will lose control
- Not wanting to burden others
- Doubting it will be helpful or that others won't understand
- Having tried to get help and felt that it was not there before
- Wanting to avoid thinking or feeling about the event
- Feeling that others will be disappointed or judgmental
- Not knowing where to get help

Good Things to Do When Giving Support

- Show interest, attention, and care.
- Find an uninterrupted time and place to talk.
- Be free of expectations or judgments.
- Show respect for individuals' reactions and ways of coping.
- Acknowledge that this type of stress can take time to resolve.
- Help brainstorm positive ways to deal with their reactions.
- Talk about expectable reactions to traumatic stress, and healthy coping.
- Believe that the person is capable of recovery.
- Offer to talk or spend time together as many times as is needed.

Things That Interfere with Giving Support

- Rushing to tell someone that he/she will be okay or that they should just "get over it"
- Discussing your own personal experiences without listening to the other person's story
- Stopping the person from talking about what is bothering them
- Acting like someone is weak or exaggerating because he or she is not coping as well as you are
- Giving advice without listening to the person's concerns or asking the person what works for him or her
- Telling them they were lucky it was not worse

Appendix N

When Your Support is Not Enough

- Let the person know that experts think that avoidance and withdrawal are likely to increase distress, and social support helps recovery.
- Encourage the person to get involved in a support group with others who have similar experiences.
- Encourage the person to talk with a counselor, clergy, or medical professional, and offer to accompany them.
- Enlist help from others in your social circle so that you all take part in supporting the person.

Listening Skills	**Examples**
Reflective comments:	• "From what you are saying, I can see how you would be…" • "It sounds like you're saying…" • "It seems that you are…"
Clarifying comments:	• "Tell me if I'm wrong. It sounds like you…" • "Am I right when I say that you…"
Supportive comments:	• "It sounds really hard…" • "It sounds like you're being hard on yourself…" • "It is such a tough thing to go through something like this." • "I'm really sorry this is such a tough time for you." • "We can talk more tomorrow if you'd like…" • "No wonder you feel…"
Empowering Comments and Questions:	• "You are a strong person and have been through a lot. What have you done in the past to make things better when life got difficult?" • "I have an information sheet with some ideas about how to deal with difficult situations. Maybe there is an idea or two here that might be helpful for you." • "People can be very different in what helps them to feel better. When things get difficult, for me, it has helped me to… Do you think something like that would work for you?"

Appendix O: Changing Perspective to Build Confidence

After operational stress, a person's view of the world and himself or herself may change. For example, persons may see the world as more dangerous, have difficulty trusting other people, or see themselves as less able to cope. It is not uncommon to develop frequent thoughts related to guilt, fear, and anger. Many are temporary and only require a caring person to shift their focus. However, there may be opportunities for caregivers to help persons change their perspective in a way that helps them to gain insight, reduce distress, and move forward more effectively.

Caregivers can help persons change their perspective about the things that happen to them in the following ways:

1. Help them understand how thoughts influence their emotions by comparing how their current thought affects their emotions versus how a new, more positive thought affects their emotions (use examples from table below).
2. Guide the person to consider replacing these appraisals with a different perspective (which leads to new emotions).
3. Suggest that they try to think about things differently for a while and see how it affects them. Check back in with them later if possible to see how they did.

Below is a table outlining some of the more common unhelpful appraisals that can lead to distress. The table also includes some examples of alternative appraisals that can lead to less distress.

Emotion	Unhelpful Thoughts	Helpful Thoughts
Guilt	• I was a coward. • Because of me, other people died. • I should have gotten over this by now.	• Your actions kept you from further injury. • Many factors beyond your control resulted in the deaths that occurred. • It takes time get through something like this. • Many other survivors are at the same place that you are right now. • How could you have done it differently and still helped achieve the mission? • This contributed to your learning a valuable lesson that you can use in the future. • At the time, you did the best you could. • "If this had happened to your team/family member, what would you say to him/her?"

Emotion	Unhelpful Thoughts	Helpful Thoughts
Fear	I was helpless then; I won't be able to cope with future events either. • It's unacceptable to experience fear. The world is extremely dangerous. • I must constantly be on guard protect myself and my friends.	• You felt helpless, and your actions saved your life… and it appears that you continue to help yourself. • Fear is natural and helped you to survive. Gradually you can ease out of it when the time is right. • You feel it is important to protect your buddies – that is admirable, and it can also add to your fear because you feel the need to watch out for many people. • You don't always have to be on guard.
Anger	• Other people can't be trusted. • If the proper measures were in place, this wouldn't have happened.	Anger can often be shaped by many factors, including fear, sadness, bereavement, suffering of others, and revenge. • It sounds like you feel let down. There are people who can/will help you and there are people who can't or won't. • It sounds like you feel angry that the leaders weren't able to prevent this. Perhaps you are wondering what you could do to see that it doesn't happen again. Can you see how blaming people might keep you stuck and unable to move on? Perhaps if you find a way to let go of this blame, you might be able to plan for your future better.

Appendix P: Calming and Focusing Techniques

Deep Breathing

Taking control of your breathing is a good way to calm yourself down and restore your focus. This is one reason that breathing is stressed in martial arts; it creates a body-mind connection. This connection can help you control how well your body receives oxygen, help you reduce stress, and increase your self-awareness. Once you get your mind and body in tune with one another, you'll be able to better control your breathing. By controlling your breathing, you'll gain better control over your body, including its emotional reactions.

Prepare:

- Make sure you are in a safe, quiet place and a comfortable position, preferably either sitting or lying, if possible.
- Close your eyes and place one hand on your belly.
- Turn your attention to your breath. If other thoughts come to your mind, do not fight them. Just notice that they are there and return your attention to your breath.

Do:

- Inhale slowly and deeply into the bottom of your lungs, so that your belly rises with the breath.
- Breathe in for a count of 4, hold it for a count of 2, and exhale slowly for a count of 4
- Let tension leave your body each time you exhale.

Check and Repeat:

- Repeat for 5-10 minutes.
- Check in with yourself; if you are still feeling keyed up, repeat the deep breathing until you are feeling calmer and more relaxed.

Grounding

Responder training and operations can be very intense at times, and may stir up strong feelings that may detract from your ability to focus on your duties. Letting yourself experience strong feelings at the right time is good, such as when it is safe and you are with people you trust. At other times, however, you may need to maintain control over your emotions and thoughts to focus on the task at hand. The following strategies can be used when you need to put your feelings aside and restore your focus.

Prepare:

- Make sure you are in a safe place, if possible.
- Keep your eyes open as you prepare to turn your attention from your inner world of distress to the calmer outside world.

Do:

- Look around you and see that you are safe – that there are no immediate threats to your life or safety.
- Notice that the thoughts and feelings you have had that have made you feel unsafe do not belong where you are now.
- Now try to imagine putting a barrier between you and all of your unsafe feelings by wadding them up, stuffing them into a container, and sealing it.

Appendix P

- Next, imagine the container of your unsafe feelings has been placed behind a thick concrete barricade far away from you.
- Now look around the place where you are, and name as many objects and colors as you can, one by one.
- Notice and name what is in front of you, to your left, to your right, behind you, above you, and beneath you.
- If you see any printed words, read them, and them name each letter backward.
- Now focus your thoughts on naming things you are interested in (such as sports teams, types of dogs, the names of entertainers or athletes, or TV shows).
- Count slowly forwards (1-10) or backwards (10-1).
- Notice the pressure of your body on the ground or floor.
- Stretch and take a deep breath.

Check and Repeat:

- Check in with yourself, and if you are still feeling unsafe or your thoughts are unclear and unfocused, repeat these exercises.

Other Strategies

Cognitive functional impairments can occur with sudden or overwhelming stress. When you turn anxiety and dread inward, it can result in impaired decision-making or situational awareness, Engaging in a focused task can be used as a calming technique. An example of this technique is when a person is assisting another team member. If the person remains focused on having a job to do to continue the work, he or she will be distracted from the stress and will have an impact on sense of self-efficacy/competence. The following strategies can be used when you need to help someone put his or her feelings aside and restore focus.

Prepare:

- Make sure you are in a safe place, if possible.
- Instruct the person to keep his or her eyes open, then instruct them to turn attention
- from his or her inner world of distress to the outside world.
- Get the person's attention and check if he or she can focus on you or hear your voice.
- Assess his or her physical capabilities.

Do:

- Instruct the person to provide assistance with a task at hand that is congruent with the situation. For example:
    - Maintain situational awareness to protect team members.
    - Hold instruments or tools that are relevant to the task.
    - Provide direct assistance to the helper (for example, "I need you to help me…").
    - Ask them to tell you what work elements/tasks need immediate attention.

Check and Repeat:

Check to see if the person is able to focus on the task, and use deep breathing in conjunction with the focused task to help improve his or her focus, if needed.

Appendix Q: Comparing Burnout, Empathy Fatigue, and Compassion Fatigue[1]

Burnout

Burnout is the most obvious reaction to long-term stress. Burnout is emotional, mental, and physical exhaustion that occurs when several events in succession or combination impose a high degree of stress on an individual. Burnout could happen to the healthiest of pastoral caregivers.

Contributing factors in caregiver burnout include:

- Professional isolation
- Tasks
- Deadlines
- Expectations
- Emotional and physical exhaustion of providing continual empathy
- Ambiguous results
- Erosion of idealism
- Lack of expected results or rewards
- Feeling obligated instead of called
- Maintaining an unrealistic pace
- Unrealistic personal expectations
- Poor physical condition
- Continuous correction or rejection
- Human finitude

Symptoms of burnout include:

- Isolation
- Emotional and physical exhaustion
- Depersonalization
- Reduced vocational productivity
- Reduced personal accomplishment
- Lack of confidence or self-esteem
- Changes in beliefs, values, and view of workplace or world
- Depression
- Apathy
- Pessimism
- Indifference
- Helplessness or hopelessness
- Irritability
- Cynicism
- Short temper
- Negative attitudes

Self care for burnout

[1] Naomi Paget, *Stress Management for Disaster Relief Chaplains*, (Bellville, TX: Crisis Plumbline, 2008).

- Delegate
- Negotiate
- Redefine success
- Set personal boundaries
- Create margin
- Make changes in your life

Burnout *is too much to do, too little time, insufficient resources, lack of validation, unrealistic expectations, and cumulative physical and emotional distress.*

Empathy Fatigue

Empathy fatigue is emotional and physical fatigue resulting from empathizing with other people's pain, grief, anxiety, anger, and other strong emotions over an extended period of time.

The experience of empathy fatigue results from a state of psychological, emotional, spiritual, and cognitive exhaustion that occurs as the listener continually experiences their clients' crisis experiences through stories of trauma, grief, moral failure, and wear and tear. Empathy fatigue, burnout, and compassion fatigue are natural products of working in "high touch," stressful professions. Empathy is a special skill developed by chaplains, counselors, peer support personnel and others who support people impacted by disaster and crisis through listening and psychological first aid. Intense, compassionate listening and getting in touch with the wounds of those they serve, these compassionate, empathetic listeners become deeply involved in the experiences of the client. The skill that makes them competent as listeners also demands a great price. The caregiver sometimes becomes wounded, too. How does the wounded care for the wounded?

- Typical causes
    - Non-compartmentalized compassionate care
    - "Owning" other people's problems/issues/concerns
    - Over identifying with other people's distress
- Typical reactions and symptoms
    - Emotional exhaustion
    - Over-personalization
    - Reduced compassionate attitude
    - Reduced personal ministry satisfaction
    - Lack of ministry confidence or self-esteem
    - Changes in beliefs, values, and view of workplace or world
- Self care for empathy fatigue
    - Systematic, strategic, intentional breaks, rest, restoration periods
    - Set personal boundaries
    - Redefine ministry expectations

Compassion Fatigue

Compassion fatigue results when caregivers experience a trauma event through listening to the story of the event or experience the reactions to the trauma through empathetic contact with victims or survivors, and are unable to distance themselves from the event. Compassion fatigue is trauma-specific and the symptoms are similar to posttraumatic stress syndrome (PTSD).

Charles Figley identified compassion fatigue as a secondary form of post traumatic stress in *Compassion Fatigue*. It is the costly result of providing care to those suffering from the consequences of traumatic events. Professionals especially vulnerable to compassion fatigue include pastoral caregivers and other helping professionals – emergency services personnel, mental health

professionals and counselors, medical professionals, clergy, victim advocates and assistants, and human services personnel

Signs and symptoms of compassion fatigue

Compassion fatigue is preoccupation with the victim or cumulative trauma of victims, emotionally re-experiencing the traumatic event, and persistent arousal. Those suffering the effects of compassion fatigue absorb the trauma through the eyes and ears of the victims to whom they provide ministry – they become vicariously traumatized as though it was a personal experience.

Some indicators of compassion fatigue include:

- Nightmares, dreams, or disturbing memories of the critical incident
- Intrusive memories
- Emotional numbing
- Feelings of despair and hopelessness
- Feelings of isolation, detachment, estrangement
- Disconnection from loved ones, social withdrawal
- Increased sensitivity to violence
- Avoidance of thoughts and activities associated with the incident
- Increased and persistent cognitive dysfunction – difficulty concentrating
- Avoidance or distancing
- Stress arousal Insomnia
- Headaches
- Increased susceptibility to illness

Self care for compassion fatigue

- Catharsis
- Self awareness
- Clarifying options
- Reframing circumstances or situations
- Intercession
- Relaxation techniques
- Pastoral counsel, therapeutic

In the final analysis, there is a cost associated with compassion fatigue – performance declines, mistakes increase, morale drops, health deteriorates, and personal relationships are at risk. The cost is more than physical; it is emotional, cognitive, social, and spiritual.

Compassion fatigue is the costly result of providing care to those suffering from the consequences of traumatic events. Caregivers are especially vulnerable to compassion fatigue.

Countertransference

Pastoral caregivers in disasters are emotionally involved with many hurting people. Emotional involvement comes from the very nature of being *present* to victims, relief workers, and survivors. Empathetic listening and compassion create the environment that causes pastoral caregivers to vicariously share the
trauma of disaster victims. Suffering on behalf of another person causes the pastoral caregiver to return to a place of hurt and disappointment—perhaps even severe trauma—in his own life. When countertransference occurs, the pastoral caregiver becomes a victim, needing the same post critical incident interventions as the primary victims.

Experiencing the same sights and sounds of a previous critical incident may cause countertransference. Some similarities that result in countertransference include:

- Past experience – The *traumatic* event causes the new crisis. Pastoral caregivers must be aware of their own history and experience. Those who have experienced similar critical events or trauma will be more likely to relive his or her previous experience through the current critical event.
- Personal Identification – The *similarities between the victim and the pastoral caregiver* cause the new crisis. Personal identification may be a *plus* for the victim as he or she seeks safety and security (trust), but that same personal identification may be a *minus* for the pastoral caregiver who becomes overly identified with the victim's crisis. Personal identification may result from a perceived relationship due to ethnic heritage, gender, profession, language, or nationality.
- Physical Fatigue – When pastoral caregivers are physically exhausted or *out of shape,* they are unable to cognitively function at their highest levels. They tire easily, have a low resistance to excessive emotional involvement, and have difficulty separating the victim's experience from their own past and present experiences. Consequently, empathy grows and personal identification becomes more intensified, resulting in countertransference.

Changes in Values and Beliefs

One of the chief characteristics of a critical incident—disaster—is the inevitable *change* it causes. Some changes are very temporary and victims return to pre-incident levels of functioning within a *normal* time frame. However, when pastoral caregivers are subjected to long-term stress and their reactions of burnout, countertransference, and mental and physical exhaustion, they often experience changes in their values and beliefs. That which was held as *sacred* has been desecrated. Reality has been changed and perspectives have been changed. They may experience doubt and uncertainty regarding physical survival—this was an expectation pre-critical incident. They may become fearful about their safety and security—this was a non-issue prior to the trauma. They may become less trustful of people, institutions, God. The long-term exposure to critical incidents and the resulting stress may cause the pastoral caregiver to drastically redefine his values and beliefs based on a single event rather than the implications of his entire experience.

Burnout	Empathy Fatigue	Compassion Fatigue
Emotional and physical fatigue	Emotional fatigue	Emotional exhaustion
Many tasks, deadlines	Many distressful encounters	One acute traumatic event
Extended period of time	Extended period of time	One specific moment in time
Cumulative	Cumulative	Acute
Unspecific source	Unspecific source	One specific traumatic event
Direct impact to the caregiver	Direct impact to the caregiver	Secondary impact to the caregiver – vicarious trauma

Appendix R: Overview of the Trauma Response[1]

The Nature of Stress[i]

Hans Selye, the "father" of stress research, defined stress as "the non-specific response of the body to any demand made upon it."[ii] *Stress* is a response to circumstances, not necessarily a negative experience. In danger, stress causes certain physiological changes in one's body that prepares it for *fight or flight*. *Eustress* is "good stress." *Eustress* enables one to perform at peak ability or exceed normal capacities. *Distress* is the destructive side of stress, a stress reaction that is prolonged or excessive. *Distress* can cause harm.

> Distress is nothing new—poverty, disease, and war have always led to fear, uncertainty, vigilance, and frustration. But today, even those of us who are neither poor, sick, nor in imminent danger of war are suffering stress from an unprecedented number of sources. Stress is a response to change, and we are experiencing change at faster and faster rates. Debt, hurry, and complexity cause stress. Rapidly changing job markets make us feel insecure even when we're employed. Mobility and divorce separate us from supportive relationships that would absorb distress. Study after study confirms that a healthy marriage, family, or community support structure yields better health and increased longevity. Yet the very stressors for which we need support often put intolerable pressure on those relationships.[iii]

Eustress causes one to make positive changes in one's lifestyle while distress is destructive to one's health, emotions, and relationships. Jeffrey Mitchell says, "You will probably die from a stress-related disease if you are not involved in an accident . . . . Life without stress is impossible."[iv]

One or two stressors usually do not cause a major stress response; however, a "pileup effect" occurs when there is a lack of margin in one's life and multiple stressors are introduced. When a major distressing event occurs and there is no margin available, the event is called a critical incident—an event that overwhelms a person's usual coping mechanisms. Disaster relief is ministry to people experiencing critical incident stress (from major disasters).

The Internal Trauma Response

Most people live in a reasonably balanced state of equilibrium—physically, emotionally, mentally, and socially. When they are exposed to a critical event, these people must quickly adapt to new levels of equilibrium or their distress will remain greater than their eustress.

The physical response to trauma[v] is a complicated physiological interaction between the body and the mind. Basically, when the brain receives the trauma information through one of the five senses, it quickly processes the information and interprets its significance based on historical evidence (memories of previous events), logic, and predictions. If the information

[1] *Disaster Relief Chaplain Training Manual*, North American Mission Board: Alpharetta, 2008, pp 26-31.

is processed as a threat, challenge, or significant change, a physiological stress reaction begins. This reaction prepares the entire body to deal with the threat (trauma, stress).[vi]

> When faced with a sudden, uncontrollable, extremely negative event, a person is fearful and seeks to protect himself from danger. This "fight or flight" response observed in humans and animals facing danger (Lorenz, 1966) is characterized by high levels of physiological and behavioral arousal. In humans, high levels of cognitive and affective arousal have also been observed. High arousal when facing danger seems to be an unlearned, preparatory response of the body and the mind to danger. In other words, when you experience loss of control over your safety, your body and mind automatically go on "red alert" in an attempt to regain control. The "red alert" status might involve being hyperalert or hypervigilant to your surroundings and having an increase in physiological arousal to allow for flight or defense.[vii]

Typically, adrenaline pumps through the body in a lifesaving response, preparing the body to fight the danger actively or run away from the threat. Breathing, heart rate, and blood pressure increase to provide more oxygen to the body; pupils dilate to take in more light and increase visual acuity; sensory perceptions increase; the body may relieve itself of excess materials through regurgitation, defecation, or urination to facilitate fight or flight; muscles tighten; and the liver produces ten times more blood glucose (the fuel for muscles). All of these responses are healthy, normal responses to preserve life.

Selye called the flight or flight response the general adaptation syndrome. The body does not distinguish between "good" stressors or "bad" stressors. An extremely happy event could cause the same response as a life-threatening event (e.g., seeing the birth of a child may cause a happy father to faint). However, recent research does indicate that different chemicals and enzymes are released into the bloodstream as a result of anger versus joy.

The mental response to trauma parallels the physical response. The initial cognitive response is shock, disbelief, and denial. When cognitive function temporarily stops, the victim may experience regression to a childlike state or infancy (emotions become dominant). After the physical danger has ebbed, a logical order of emotional reactions is manifested—fear and terror; anger, fury, and outrage; confusion and frustration; guilt or self-blame; shame or humiliation; grief or sorrow.[viii]

In a crisis event, trauma causes the cognitive functioning of the brain to become secondary, and there is a heightened state of emotional arousal. Victims are overwhelmed with the event and cannot make normal, logical, or rational decisions. They may seem "lost" or "in shock." Common distress signals or "symptoms of stress" may include the following: profuse sweating, nausea, shakes, difficulties making decisions, generalized mental confusion, disorientation (to person, place, time), seriously slowed thinking, denial, feeling hopeless, wishing to hide, withdrawal, excessive humor or silence, change in communications. Some symptoms require immediate medical attention (e.g., chest pain, excessive blood pressure, signs of severe shock, difficulty breathing). However, most symptoms are typical and normal reactions to an extraordinary event. Most people live in world in which they balance their physical, emotional, cognitive, social, and spiritual lives. The balance is dynamic in nature. Influenced by circumstances and daily events, each aspect of their nature is called into priority. During a critical incident—a disaster or other traumatic event—a person's usual coping mechanism fails and signs or symptoms of distress, dysfunction, or impairment become evident.

Critical incidents are constantly occurring. However, unless they are perceived as threatening, the human response is not a trauma response—not a response that is markedly distressing. During disasters, however, most people interpret the event as a critical incident.

Biological Factors – Physical Response

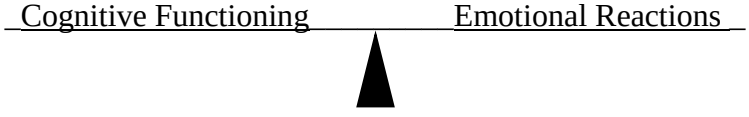
After a shock to the system, the body's response is biologically visible. Generally, there is physical shock, disorientation, and numbness. In the 1930's Walter Cannon described this response as the "fight or flight" response. When faced with overwhelming danger, the body instinctively prepares to *fight* against the danger or to *flee* from the threat. In order to *fight or flight,* adrenaline begins to course through the body, giving it energy and ability beyond its normal capabilities. The body relieves itself of excess fluids and material to facilitate increased action. The heart rate increases the flow of oxygen to the muscles and the body begins to cool itself down for work by sweating or hyperventilating. Self preservation dictates that sensory perception must increase and the senses become acute. This physiological response is an emergency lifesaving response.

Symptomatic of this shock to the body and the need to *fight or* flight is the decrease of mental efficiency. Cognitive functioning decreases as the body prepares to "react emotionally" rather than "respond intellectually." The victim is less able to concentrate, experiences short-term memory deficiencies, becomes mentally inflexible, and confused.

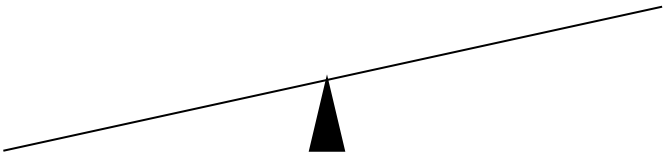
The alarm causes hyperarousal. People are known to physically accomplish feats which would not normally be possible—lift a car off a child, run miles without stopping. But hyperarousal cannot be sustained indefinitely. Hyperarousal causes deep exhaustion and exhaustion creates more distress which often manifests itself in other ways. Prolonged hyperarousal leads to hypersensitivity of the stress arousal centers of the brain and future stress responses become too easily activated (Every and Benson, 1989). Rest and recovery are essential to return to a pre-critical incident level of functioning.

Psychological Factors - Mental Response

The psychological response to critical incidents is very similar to that of the body—shock, disorientation, numbness. There is disbelief and denial over the event because the mind is overwhelmed with the implications of the traumatic event—it is more than the mind can comprehend. Consequently, cognitive functioning becomes secondary to emotional functioning. During the "normal" circumstances of life, the mind and body work in a fairly balanced manner with little movement back and forth. When stimulated, the mind or body will become dominant… somewhat like the teeter-totter effect in Fig. 3.



During "normal" circumstances



Cognitive Functioning Emotional Reactions

During "disaster" circumstances
Fig. 3

Congruent with the *fight or flight* theory, during disasters, emotions are at a peak, confused, and disorganized. The victim may be terrified, angry, confused, or frustrated. The threat has caused the brain and cognitive abilities to diminish so the emotions, which have taken precedence, can cause the body to positively react out of fear, anger, or vulnerability (e.g. run away from danger). This is a lifesaving emergency action. According to Maslow's theory, survival is paramount. Therefore, the victim's mind will not be logically considering the event, but his emotions will be racing for self-survival! Other emotions may also come into play—guilt, shame, grief, helpless, abandoned, or worry. Disaster scenes are chaos and so is the mind.

The pastoral caregiver in disasters must be very sensitive to the victim's *perceived* threat or danger. The victim's *perceptions* affect the reactions to the actual traumatic event regardless of the caregiver's perception or the "reality" of the event.

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[i]Paget, "Disaster Relief Chaplaincy for Community Clergy," 42-44.

[ii]Hans Selye, *Stress ithout Distress* (New York: New American Library, 1974), 14; quoted in Jeffrey T. Mitchell and George S. Everly, Jr. *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services,* 3d ed. (Ellicott City: Chevron Publishing Corporation, 2001) 15.

[iii]Richard A. Swenson, *Restoring Margin to Overloaded ives* (Colorado Springs: Navpress, 1999), 29.

[iv] Jeffrey T. Mitchell and Grady P. Bray, *Emergency Services Stress (*Englewood Cliffs: Brady Prentice Hall Career & Technology, 1990), 3.

[v]Mitchell and Bray define trauma as an event outside the usual realm of human experience that would be markedly distressing to anyone who experienced it. Experiencing the event may be personal or vicarious, the exposure to human suffering.

[vi]Mitchell and Bray, 7-10.

[vii]Eve B. Carlson, *Trauma Assessments* (New York: The Guilford Press, 1997), 40.

[viii]Marlene Young, "Coordinating a Crisis Response Team," *The Community Crisis Response Team Training Manual,* 3d ed. (Washington, D.C.: National Organization for Victim Assistance, 2002), 2-6 – 2-13.

STRESS SYMPTOMS

PHYSICAL	COGNITIVE	EMOTIONAL	BEHAVIORAL	SPIRITUAL
Chest pain*	Blaming someone	Abandonment	Alcohol consumption	Acceptance or rejection of Providence
Chills	Confusion	Agitation	Antisocial acts*	Alienation
Diarrhea	Difficulty identifying familiar objects or people	Anger	Avoiding thoughts, feelings or situations related to the event	Anger directed to God
Difficulty breathing*	Disturbed thinking	Anxiety	Changes in activity	Awareness of the Holy
Disorientation	Flashbacks	Apprehension	Changes in sexual functioning	Changes in religious observances
Dizziness	Heightened or lowered alertness	Denial	Changes in speech patterns	Confusion regarding God
Elevated blood pressure*	Hyper-vigilance	Depression	Changes in usual communications	Deepened spiritual awareness
Equilibrium problems	Impaired thinking	Emotional shock	Emotional outbursts	Emphasis on religious rites
Fainting*	Increased or decreased awareness of surroundings	Excessive worry	Erratic movements	Hyper-repentance
Fatigue	Intrusive images	Fear	Hyper-alert to environment	Imposed gratefulness
Grinding of teeth	Loss of time, place or person orientation	Feeling helpless about life	Inability to relax	Increased emphasis on religion
Headaches	Memory problems	Feeling hopeless	Inability to rest	Isolation
Insomnia	Nightmares	Feeling overwhelmed	Loss or increase in appetite	Renewed search for meaning
Lower back pains	Overly critical of others	Flat affect - numbness	Non-specific bodily complaints	Sense of abandonment
Muscle tremors	Overly sensitive	Grief	Pacing	Sense of betrayal
Nausea	Poor abstract thinking	Guilt	Silence	Sense of communion
Neck & shoulder pains	Poor attention	Inappropriate emotional response or lack of it	Startle reflex intensified	Sense of meaninglessness
Nightmares	Poor concentration	Intense anger	Suspiciousness	Sense of vocation in creation and providence
Profuse sweating	Poor decision	Irritability	Withdrawal	Etc.
Rapid heart rate*	Poor problem solving	Loss of emotional control	Etc.	
Shock symptoms*	Etc.	Phobias		
Stomach problems		Rage		
Thirst		Resentment		
Twitches		Sever panic* (rare)		
Uncoordinated feeling		Uncertainty		
Visual difficulties		Etc.		
Vomiting				
Weakness				
Etc.				

Naomi Paget, *Stress in the Workplace,* Marketplace Samaritans, Inc., 2000.

*Requires immediate medical intervention

Appendix T: Self-Regulation[1]

" When we are no longer able to change a situation we are challenged to change ourselves." Victor Franklin

The victim and survivor – those who are impacted by crisis of every kind – face the challenges of critical impact. Between that critical impact and the reaction one has, there exists a space in which we have the power to choose our response. Ultimately, one chooses defeat or victory. One chooses growth or stagnation. With growth comes freedom – freedom from the emotional and spiritual injury that is caused by distress. This injury is more than impairment and often requires professional assistance.

Traditional ways to build responder resiliency

- Education, preparation, training
    - Learn about stress, crisis, resilience
    - Prepare for duties, responsibilities, aftermath
    - Train under supervision to increase skills
- Catharsis, reflection, cognitive restructuring
    - Processing the experience in the cognitive realm while being informed by the affective realm
        - Verbal, written, art, music
    - Considering the event and reactions through multiple lens
    - Maintain perspective
- Emotional regulation, thought awareness
    - Diaphragmatic breathing
    - Progressive muscle relaxation
    - Grounding
    - Never a victim but a survivor
    - Optimism, positive thinking
- Stress management
    - Regular exercise and rest
    - Healthy diet and hydration
    - Control over alcohol, drugs, prescriptions
- Social support
    - Maintain healthy relationships
    - Family, friends, colleagues
    - Provide and expect respectful treatment
    - Maintain community spirit and morale
- Values and beliefs
    - Clarify personal values
    - Define personal and corporate mission
    - Set challenging and achievable goals
    - Practice spiritual disciplines

[1] Naomi Paget, *Stress Management for Disaster Relief Chaplains*, (Bellville, TX: Crisis Plumbline, 2008).

Innovative ways to build transformational responder resiliency

- Practice the 3x3A action/reflection method
  - Assess, Analyze, Act
  - Assess, Analyze, Adjust
  - Assess, Analyze, Adapt
- Build self confidence
  - Trust your instincts
  - Consider your strengths and accomplishments
  - Be your best self: dress, act, speak and think like your best self
  - Strive for team readiness and competency
  - Avoid people who make you fell bad about yourself
- Self regulate
  - Choose your response in the midst of adversity
  - Fill the space between stimulus and response with positive personal change
  - Motivate yourself towards changing your attitude through self-discipline

Factors that influence resiliency

Internal Characteristics

- Optimism
- Self confidence
- Flexibility
- Receptivity
- Self-reliance
- Patience
- Hopefulness
- Creativity
- Self-regulation

External Characteristics

- Positive reinterpretation
- Cognitive restructuring
- Social support fulfillment
- Emotional regulation
- Adequacy of resources
- Positive coping mechanisms
- Community spirit and morale
- Belief in mission, purpose, calling, goals
- Open communication

Spiritual Resilience Possibilities

- Accentuate the positive
- Have mission and purpose
- Have a heart of gratitude
- Act consistent with values and beliefs
- Practice the 3x3A Action/Reflection Model

- Can laugh at themselves
- Cling to their faith
- Honor self and others through ritual and symbolism

According to the research of leading psychologist, Susan Kobasa, there are three elements that are essential to resilience:[2]

1 Challenge – Resilient people view a difficulty as a challenge, not as a paralyzing event. They look at their failures and mistakes as lessons to be learned from, and as opportunities for growth. They don't view them as a negative reflection on their abilities or self-worth.
2 Commitment – Resilient people are committed to their lives and their goals, and they have a compelling reason to get out of bed in the morning. Commitment isn't just restricted to their work – they commit to their relationships, their friendships, the causes they care about, and their religious or spiritual beliefs.
3. Personal Control – Resilient people spend their time and energy focusing on situations and events that they have control over. Because they put their efforts where they can have the most impact, they feel empowered and confident. Those who spend time worrying about uncontrollable events can often feel lost, helpless, and powerless to take action.

Another leading psychologist, Martin Seligman, says the way that we explain setbacks to ourselves is also important. (He talks in terms of optimism and pessimism rather than resilience, however, the effect is essentially the same.) This "explanatory style" is made up of three main elements:[3]

1. Permanence – People who are optimistic (and therefore have more resilience) see the effects of bad events as temporary rather than permanent. For instance, they might say "My boss didn't like the work I did on that project" rather than "My boss never likes my work."
2. Pervasiveness – Resilient people don't let setbacks or bad events affect other unrelated areas of their lives. For instance, they would say "I'm not very good at this" rather than "I'm no good at anything."
3. Personalization – People who have resilience don't blame themselves when bad events occur. Instead, they see other people, or the circumstances, as the cause. For instance, they might say "I didn't get the support I needed to finish that project successfully," rather than "I messed that project up because I can't do my job."

[2] https://www.mindtools.com/pages/article/resilience.htm

[3] https://www.psychologytoday.com/blog/hide-and-seek/201205/building-confidence-and-self-esteem

Appendix U: Self Care

Professionals who are experiencing high levels of stress find it beneficial to pay special attention to their general health during these times. The following are some suggestions, which will help increase stress management.

DIET

Eat a well-balanced, proper diet
Proteins are important – consume more fish and poultry
Increase complex carbohydrates
Reduce fatty food
Limit caffeine, salt, sugar, cholesterol, white bread, processed foods
Avoid alcohol

EXERCISE

Engage in a regular exercise program
Walking, running, swimming, calisthenics, weight training, jogging, bicycle riding, sports, martial arts
Do aerobic exercise

STOP SMOKING

Nicotine increases stress
Chewing tobacco is not a good substitute for smoking

RELAXATION

Deep breathing
Progressive muscle relaxation
Visual imagery
Meditation
Prayer & Spirituality
Biofeedback
Hobbies
Time-off
Vacations
Get regular sleep and rest

TALK IT OUT

Coworkers and colleagues
Family
Friends
Professionals

STAY CONNECTED

Maintain healthy relationships within family and friends
Do not isolate yourself when feeling distress
Stay spiritually connected through worship, prayer, scripture, and meditation

Appendix V: Post Traumatic Stress Disorder (PTSD)

What is PTSD?

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after you have been through a traumatic event. A traumatic event is something horrible and scary that you see or that happens to you. During this type of event, you think that your life or others' lives are in danger. You may feel afraid or feel that you have no control over what is happening.

Anyone who has gone through a life-threatening event can develop PTSD. These events can include:

- Combat or military exposure
- Child sexual or physical abuse
- Terrorist attacks
- Sexual or physical assault
- Serious accidents, such as a car wreck.
- Natural disasters, such as a fire, tornado, hurricane, flood, or earthquake.

After the event, you may feel scared, confused, and angry. If these feelings don't go away or they get worse, you may have PTSD. These symptoms may disrupt your life, making it hard to continue with your daily activities.

For a more information, please see our fact sheet What Is Post-Traumatic Stress Disorder. (http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_what_is_ptsd.html)

What treatments are available for PTSD?

There are many types of treatment for PTSD. You and your doctor will discuss the best treatment for you. You may have to try a number of treatments before you find one that works for you.

A type of counseling called cognitive-behavioral therapy and medicines known as SSRIs appear to be the most effective treatments for PTSD. Treatment can help you feel more in control of your emotions and result in fewer symptoms, but you may still have some bad memories.

For more information, please see our fact sheet on Treatment for PTSD. (http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_treatmentforptsd.html)

How do I locate specialists or support groups for PTSD?

If you are in an immediate crisis, please go to your nearest Emergency Room or call 911.

Although the Center does not provide any direct clinical care, we provide links and information to help you locate mental health services in your area. See our fact sheets on:

- Finding a Therapist (http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_finding_a_therapist.html)

I am an American Veteran. Who do I contact for help with PTSD?

You can contact your local VA Hospital or Veterans Center located in your telephone book, or call the VA Health Benefits Service Center toll free at 1-877-222-VETS. In addition to its medical centers, VA also has many CBOCs (Community Based Outpatient Clinics) around each state so you can look for one in your community. You can also use any of the information on treatment for the general public.

For online help, the VA also offers the MyHealtheVet and Seamless Transition websites. Please also see Specialized PTSD Treatment Programs in the U.S. Department of Veterans Affairs.

As an American Veteran, how do I file a claim for disability due to PTSD?

A formal request ("claim") must be filed by the veteran using forms provided by the VA's Veterans Benefits Administration. After the forms are completely submitted, the veteran must complete interviews concerning her or his "social history" (a review of family, work, and educational experiences before, during, and after military service) and "psychiatric status" (a review of past and current psychological symptoms, and of traumatic experiences during military service). The forms and information about the application process can be obtained from Benefits Officers at any VA Medical Center, Outpatient Clinic, or Regional Office.

The process of applying for a VA disability for PTSD can take several months, and can be both complicated and quite stressful. The Veteran's Service Organizations (VSOs) provide "Service Officers" at no cost to help veterans and family members pursue VA disability claims. Service Officers are familiar with every step in the application and interview process, and can provide both technical guidance and moral support. In addition, some Service Officers particularly specialize in assisting veterans with PTSD disability claims.

Even if a veteran has not been a member of a specific Veterans Service Organization, the veteran still can request the assistance of a Service Officer working for that organization. In order to get representation by a qualified and helpful Service Officer, you can directly contact the local office of any Veterans Service Organization -- or ask for recommendations from other veterans who have applied for VA disability, or from a PTSD specialist at a VA PTSD clinic or a Vet Center.

Common Reactions After Trauma

Following a traumatic event, people typically describe feeling things like relief to be alive, followed by stress, fear, and anger. They also often find they are unable to stop thinking about what happened. Having stress reactions is what happens to most people and has nothing to do with personal weakness. Many will also exhibit high levels of arousal. For most, if the following symptoms occur, they will slowly decrease over time.

Remember that most trauma survivors (including veterans, children, disaster rescue or relief workers) experience common stress reactions. Understanding what is happening when you or someone you know reacts to a traumatic event will help you be less fearful and better able to handle things. These reactions may last for several days or even a few weeks and may include:

- Feeling hopeless about the future & detached or unconcerned about others

- Having trouble concentrating, indecisiveness
- Jumpy & startle easily at sudden noise
- On guard and constantly alert
- Having disturbing dreams/memories or flashbacks
- Work or school problems

You may also experience more physical reactions such as:

- Stomach upset, trouble eating
- Trouble sleeping & exhaustion
- Pounding heart, rapid breathing, edginess
- Severe headache if thinking of the event, sweating
- Failure to engage in exercise, diet, safe sex, regular health care
- Excess smoking, alcohol, drugs, food
- Worsening of chronic medical problems

Or have more emotional troubles such as:

- Feeling nervous, helpless, fearful, sad
- Feeling shock, numb, unable to experience love or joy
- Avoiding people, places, and things related to the event
- Being irritable or outbursts of anger
- Becoming easily upset or agitated
- Self-blame or negative views of oneself or the world
- Distrust of others, conflict, being over controlling
- Withdrawal, feeling rejected or abandoned
- Loss of intimacy or feeling detached

Use your personal support systems, family and friends, when you are ready to talk. Recovery is an ongoing gradual process. It doesn't happen through suddenly being "cured" and it doesn't mean that you will forget what happened. For most, fear, anxiety, remembering, efforts to avoid reminders, and arousal symptoms, if present, will gradually decrease over time. Most people will recover from trauma naturally. If your emotional reactions are getting in the way of your relationships, work, or other important activities you may want to talk to a counselor or your doctor. Good treatments are available.

Common problems that can occur

Posttraumatic Stress Disorder (PTSD): PTSD is a condition that can develop after someone has experienced a life-threatening situation. People with PTSD often can't stop thinking about what happened to them. They may try to avoid people and places that remind them of the trauma and may work hard to push thoughts of the event out of their head. Feeling numb is another common reaction. Finally, people find that they have trouble relaxing. They startle easily and are often on guard.

Depression: Depression involves feeling down or sad more days than not, and losing interest in activities that used to be enjoyable or fun. You may feel low in energy and be overly tired. People may feel hopelessness or despair, or feeling that things will never get better. Depression may be especially likely when a person experiences losses such as the death of close friends. This sometimes leads a depressed person to think about hurting or killing him or herself. Because of this, it is important to get help.

Self-blame, guilt and shame: Sometimes in trying to make sense of a traumatic event, people take too much responsibility for bad things that happened, for what they did or did not do, or for surviving when others didn't. Remember, we all tend to be our own worst critics and that guilt, shame and self-blame are usually unjustified.

Suicidal thoughts: Trauma and personal loss, can lead a depressed person to think about hurting or killing themselves. If you think someone you know may be feeling suicidal, you should directly ask them. You will NOT put the idea in their head. If they have a plan to hurt themselves and the means to do it, and cannot make a contract with you to stay safe, try to get them to a counselor or call 911 immediately. National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org/ 1-800-273-TALK (8255)

Anger or aggressive behavior: Trauma can be connected with anger in many ways. After a trauma people often feel that the situation was unfair or unjust. They can't comprehend why the event has happened and why it has happened to them. These thoughts can result in intense anger. Although anger is a natural and healthy emotion, intense feelings of anger and aggressive behavior can cause relationship and job problems, and loss of friendships. If people become violent when angry, this can just make the situation worse as people can become injured and there may be legal consequences.

Alcohol/Drug abuse: Drinking or "self-medicating" with drugs is a common way many cope with upsetting events to numb themselves and to try to deal with the difficult thoughts, feelings, and memories related to the trauma. While this may offer a quick solution, it can actually lead to more problems. If someone close begins to lose control of drinking or drug use, it is important to assist them in getting appropriate care.

Recovery

Immediately following a trauma, almost everyone will find themselves unable to stop thinking about what happened. Many will also exhibit high levels of arousal. For most, fear, anxiety, remembering, efforts to avoid reminders, and arousal symptoms, if present, will gradually decrease over time. Use your personal support systems, family and friends, when you are ready to talk. Recovery is an ongoing gradual process. It doesn't happen through suddenly being "cured" and it doesn't mean that you will forget what happened. But, most people will recover from trauma naturally over time. If your emotional reactions are getting in the way of your relationships, work, or other important activities you may want to talk to a counselor or your doctor. Good treatments are available.

> *"PTSD is the second most commonly diagnosed psychiatric disorder. One cannot overestimate the degree to which trauma warps character. The most corrosive impact of horrific emotional trauma is to be found in the spiritual fabric of persons. The condition of PTSD is spiritual at its deepest level."*
>
> (Bessel van der Kolk)

What to Look For

Diagnostic Statistical Manual of Psychiatry (DSM) Development

- DSM I (1950) and DSM II (1968)
- DSM III (1980) - First lists PTSD as a diagnosis
- DSM III-R (1987) - Expanded
- DSM IV (1994) - Nature of stressors, functioning.
  - Acute Stress Disorder (ASD) introduced.

DSM-IV Diagnostic Criteria

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) The person's response involved fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions (while awake).

(2) Recurrent distressing dreams of the event (nightmares).

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.

(3) Inability to recall an important aspect of the trauma.

(4) Markedly diminished interest or participation in significant activities.

(5) Feeling of detachment or estrangement from others.

(6) Restricted range of affect (e.g., unable to have loving feelings).

(7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) Difficulty falling or staying asleep

(2) Irritability or outbursts of anger

(3) Difficulty concentrating

(4) Hypervigilance (preoccupied with safety, a big one)

(5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational,

or other important areas of functioning.

Specify if: Acute: If duration of symptoms is less than three months.
Chronic: If duration of symptoms is three months or more.

Specify if: With delayed onset: If onset of symptoms is at least six months after the stressor.

Symptoms may include:

Anger, Anxiety/Hyper-arousal, Chronic Pain, Compulsion, Confusion, Crisis, Delusions, Denial, Dependence, Depression, Disordered Eating, Flashbacks, Grief, Guilt, Isolation, Loneliness, Low Self-esteem, Obsessions, Paranoia/Hypervigilance, Passive Aggressive Behavior, Phobia, Sexual Trauma, Sleep Disorders, Substance Abuse, Suicidal Thoughts or Ideations, Secondary Traumatic Stress Disorder.

Prevalence

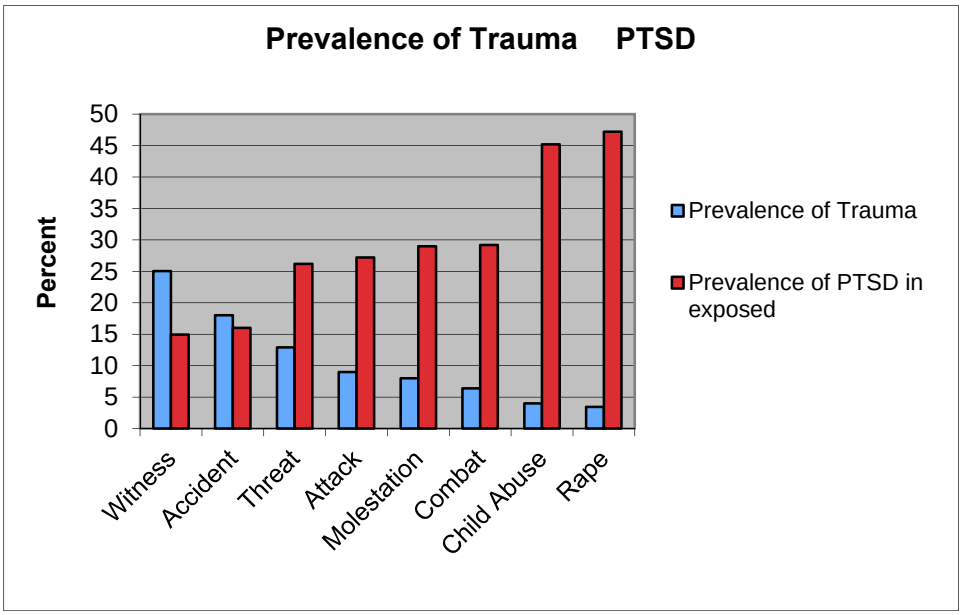
From the National Comorbidity Survey (NCS) (1995) and repeated in 2005. These studies used large national probability samples of 5,000 adults, and serves as the benchmark for prevalence of all mental disorders in the U.S.

- Lifetime PTSD prevalence in America = 6.8%
  - 9.7% women
  - 3.6 % men
- Current PTSD prevalence = 3.6%
  - 5.2% women
  - 1.8% men

<u>Prevalence of Trauma and PTSD</u> (Kessler et al., 1999)

In America:

- More than 60% experience a traumatic event in their life.
- More than 25% experience multiple traumatic events.



Compare:
- Witnessing trauma (most prevalent) to rape (least prevalent).
- Prevalence of trauma is inversely related to the prevalence of PTSD

Notice that one who is raped is more likely to develop PTSD than one who witnesses a traumatic event. Thus, all traumatic events are not equally toxic in leading to PTSD.

Burden of PTSD

Individuals with PTSD have:
- Elevated risk of mood, other anxiety, and substance abuse disorders
- Elevated risk of suicide attempts
- Greater functional impairment
- Reduced quality of life
- PTSD had the greatest impact of all anxiety disorders on economic burden to society (Greenberg et al., 1999)

PTSD and Functioning (NCS)

PTSD is associated with:
- 40% elevated odds of academic failure
- 30% elevated odds of teenage parenthood
- 60% elevated odds of marital problems
- 150% elevated odds of current unemployment

Reactivation and Exacerbation

Triggers include:
- Exposure to reminders
- New traumatic events
- Medical illness
- Bereavement
- Retirement (a big one)
- Other stressors

Risk Factors (Friedman, NCPTSD)

The risk of developing PTSD varies with a number of factors:

1) Pretraumatic factors: (less important than later factors)
- Female gender
- Early age of onset and longer lasting childhood trauma
- Genetic factors
- Lack of functional social support
- Prior psychiatric problems
- Concurrent stressful life events

2) Peritraumatic factors:
- Severity of exposure to the traumatic event; i.e., the greater magnitude and intensity of trauma = greater risk of PTSD
- Greater perceived threat of danger, suffering, and fear increases risk

- Unpredictibility and uncontrollability of traumatic event = increased fear and helplessness, thus it also increases risk

3) Posttraumatic factors (most important of three factors)

- Lack of social support following the event
- Continued exposure to further stressors, including injuries, threat to life, and poverty
-

Acute Stress Disorder: DSM IV (1994)

A. (Same as for PTSD) The person has been exposed to a traumatic event in which both of the following were present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) The person's response involved fear, helplessness, or horror.

B. Have three (or more) dissociative symptoms.
C. Have one (or more) re-experiencing symptoms.
D. Have one (or more) anxiety/arousal symptoms.
E. Onset of the disturbance (symptoms in Criteria B, C, and D) is two days to four weeks.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Internet References

National Center for PTSD - www.ncptsd.org

Substance Abuse and Mental Health Services Administration - http://www.samhsa.gov/

National Institute of Mental Health - http://www.nimh.nih.gov

National Child Traumatic Stress Network - http://www.nctsnet.org

Psych Central - http://psychcentral.com/lib/category/disorders/ptsd/

The International Society for Traumatic Stress Studies - http://www.istss.org/

DSM-5 Criteria for PTSD

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (1). The diagnostic criteria are specified below.

Note that DSM-5 introduced a preschool subtype of PTSD for children ages 6 years and younger. The criteria below are specific to adults, adolescents, and children older than 6 years.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition. Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5.

Criterion A: stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: **(1 required)**

1. Direct exposure.

2. Witnessing, in person.

3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.

4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): **(1 required)**

1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.

2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).

3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.

4. Intense or prolonged distress after exposure to traumatic reminders.

5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event:(1 required)

1. Trauma-related thoughts or feelings.

2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: **(2 required)**

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: **(2 required)**

1. Irritable or aggressive behavior.
2. Self-destructive or reckless behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems in concentration.
6. Sleep disturbance.

Criterion F: duration

Persistence of symptoms (in Criteria B, C, D and E) for more than one month.

Criterion G: functional significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: attribution

Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

1. Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
2. Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

Specify if: With delayed expression.

Full diagnosis is not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

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