



PTSD 101 Course

Transcript for: Recommendations for Acute Stress Management and Prevention of PTSD

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Welcome everyone, today we're going to be talking about the 2010 VA DoD Clinical Practice Guidelines for PTSD with a focus on recommendations for acute stress management and prevention of PTSD.

My name is Patricia Watson. I'm a senior educational specialist at the National Center for PTSD.

Our objectives today are to summarize the recommendations in the 2010 VA DoD Clinical Practice Guideline for PTSD for management of acute stress and prevention of PTSD.

To Describe the evidence-informed principles underlying the intervention strategies of Psychological First Aid and Stress First Aid.

And to describe the basic objectives and intervention strategies of Psychological First Aid and Stress First Aid.

Objective 1: Summarize the recommendations in the 2010 VA/DoD Clinical Practice Guideline for PTSD for management of acute stress and prevention of PTSD

The current clinical practice guideline, published in October of 2010, updates the 2004 version of the VA/DoD Guideline on Management of posttraumatic stress. It can be available for download at www.healthquality.va.gov.

The current revision incorporates the four modules of the 2004 guideline into two modules focusing on Acute Stress Reactions (ASR) and Post-Traumatic Stress Disorder (PTSD).

Module 1 incorporates the assessment, diagnosis, and management of symptoms of Acute Stress Reaction in the immediate period after exposure to trauma, the management of Acute Stress Disorder, and the effective early interventions to prevent progression of stress reactions to full PTSD.

Very few VA providers will see patients in this acute phase, but it is important to know this information if you do. We know that Veterans with PTSD often present to the emergency room, so it is not out of the realm of possibility that you would see someone in acute distress who has experienced a recent trauma.

In the first few hours or days after trauma, the VA/DoD guidelines current recommendation is to focus first on providing protection, safety, comfort, and care for the Veteran's basic needs. Then provide Psychological First Aid, and avoid Psychological Debriefing

After two weeks, provide brief psychotherapy for symptomatic trauma survivors.

Pharmacotherapy for the prevention of PTSD is not recommended, due to the limited research evidence, although it may be considered to aid in the management of specific symptoms such as addressing sleep disturbance, irritability, or the control of pain. There is evidence to suggest that benzodiazepines, which have historically been prescribed for PTSD and other anxiety disorders, may actually worsen recovery from trauma by interfering with extinction of fear conditioning or potentiating the acquisition of fear responses. And benzodiazepines are also contraindicated because of their potential problems with tolerance and dependence.

In the VA/DoD guidelines, the writers endeavored to create a table of evidence base about what we know about these interventions, and in the acute interventions, less than 4 days. What they tried to do was find a balance that was a combination of a benefit, and a lack of harm.

As you can see in this table, there is no substantial evidence for any acute interventions prior to four days however there is somewhat of a reason to believe that Psychological First Aid, provision of basic needs, psychoeducation, normalization, social and spiritual support would have some benefit to individuals in these early phases. And there is an indication in the literature that Psychological Debriefing is going to provide no benefit or potentially harm individuals.

This is the algorithm In the VA/DoD guideline for dealing with acute stress reactions.

When a person shows signs of a stress reaction, the provider should both observe their general appearance and behavior, and seek collateral information from leaders, peers and family members to assess for changes in that person's functioning and distress levels.

If urgent medical care is needed, or if the person is unstable or dangerous, immediate referral to emergency care is recommended.

However, if the person is not deemed to be unstable, dangerous, or in need of urgent medical care, then it is recommended that the provider assess for any ongoing physical or perceived threat, protect the person from further harm or exposure to perceived threat, ensure that their basic needs are met, and provide Psychological First Aid.

Objective 2: Describe the evidence-informed principles underlying the intervention strategies of Psychological First Aid and Stress First Aid

So, what is different about acute stress management than what might have been recommended years ago, is that there is an emphasis on Psychological First Aid as an appropriate initial intervention, although it is not meant as the only means of intervention for those who are at more severe risk. Psychological First Aid is recommended for the first few hours and days after a trauma, and provides a focus on practical, basic needs.

At the same time, the recommendations specifically suggest avoiding Psychological Debriefing (both individual and group), citing a fair amount of evidence that suggests that Psychological Debriefing is ineffective in reducing distress, improving functioning, or preventing long term psychopathology

Finally, it is recommended that support and group activities be offered as a way of providing education about what is happening, coping skills, or to restore morale.

The National Center for PTSD and the National Child Traumatic Stress Network have developed a Psychological First Aid model for disaster and mass violence situations that is designed to reduce distress, foster adaptive functioning, and increase a person's feeling cared for, and respected.

This model is currently being versioned for VA hospital settings. In this presentation, I will be discussing how this intervention has been applied to disaster situations.

While in the process of developing the Psychological First Aid model, an international expert panel reviewed the literature on interventions in situations of ongoing threat, and distilled the very broad literature into five intervention principles. What we found was that recovery seems to be linked to these five principles, which are:

A psychological sense of safety, calming, connectedness with others, self-efficacy - which is the belief that you can cope even in difficult situations - and a sense of hope. Psychological First Aid is grounded in providing these principles.

Objective 3: Describe the basic objectives and intervention strategies of Psychological First Aid and Stress First Aid

With these essential principles in mind, the PFA guide that the National Center for PTSD and National Child Traumatic Stress Network put together has eight core actions. I want to make sure that you understand that Psychological First Aid is generally not necessarily for everyone. It was really designed to be for people who seem to be in distress or are having difficulty functioning. So we have these eight actions in mind, they're not meant to be used in all circumstances, but as needed.

And these actions include contacting and engaging individuals, enhancing their safety and comfort, stabilizing individuals when it's needed, gathering information to help guide you provide PFA actions or refer to other services, giving practical help as needed, connecting people to family members, friends and other social support, promoting their coping in different ways, and reducing maladaptive coping, and coordinating with other services that might be needed.

When we were developing the Psychological First Aid model we realized, as we talked with people, that one of the most difficult things for many people is just to know how to contact and engage survivors. So, the goal of the contact and engagement module is to teach disaster mental health providers to respond to contacts that are initiated by survivors, or initiate contacts themselves in a non-intrusive, compassionate and helpful manner. So we give basic guidance on how to simply give your name or ask for their name, use their name when directing them or talking to them, or to tell them what you're doing when you're doing different things for them.

Following contact and engagement, there are a number of different PFA actions, many of which you will not be using because PFA is designed to be a model that can be used in a flexible manner based on the needs of the situation and what is going on at that moment. However, the safety and comfort module is one that you will most likely be using with every person you encounter in one form or another.

The goal of this action is to enhance the immediate and ongoing safety of the person, as well as making sure that their environment is comfortable for them.

This includes ensuring their immediate sense of safety, so therefore, it might not be absolute safety, but if they need to feel safer in one sense or another, that's what you'll be doing. For instance, if you're in a

situation where a person is concerned about being close to something that might impact them in a negative way, you could simply remove them to another area.

You also will be attending to their physical comfort and making sure that they're well attended to with food, water, shelter, that type of thing.

You might be helping them, those that have a missing family member, or helping people who have a family member close friend who has died.

Also in this module, we have information about how to attend to children who are separated from their parents and caregivers.

In all of these modules, we have guidance about working with people across the full spectrum of developmental levels from childhood up to old age, and we also have cultural alerts within each of the modules to help you understand that there might be actions that you have to attend to the culture of the individual to make sure they fit with that person's culture.

I'd like to show you a video that we made that illustrates the principles of PFA in providing comfort to an individual whose wife has died in a traumatic situation, and what I'd like you to look at as you're watching this video is the way that the PFA provider identifies this man's needs, provides some sense of validation, support and normalization, provides some education about acute grief, and adjusts her guidance to fit the context, doesn't overwhelm him with information, and finally, provides follow up and referral information.

Provider: You know everyone in every situation is really unique, but I can tell you from what I know about trauma is that when someone dies like this is an sudden and unexpected way it's really common for their spouse to feel numb.

Man: Really? So I'm not crazy.

Provider: No, not at all. It's really common to feel numb. That's what comes first before the grief in a lot of ways.

Man: That's so true. That's right. I'm just in shock. It's just too much. I can't believe it half the time.

Provider: I know. Just remember you might not cry now. You might not cry at the funeral. You might not cry until much later. The focus on the shock of the death can take over for a while until it sinks in. It's really common for it to delay or interfere with grieving. So it's important not to also feel bad about yourself on top of all that. For not feeling something like you or your family would expect. Instead just let it be. Just let your reactions follow at their own pace. You know?

Man: That's really good to know. I'm actually relieved to hear that. I just never thought about it that way. No one in my family has ever died like this, so none of us would really know. I'll have to tell my family this.

Provider: I think that's a really good idea, and from what you've said I know none of this makes it any easier to be a parent either.

Man: Yeah, I know. What can I do? I'm not sure how to handle this.

Provider: You know you've got time to deal with that. For now you've got a lot to handle. Each of you will have your own way of handling this and your own pace.

Man: You know, it's really true. We all have our own personalities. It's amazing for being related.

Provider: Yeah, and that has to be appreciated and respected. If you can just set up an attitude of the family respecting and understanding each other you're doing really well. If you're having a hard time you can tell them something like, "I'm not doing so well, but in a few months I'll feel better." But we don't need to go into that now. You can talk about that later when you have time and less pressure.

Man: Ok.

Provider: I don't want to leave you in the middle of it. If you want to take more time later you can choose the right place and time.

Man: Ok.

Provider: I'll be here from 10 until 6 for another 2 weeks, and I can also give you a card with a website address and an 800 number for you to call if you have any questions or if you want to talk about anything else.

Thanks. That would be great.

Provider: Someone will always be at that number whenever you want. There are some good people down there who can talk with you about yourself, your kids, you name it. You know, none of us are experts on how to handle a shock like this in our lives, and sometimes it's helpful just to bounce your thoughts off of someone else who's familiar with this.

Man: You know, it's really been good to talk with you. It's been very helpful.

Provider: No problem. You just keep taking care of yourself, and please feel free to call if you ever need anything.

Man: Thanks.

The counselor provides validation and support and normalization after she perceives Eric to be feeling overwhelmed, exhausted and in shock. She provides him support by telling him that the way he's feeling is to be expected in these circumstances.

Next she provides basic psychoeducation about early grief reactions, informing Eric that it's common to feel numb just after experiencing a traumatic death, and as you can see, that makes him feel much better about himself and reduces his sense of guilt.

Then she helps Eric to identify ways he could explain his reactions to his family in simple terms so that they will stop pressuring him to open up, and she's careful not to overload Eric with too much information at a time when he's already feeling overwhelmed. She sticks with the current concerns, assures him that he can reconnect with her, and reminds him of her hours at the shelter.

And finally, she gives Eric a toll-free number and website address, and making a positive connection with him, so that she can open the door for him to get future help.

In the next PFA core action, stabilization, the goal is to calm and orient overwhelmed or disoriented individuals.

Of all of the PFA actions, this is probably the one that is going to be used least frequently, however, we have guidance in this module to help in situations where an individual is either overwhelmed emotionally, or exhibiting a sense of being disoriented or out of touch of what's going on around them. So we provide guidance about just remaining present, being there with the individual, helping them to have space to be overwhelmed, and knowing that you're there to help them, as well as some basic grounding techniques that might help them come back to the present moment rather than being overwhelmed by what has happened to them.

Our next PFA action is gathering information. While this action comes after safety and comfort and stabilization, it's important to note that you will most likely be gathering information across the whole course of any PFA action that you provide to somebody.

The goal really is to identify the immediate needs and concerns of an individual. So, different factors should be considered, including mainly what are their immediate needs? What do they need right now, and what should you be doing to address those needs. You should be prioritizing and not trying to do too much with individuals, really focusing on what they need the most.

Do they need immediate referral? In which case, you should be asking questions about their functioning, how out of control they feel, how much their reactions are interfering with their normal daily life, and their level of distress.

You should be checking for their need for additional services such as insurance, such as getting housing, getting hooked up with different providers who might provide spiritual support, that type of thing.

You should also be gathering information about which PFA action should be the most important for this individual to get back on their feet.

You might also, if you have time, ask about separations or concern about loved ones, any illness, injury, or need for medications that they have, and their available resources, what social support they have, what things they've done in the past to cope with situations, what other providers they have who can help them.

Psychological first aid is very much grounded in the literature on providing resources to help people get through difficult times. And this action of giving practical help can sometimes be one of the most tricky for mental health providers who are providing Psychological First Aid because we feel that we have to bring all our tools to this situation.

What we found in most situations, particularly in disasters and mass violence, is that giving practical help might be the most prominent Psychological First Aid action that help people to feel that they're getting the resources they need to get back on their feet.

This action promotes access to any practical help that the individual needs at the time of your contact with them, and what you'll also be doing other than providing practical help is helping to clarify what their needs are, what their concerns are, and what their priorities are. That in and of itself can sometimes move a person from feeling overwhelmed and out of control into feeling like they have a partner who can help develop a plan to address their needs and some sort of way to act on that plan.

What we know about stress is that in the immediate phases after a very large stressor, a person can often lose their ability to problem solve and be creative, so having a PFA provider help brainstorm with them and problem solve can really help people feel like they have more of a sense of self efficacy.

The next PFA action is connecting survivors to positive social support. There's a large literature to suggest that having access to social support is one of the strongest indicators of how well a person recovers after traumatic stress.

So the goal of the connect action is to help establish either brief or ongoing contacts with primary support persons or other sources of support including family members and friends. In the disaster situation, for instance, this might be that you're giving access to family members and friends, finding family members and friends who've been lost.

If this is not possible, we also recommend that you encourage the use of immediately available support persons. This could be yourself, this could be other PFA providers, or other disaster survivors in the area who are going through similar circumstances who can be of support to the person at that moment.

The longest core action of the Psychological First Aid manual is the promote coping action, whose goal is to provide basic information about stress reactions and coping. Now, this is not meant to be psychotherapy, or in any way a long intervention, however we have a number of sub-modules in this action that help with different stress reactions that you might see in an individual.

So for instance, it may be that you're just giving information about the disaster recovery efforts that can help an individual with their problems.

You might be providing normalization about stress reactions. We know that when people are concerned about their own stress reactions, they tend to have a harder time.

You also might be providing basic information about ways of coping, and ways to prevent maladaptive coping such as substance abuse and alcohol use. These are very basic ways of coping, I want to reinforce. I'd like to reinforce that this should be very conversational, not therapeutic necessarily, but in the form of showing a person that we know that certain ways of coping are more effective than others.

You also might be teaching simple relaxation techniques - again, in a very conversational way. Let's take a minute to show a video about this, and I want you to notice how easy and brief this intervention is.

Provider: Have you had any experience with breathing techniques?

Man: No. Isn't it just breathing deeply?

Provider: Actually it's more about breathing slowly from diaphragm. Have you had any negative experiences with relaxation techniques before?

Man: No.

Provider: If you have any discomfort with this, we'll stop immediately. Are you ok with me sharing this breathing technique with you?

Man: Yeah, sure.

Provider: Good. Before we begin let me describe it a bit. Each breath in and each breath out is done very slowly. You'll breathe in from your diaphragm. If you would, place your hand on your stomach. And also, again, breathe very slowly. Slowing the breathe helps calm us down. As we go through this notice the sensation of your breathing. Is your nose pretty clear?

Man: Yeah. It's fine.

Provider: Good. Sit comfortably. Do you prefer to close your eyes or have them open?

Man: Closed.

Provider: Ok. Feel free to do whatever makes you feel comfortable as we go along. There will be four sets of breathing in and out.

Let's begin. So begin with an inhalation through your nose. Make it a long slow breath, and hold for a count of two. Exhale through the nose and bring the thought, "calm" to your mind. At the end, hold for four.

Ok, a slow and steady breathe in through the nose.

Hold for a moment.

Exhale from the mouth this time again repeating the thought, "calm" to yourself.

Good. Hold for a count of four.

Now, third breathe in, this time through the mouth, and again, hold for a moment.

And exhale from the nose.

Hold for four.

Lastly, breathe in through the mouth again. Hold. Then slowly exhale through the mouth.

Now resume your normal breathing, and slowly open your eyes.

How was that for you?

Man: It was nice. It definitely had an effect.

Provider: Good. Good. I'm going to give you an instruction card for future reference, and it'll help you remember what we covered.

Man: Thanks so much.

Provider: You're welcome. You can use this technique whenever you wish, but I would suggest first practicing it when you are not overly anxious or stressed. Say, when you first get up in the morning or at bedtime. Once you know how to do it, you can use that type of breathing anytime except, say, when driving. Like when you are waiting in line or feeling anxious filling out forms, or beginning to feel uncomfortable, whenever.

Man: That sounds good. Should I do it the same way we did it today?

Provider: I tried some different combinations of nose-mouth breathing with you to give you a sense of what feels best, and when you do this on your own you can also experiment with whatever combinations feel best to you. Also, you can use whatever word is calming to you as you exhale. As I said, we found that this is really helpful on a number of levels for your system, just to give it a break.

Man: Sounds so simple, but I definitely could use little breaks during the next week. I just have to remember to use it.

Provider: I appreciate you sitting down and sharing this with me, thank you.

Man: You're welcome.

So you may have noticed in this video that the PFA provider asked for permission, first and foremost, to make sure it was OK to teach a very simple relaxation routine.

He acknowledged the survivor's fears and offered a rationale as to why breathing, and slowing down your breathing is helpful.

He checked on the person's previous experiences before using the technique, and then he very simply, conversationally demonstrated the technique.

He gave the survivor a sense of control in using the technique, as well as an instruction card so that he could refer back to the simple instructions later when he needed to use the technique again.

And he encouraged the survivor to have practice, but in a very unpressured way, and in times when he's in an environment that's not highly stressful.

And finally, he encouraged engagement with the survivor at a later date.

Additional coping actions in this module include information about how to help families cope in situations of disasters and mass violence. We know that families often have different reactions for instance, and this instruction gives you ideas about how to help families respect each other's reactions, how to help parents deal with children who have different reactions, and how to help families plan activities into their schedule so that they can make sense of what happened and have some positive activities together with each other.

We also have very simple guidance on addressing anger, guilt and shame, and ways to help people deal with reminders after traumatic stress. We know from looking at the literature that people who've had a traumatic stressor oftentimes haven't prepared to cope when an anniversary comes up, when they see a movie that reminds them of what happened, and they are all of a sudden flooded with different reactions. So we teach them to be prepared for those reminders so that they have a sense of control when they happen.

One of the things that I find most exciting about the Psychological First Aid model is that you have an opportunity to interact with people at a moment when they're quite open. They're in a state of being very open and shocked by what has happened, and you have an opportunity to plant seeds to teach them very basic things that they can come back to later that might help them, and they may never present for formal mental health treatment, but you may have had an opportunity to educate them a little bit about ways that they can help themselves and their family members and friends. So its actually a really wonderful way to interact with people in a positive way that also might give them a sense of connecting later with other resources if they need those resources.

The last PFA action is coordination with other services, and the goal is to provide a link to needed services.

Examples of situations requiring a referral include need for shelter, insurance need, and other practical needs, a medical or mental health problem that needs immediate attention, or when pastoral counseling is desired.

What we know about individuals who in situations that PFA is needed is that they might need referral to, for instance, more intensive mental health treatment, however they have a reluctance to seek mental health treatment. So we also have guidance in this module about how to refer people to mental health treatment. Many people for instance don't know what mental health treatment looks like, they still have an outdated view of psychotherapy as being psychoanalysis, where you lay on a couch and talk about your dreams and your relationship with your mother, so one of your goals as a PFA provider is to give them a realistic viewpoint of what current mental health models look like and to encourage them to go even just for an assessment to see if they like the provider and to get a sense of what's offered. It's a much more collaborative model than many people are aware of. It's based on building their skills and increasing their resources.

One of the functions for coordinating for further services is for the PFA provider to be able to increase the survivor's acceptance of referral to mental health care.

You may have an individual who seems to be very much in need of further mental health care who's resisting it and that could be for many reasons.

So, in the PFA manual we talk about making it more acceptable for a person to consider referral to mental health care by normalizing the idea of treatment.

Many people don't know what to expect from mental health treatment so the PFA provider would simply educate them about what treatments look like. You may give them educational materials about the effectiveness of different treatments for PTSD or Acute Stress Disorder.

You might suggest an evaluation, rather than treatment, just to have them go in and meet with a provider and see what that provider would recommend.

And finally, we find it to be very helpful oftentimes to involve the person's spouse or partner in the discussion, because they are often the ones who are more likely to follow up on getting the person to mental health treatment.

Stress First Aid is an adaptation of Psychological First Aid for combat and operational stress situations. It was produced by the Bureau of Medicine and Surgery at the Department of the Navy, in cooperation with Combat and Operational Stress control at Headquarters, Marine Corps, and Navy Operational Stress Control as well as the National Center for PTSD.

Stress First Aid is a peer to peer model that aims to reduce stress, foster adaptive functioning, increase peoples' feelings of being cared for and respected, and increase their sense of competence and confidence, which is different from the Psychological First Aid model. In a situation of stress that's related to operational duties, peers and leaders have much more of an ability to increase a person's ongoing sense of competence and confidence, so it gives them much more range than the Psychological First Aid model for disasters.

Within the context of Stress First Aid as a model, there's a difference between this model being applied to peer to peer support in combat and operational stress in the military versus disasters situations. One of the main differences is in combat and operational stress there are four different causes of what we call stress injury that are created by intense or prolonged stress.

One of those causes is Life Threat, which is the typical traumatic injury due to an experience of death, terror, horror, or helplessness being provoked in an individual.

The second cause of stress injury is Loss. We call this a grief injury, and it's usually due to the loss of cherished people, or things, or parts of oneself.

Next is the stress injury of Inner Conflict, which often called moral injury. This is usually due to behaviors, or witnessing behaviors, that violate a person's moral values.

And finally, a piece that's very important in situations of combat or operational stress is Wear and Tear, which we call a fatigue injury. This is due to the accumulation of stress from all sources over time without sufficient rest and recovery. The combination of these different sources of stress can often create a much more greater likelihood of risk from long term problems.

One of the core foundations of the Stress First Aid model is the Stress Continuum Model upon which it is based. In the Stress Continuum Model, the Navy and Marine Corps have acknowledged that there could be four zones of stress in an individual.

In general, what the military aims to do is place people in the ready green zone by their training and their support. The definition is that the person is optimally functioning and has wellness and adaptive growth. So, people should be at their best in this zone.

The next zone is the reacting zone or the yellow zone. And this is defined as having mild and transient distress or impairment that always goes away, and it's usually a low risk for ongoing problems. It could have any stressor be a cause, and generally what you'll see in a person is that they'll feel irritable, anxious, might have difficulty sleeping or muscle tension. Many of us are in the yellow zone, fairly often, if we have a lot of job stress.

I'm going to skip over to the red zone, because this is the zone that most people attribute to psychopathology. This is the ill zone, and it is defined as having some sort of clinical mental disorder or unhealed stress injury that's causing life impairment. So, we see PTSD, depression, and anxiety in this zone. And generally, this is a very severe or persistent impairment in a person's social occupational functioning.

Stress First Aid is really aimed towards the orange, or injured zone, which right now often doesn't have interventions that are designed to target the zone. The definition is this: This is a person who might have a severe or persistent distress or impairment level, and in the injured zone, that person is at higher risk.

The four sources of stress that I mentioned before: life threat, loss, moral injuries wear and tear contribute greatly to being injured. And, the features of this zone are more of a loss of control of stress reactions, such as panic, rage, or depression. The person no longer feels like their normal self, and they could have excessive guilt, shame or blame around their stress reactions.

The Stress First Aid model seeks to even more closely follow the five principles of recovery that I mentioned in the beginning, and we change them into words that are more easy to remember as a mnemonic which we call the 7 C's of Stress First Aid. In this model, as with the Psychological First Aid model, one size does not fit all. Not everyone is equally affected by any given event and not everyone needs any kind of intervention. So, Stress First Aid is assessment-based. It's initiated by the check function, which is a peer or leader should always continuously be observing and listening for any signs of a stress reaction, changes in function, statements of internal distress, or a known stress exposure. Stress First-Aid is different than some other models that are based on exposure to an event. Whereas, this model is more based on the reaction people have to events around them or to long term wear and tear.

So in continuous aid, you should always be checking and thinking about coordinating one step up to get help as needed.

The other core actions of Stress First Aid are cover, which is translated into getting safety. And calm which is helping the person to relax, calm down, and refocus. These are considered to be primary aid that every shipmate and every marine should be able to apply in any situation if a person is feeling unsafe or in need of being calmed down.

The other three functions we call secondary aid. And those are: connecting people to others, restoring their sense of competence, and restoring their sense of confidence.

In the cover action this slide lists both non-verbal and verbal techniques, arranged from least to most intrusive. When covering someone, we always want to choose an action that takes away the least possible degree of autonomy, and we want to give autonomy back to that person as soon as possible after the danger has passed.

So with cover, you might be offering different actions such as just simply asking the person if they are OK or asking if they need help. You might be asking staff how safe they believe the person to be to themselves, other staff and patients. Or, you might be talking to leadership about suggesting an alternative safer course of action, such as giving a warning about impending danger or getting a person to stop unsafe behaviors.

This slide lists specific non-verbal and verbal procedures for calming someone. Just as with the cover function, we want to apply calming techniques that are the least intrusive and controlling possible, while still getting the job done.

If just being a calming presence and making eye contact is enough to calm someone down, then there's no need to do something more intrusive like coaching someone in slow, deep breathing. But each of these techniques listed has a place in a certain type of situation. And there are many other ways to calm someone that are not listed here. Use your judgment about what you think would be helpful for the individual. What we know is that when people are overly stressed they benefit from both non-verbal and verbal calming from people around them.

Moving into the secondary part of stress first aid, the connect action assumes that peers and leaders have time to observe and help individuals with this function. So the components of the connect action are to assess a person's resources, find out who they can talk with, identify both peers and leaders who they can use as resources, to assess obstacles such as the way a person feels about themselves or others that might interfere with their reaching out others.

And then to go about removing those obstacles. There are a lot of examples here including just being a good listener to a person so they feel they can talk with you, helping them get connected to social activities, and encouraging active problem solving around connecting with others.

Finally a very effective way of removing obstacles to connect is the after action review that many military leaders use to good effect to talk about lessons learned and what happened after events.

In the competence action of Stress First Aid, we find that this, to me, is the most exciting actions of Stress First Aid, because you have an opportunity in Stress First Aid over time that you don't have in disaster mental health activities. In this action, the core process is taking one step backward in order to take two steps forward. So restoring or enhancing competence in the face of orange zone stress can require stopping, allowing the person to take time, respite to recover from what has happened, to identify their challenges, to three different areas of functioning.

We often see that people have problems with social functioning when they are feeling that they have some sort of stress injury. As I said, they feel isolated or alienated. You can also see occupational problems when a person is confronted with stress injury such as they weren't trained well enough so they feel incompetent to deal with what's going on or they might in the face of stress have frozen and need to know how to react differently in the future.

And then finally, we know that people often don't realize that their well-being is compromised in situations of orange zone stress where they don't know how to handle their own stress reactions so that might be an area where you need to stop and take a look at what's happening.

Then you would back up and basically retrain or refresh their skills. So, this is an area where you can use a lot of mentoring or problem solving with them where they learn new skills about how to handle their own stress reactions or how to deal with what is happening around them or they retrain in new areas of occupational functioning to help them feel more competent.

And finally, they are going to be practicing their refreshed skills, moving forward again to gradually move into an area of being more competent. In this zone of moving forward again, you want to help them set achievable goals and problem solve and troubleshoot when things come up that prevent them from feeling more competent and you want to reinforce their successes and motivation.

The confidence action in Stress First Aid is closely tied to the principle of hope that I spoke about in the beginning of this presentation. More than any other aspect of COSPA, the confidence function requires an empathic and honest relationship that evolves over time. What we find is that when people are subject to different stressors over time, they can often lose their sense of confidence in themselves, their hope for their future, or their confidence in leadership or mission.

So in this step, what needs to happen is that first, Stress First Aid provider assesses the person's self image, their understanding of the meaning of life events, their level of trust, and then they restore the person's depleted resources and foster spiritual connections. This might involve coordinating with other resources or addressing different problems in the person's life including financial, family or spiritual problems.

Finally they promote growth by removing excessive guilt or shame that a person might have or promoting forgiveness of themselves or others or establishing a new meaning in purpose. This is an action that involves a lot of listening and confronting perceptions that the person might have. You may be encouraging the person to put themselves in others' shoes, making amends or giving to others in an effort to make themselves feel more confident in themselves or to establish new relationships or strengthen old ones.

So we have just covered the actions of Psychological First Aid and Stress First Aid. The goals of both of these interventions are to promote safety, attend to people's practical needs, enhance their coping, stabilize them, connect them to additional resources and in the context of Stress First Aid, improve their sense of competence and confidence.

Longer term interventions are geared to prevent or treat psychopathological reactions. So as you are moving from acute intervention such as Psychological First Aid or Stress First Aid to more intensive interventions, you should base this decision both on the extent to which a threat exists for this survivor as well as if the survivor has sufficient resources to engage in more intensive interventions.

This is a continuation of the algorithm in the VA DoD guidelines for dealing with acute stress reactions from four days out to a month. This section of the guidelines has not been changed from the 2004

guidelines. As you can see, if after applying Psychological First Aid principles, the person seems to be doing fine, the provider should offer contact information, screen them in 3-6 months, if indicated, and provide education about continued self care.

If, however, the person has continued reactions that impair their functioning or contribute to significant distress, the provider should assess for medical and functional status, preexisting conditions and risk factors for developing PTSD, and then providers can initiate acute interventions such as more education and normalization, social and spiritual support, acute symptom management or referral to mental health for brief cognitive behavioral treatment.

After each of these interventions, it is important to consistently reassess symptoms and functions. If the person is doing well after the intervention, monitoring and follow up as needed is indicated. If the person's symptoms persist or worsen after the interventions, then the provider would move on to Module B for PTSD treatment.

So in the VA DoD guideline for stress reaction from four days to one month out, the guidance is to continue to avoid Psychological Debriefing, provide support, normalization and education, provide or refer for brief cognitive behavioral therapy for those at risk for developing post traumatic stress psychopathology.

This brief cognitive behavioral therapy is usually four to five sessions and it includes education, breathing retraining and relaxation, imaginal and in-vivo exposure and cognitive restructuring.

Additionally in the VA DoD guideline for stress reaction on less than one month, pharmacotherapy is not recommended except as a short course of less than six days for specific symptom management for things like sleep or pain. They also recommend the possible use of complementary alternative medicines such as acupuncture, meditation and relaxation. What we have seen oftentimes with Veterans and military service members is they appreciate having some sort of intervention like this that substitutes for counseling because they prefer to have something that simply helps them to relax or reduce their anxiety.

So as you can see in this table, for early interventions of less than a month in the context of finding a balance of benefit with lack of harm. As you get past that initial first week, you want to be thinking in terms of providing either brief cognitive behavioral treatment, which has substantial evidence to suggest its effectiveness, or in terms of providing things like Prazosin for nightmares or social and spiritual support, a provision of basic needs, psychoeducation and normalization; as well as social and spiritual support. The other items on this list do not have as much research support and indicate either unknown or no benefit.

I just want to briefly touch on peri- and post-traumatic risk factors that have informed much of the early intervention literature. What we have seen in the risk factor literature is that there are things that are related to having long term problems that directly inform interventions in the early phases.

So things like negative perceptions of either other people's responses or negative perceptions of the person themselves symptoms, exaggerating future probability of trauma or having catastrophic attributions of responsibility, where the person feels responsible for what happened, attempts to avoid thinking about or reminders of the trauma, ongoing adversity and negative and lack of social support all contribute to more difficulty recovering from traumatic stress.

So with those risk factors in mind, cognitive behavioral techniques appear to have the most promising results in preventing subsequent psychopathology. Why might this be? We think that it's because they directly address many of these cognitive and behavioral risk factors. They are designed to address these risk factors. They create a structure that decreases a person's sense of overwhelm, they shrink the time

frame by having the person focus on what they can do in the present moment and they give the person a positive experience and sense of self efficacy for coping with some of these risk factors.

By addressing the risk factors head on, they give the person a sense of choice and control as to which way they want to go, and the provider and the survivor create a partnership and collaboration that makes the person feel supported. These cognitive behavioral techniques are also focused on building skills which give a person a sense of having resources to address the difficulties that they may encounter.

That having been said, we are very realistic about why acute interventions might not be enough. We do our best to provide resources for people that can buffer them and help them get through this difficult time however we do know that PTSD has a complex etiology. So for instance, things like differing exposure levels or ongoing adverse life circumstances can contribute to a person having more difficulty recovering.

We see differences in the way people approach problems in their personality or their culture that can make it difficult for them to receive early intervention. And compliance issues follow as well because oftentimes early interventions are offered at a time when a person is in a lot of chaos and they want to avoid thinking about this.

Finally there is a fluctuating course of PTSD that makes it likely that a person will only present in times of crisis. So you may be offering interventions only when they are at their most distressed. So therefore, the relative contribution of acute interventions oftentimes is necessarily small and we want to know this so that we make sure that we are continually assessing and monitoring and following up for people that might need more intensive interventions down the road.

Therefore we would like to suggest an integrative model over time. Here you see on this slide, there are different time intervals for intervening with people. In the acute phases of hours and days after, or early in the days and weeks after, or in chronic months and years after, and the strategies are going to be different for each of these intervals.

In the acute stages you are going to have a PFA approach that is very informal, you see the structure is flexible and it is more restrained about what it hopes to accomplish. With brief counseling you have a little bit more time with people, oftentimes three to five sessions. It could be more formal and less restrained in what your goals are. And in more extensive treatment, which is more formal, you see it as being over the long haul and you are definitely more unrestrained in terms of what your goals can be. You oftentimes can have more sessions and more time with a person. The goals therefore are going to be different for each of these different time intervals and interventions. PFA goals are going to be constrained, you're not expecting much. You're hoping to build their resources and buffer them.

With early intervention, you're less constrained in your goals and you're hoping to prevent long term pathology with people by teaching them skills and helping them to face some of the things that are most difficult for them to deal with.

And then finally in the long term, more formal interventions, your goals can be much less constrained where you are hoping to actually have great decreases in a person's symptoms and to help them deal with things in the long term.

In conclusion, the use of Psychological First Aid and Stress First Aid principles of safety, calming, connectedness, self efficacy and hope should be considered in all encounters with Veterans with acute stress reactions, after disasters or mass violence, or with distressed fellow staff members. These interventions are in accordance with the VA DoD guidelines.

After providing Psychological First Aid or Stress First Aid, you may need to monitor and follow up with cognitive behavioral therapy and targeted psychopharmacology for those who need it.

For further resources, please see the National Center for PTSD website at ptsd.va.gov. Also on that website is a link to a six-hour online Psychological First Aid course with the National Child Traumatic Stress Network website.

Thank you very much in your interest in this course and I wish you the best of luck in your work with Veterans and providing acute intervention for their needs. Thank you very much.