COMBAT AND OPERATIONAL STRESS FIRST AID:
Caregiver Training Manual

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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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INTRODUCTION

Combat and Operational Stress First Aid (COSFA) is a flexible, multi-step process for the timely assessment and preclinical care of psychological stress injuries in individuals or units with the goals to preserve life, prevent further harm, and promote recovery. Unlike other acute stress management procedures, COSFA was designed specifically to augment the physical, psychological, social, and spiritual support structures that exist in the military, and to help restore these support structures over time. It is consistent with the Navy and Marine Corps Combat and Operational Stress Continuum model, *Figure 1*, which is fundamental to the Navy Operational Stress Control (OSC) and Marine Corps Combat and Operational Stress Control (COSC) programs described in MCRP 6-11C/NTTP 1-15M. In terms of the Stress Continuum, the goal of COSFA 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 COSFA

As depicted in *Figure 2*, COSFA is a toolkit designed to fill the care gap between the resilience-building and stress mitigation tactics available to military leaders and individual service 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, COSFA 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, COSFA actions vary in complexity and the level of training and skill required to perform them. Some components of COSFA can be delivered by almost anyone, either on individual's own behalf or on behalf of others. Other components of COSFA 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 COSFA*, and most expert in its delivery and teaching, are caregivers from all disciplines, including chaplains, medical officers, corpsmen, religious program specialists, and mental health professionals. ***In this manual, we focus on training caregivers to become the champions of COSFA.***

Figure 2. Where COSFA fits into the Stress Continuum.
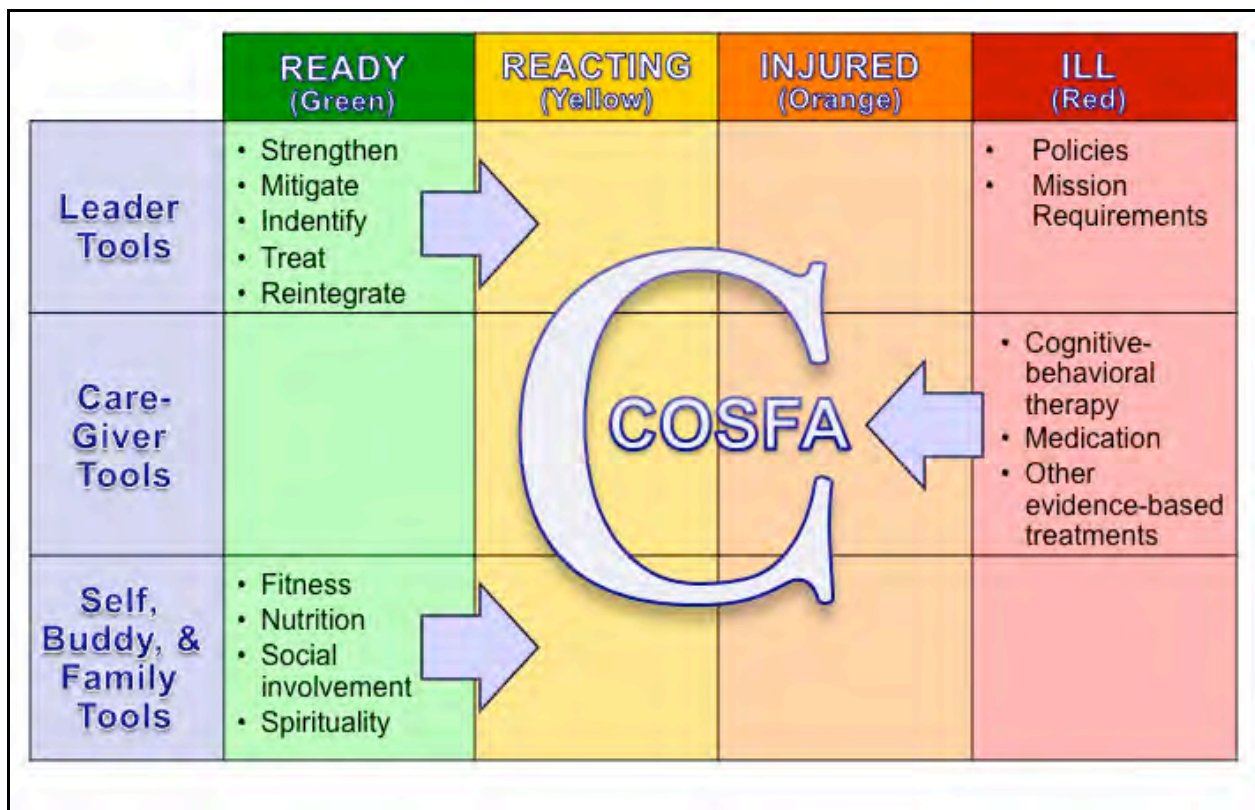
COSFA Targets Orange Zone Stress Injuries

Although individuals in both the Yellow and Orange Zones may benefit from COSFA, 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 COSFA targets the Orange Zone, service members and family members *in any setting* who are *at risk for Orange Zone stress injuries* should be trained in basic COSFA principles and should be supported by caregivers trained in all components of COSFA. 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. Units 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 COSFA adapted for use in such organizations.

Figure 3. Four sources of Orange Zone stress injury.

The Goal of COSFA is Indicated Prevention

The prevention of mental disorders caused by the stress of military operations is one of the highest priorities of the Navy, Marine Corps, and Department of Defense. ***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]

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 military units and the psychological health and well-being of the individuals that comprise them.

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[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.

COSFA TM v3.0

Introduction

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 unit-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 — 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 — below the threshold of severity and duration for the diagnosis of a mental disorder. COSFA is a set of indicated prevention interventions that target subclinical distress or impairment. ***The goal of COSFA is to prevent subclinical stress injuries from becoming clinical stress illnesses.***

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

- By continuously monitoring the stress zones of service 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 commanders and other members of chains of command regarding the effects of stress on individuals and units, and how to mitigate them
- By teaching others in units and families how to use the tools of COSFA, and being champions for their use
- By reporting lessons learned from the use of COSFA to higher headquarters so COSFA will adapt and improve over time

COSFA is Guided By a Set of Core Principles

- Military leadership and unit cohesion are potentially the most powerful forces for healing and recovery available to military service members — more powerful than the clinical skills of counselors or therapists, and more powerful than the medications prescribed by physicians.
- Family leadership and family member support are potentially the most powerful forces for healing and recovery available to military family members.

- COSFA promotes recovery and healing by augmenting, restoring, and leveraging leadership and cohesion in military units, and by parenting and family member support in military families.
- COSFA augments not only existing leadership, but also medical care, religious ministry, and other intrinsic social support resources; it never supplants or competes with them.
- COSFA occurs in natural work, field, and home contexts, wherever and whenever it is needed.
- COSFA is individualized to meet the needs of each individual in each context; there are no one-size-fits-all COSFA solutions.
- COSFA 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 — first, last, and always — is central to COSFA.
- All assessments in COSFA are based on the Combat and Operational Stress Continuum Model, the cornerstone of Navy OSC and Marine Corps COSC doctrine.
- As a first-line treatment for stress injuries, COSFA will sometimes serve as a stop-gap until more definitive care can be provided, but even after clinical care becomes available, COSFA is continued as a bridge between leadership and clinical care.
- In more mild instances of Orange Zone stress injury, COSFA may be the only intervention needed to promote recovery and reintegration.
- COSFA requires a collaborative team effort to be most effective.

COSFA Supports the Five Core Leader Functions of COSC and OSC

As described in MCRP 6-11c/NTTP1-15M, the Navy and Marine Corps Combat and Operational Stress Control doctrinal publication, all 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 military leadership, training, and unit cohesion since long before scientific concepts of stress management were introduced to the military. The last three leader functions of COSC and OSC — identify, treat, and reintegrate — require skills and concepts that may be newer to both military leaders and their intrinsic social and spiritual support personnel. COSFA is designed to provide teachable and practical tools to meet these challenges for leaders to identify, treat, and reintegrate stress injuries.

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COSFA OVERVIEW

COSFA 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). The major concepts and practices that converged in COSFA are listed in Appendix A, along with references for further reading about them.

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. This public health dictum parallels the even older concept in the military that the health and readiness of military personnel is the primary, though not sole, responsibility of line commanders.

How best to promote the psychological health, in particular, of service members and their families 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 military 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 — they are neither all normal, transient, and self-limiting, nor all harbingers of chronic mental illness.

The Navy–Marine Corps Stress Continuum Model, *Figure 1*, was developed by Marine 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 in the military. 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 in the Marine Corps 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 Marines, 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]. Because debriefing procedures similar to CISD have ***not*** been shown in a number of outcome studies to prevent stress illnesses such as PTSD, their use is no longer recommended by expert consensus, including the VA/DoD Clinical Practice Guidelines for Post-Traumatic Stress. 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 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]

COSFA was developed by adapting the principles, practices, and goals of PFA for use in military operational settings, which differ from civilian disaster and terrorism settings in several important ways. First, operational stress in the military is seldom due to a single event, such as a hurricane, fire, or plane crash. Combat and operational stressors are predictably ongoing and cumulative, especially in wartime. Second, members of the military seldom experience the stress of combat and other operations passively; combatants are never victims. Third, unlike the survivors of disasters or acts of terrorism, members of the military know in advance they will be subjected to intense and potentially overwhelming stressors. They train and prepare for it. Finally, as a critical part of that preparation, members of military units are embedded in a matrix of ongoing leadership and social support that has few analogues in the civilian world. Stress first aid in military settings must integrate with this support matrix and augment it, and it must perform its functions longitudinally across deployment cycles.

In the COSFA 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, and the satisfaction and self-esteem gained from military roles. As defined in the Navy and Marine Corps COSC and OSC doctrine, unit 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 COSFA at every step.

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[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 COSFA

As shown in *Figure 4* below*,* COSFA 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 COSFA 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 COSFA will be described in detail.

Figure 4. Combat and Operational Stress First Aid (COSFA).

Overview

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

LEVEL			CORE ACTION	
Continuous Aid	• *Ongoing* COSFA 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 COSFA 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* COSFA 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* COSFA 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 COSFA ACTIONS:
CONTINUOUS AID TO SECONDARY AID

For caregivers, COSFA 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 the intrinsic healing resources of military organizations. In the ideal case, caregivers will have an enduring presence and ongoing relationships with service 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 service members, and reestablishing unit 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 service 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 military and family 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 COSFA, 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 unit and family members under their care, throughout deployment cycles — before, during, and after exposures to stressor events. Check and Coordinate are the portals through which individual service or family members receive the other preventive interventions of COSFA, or higher levels of care, if needed. They are also the means by which other support systems are mobilized, commanding officers 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 COSFA 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 COSFA. In COSFA, 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 COSFA 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 COSFA. The first and most important component is to **observe** — 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, COSFA caregivers must also **keep track**, at least mentally, of the current and recent stressors impacting unit 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, COSFA 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 COSFA.
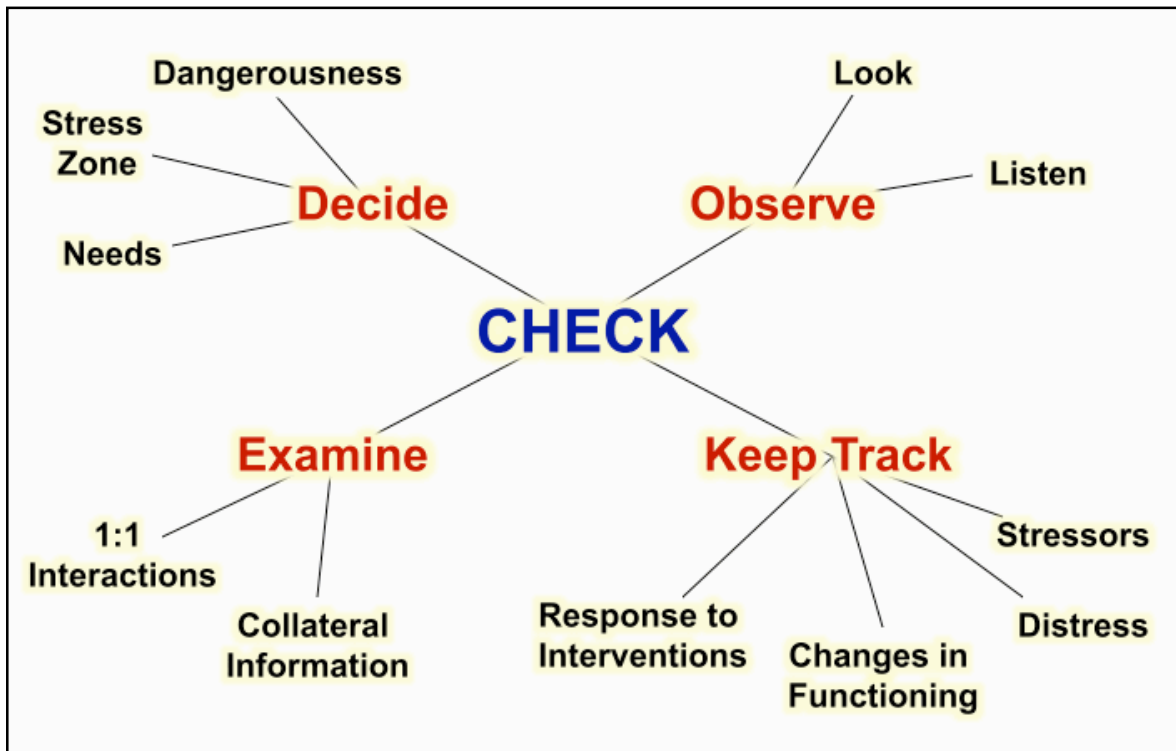
Why Is It Needed? Individuals exposed to intense and prolonged stress need COSFA caregivers to monitor continually and assess them for possible Orange Zone stress for several reasons:

- 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 COSFA 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 — First Check — is immediately undertaken.

Figure 6. The Check Cycle.
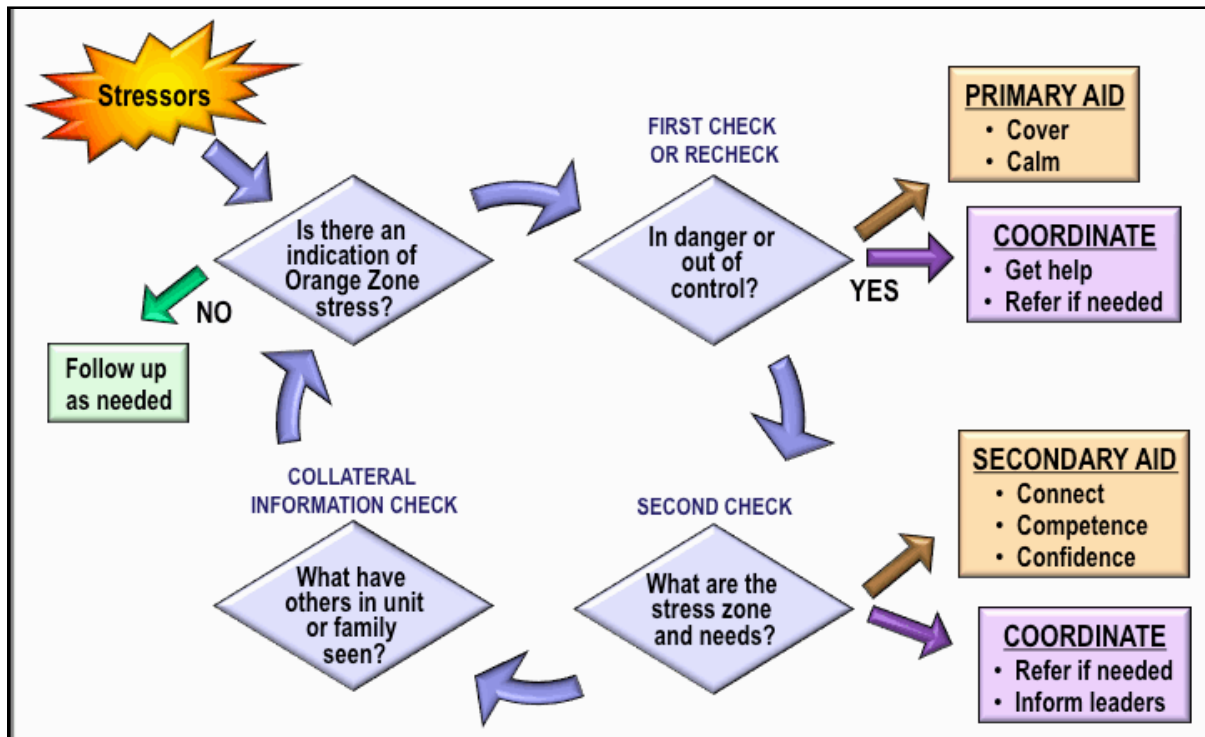
First Check is analogous to the "primary survey" in physical trauma triage — a quick once-over to assess for immediate threats to life, such the ABCs of airway, breathing, and circulation. The First Check in COSFA is a quick **crisis assessment,** looking for indications of dangerousness to self or others, 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 individual's 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 COSFA usually begin with an awareness on the part of a COSFA caregiver that someone <u>might</u> 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 COSFA. Being able to recognize Orange Zone Indicators is the most important COSFA skill to learn and practice.

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

- The caregiver may personally witness an abrupt change in the behavior of a unit member under severe stress.
- A unit 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 unit may seek the caregiver's assistance with an individual with Orange Zone stress indicators.
- A peer or family member might tell the caregiver about the changes in behavior that were witnessed or heard about in a unit member.
- The unit 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 COSFA. 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) — 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 others' 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 individual 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 individual's 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* — 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 — 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 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 — the Cover function of COSFA — 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 — after safety is addressed — is to determine whether immediate calming is required because of intense negative emotions or physiological hyperarousal. The *need for the Calm function of Primary Aid* COSFA 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 military 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 — 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 COSFA 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 COSFA caregiver covers the same three Orange Zone indicators as in the First Check — current stressors, level of distress, and impairment of functioning — 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 COSFA 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 COSFA 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 — and the reassessment process that follows — 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, corpsmen, 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 COSFA 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. The effect over time of Primary Aid or Secondary Aid must be followed up by rechecking. 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 COSFA, 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 COSFA. There are four actions that follow from answering the above questions. The first component is to **get help** — 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** – 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 COSFA.

Coordinate with commanders. The decision to inform commanders 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 at that command, and in military 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 commander or other leaders. The following are factors to consider in deciding whether and how much to tell commanders.

- How great is the risk to the individual in question, or other members of the unit, if the commanding officer and other leaders are unaware of the individual's stress?
- What is the individual's MOS or NEC?
- 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 commanders is another important reason for the COSFA 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.

Commanders and their chains of command are invaluable allies in applying the core actions of COSFA. Supervisors and small unit 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 COSFA action plan, members of the chain of command may unwittingly undermine the efforts of the caregiver. COSFA works best as a collaborative effort.

Coordinate with other sources of care and support. An equally important decision that COSFA 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 COSFA caregiver in the assessment of the individual, especially of stress zone and dangerousness?
- Is there evidence that something is missing from the picture — some way in which the facts do not add up?
- How solid is the working alliance between COSFA caregiver and the individual?
- Would the individual possibly benefit from a form of care or treatment that the COSFA 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 COSFA 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, COSFA 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 COSFA 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 military and every family member 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 – significant and persistent distress or alterations in functioning in the aftermath of one or more Orange Zone stressors. A stressor event may alert the COASFA 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 COSFA 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 others' evaluation and treatment of dangerousness.

The next part of First Check –performed simultaneously with the dangerousness check rather than after it – 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 COSFA can follow.

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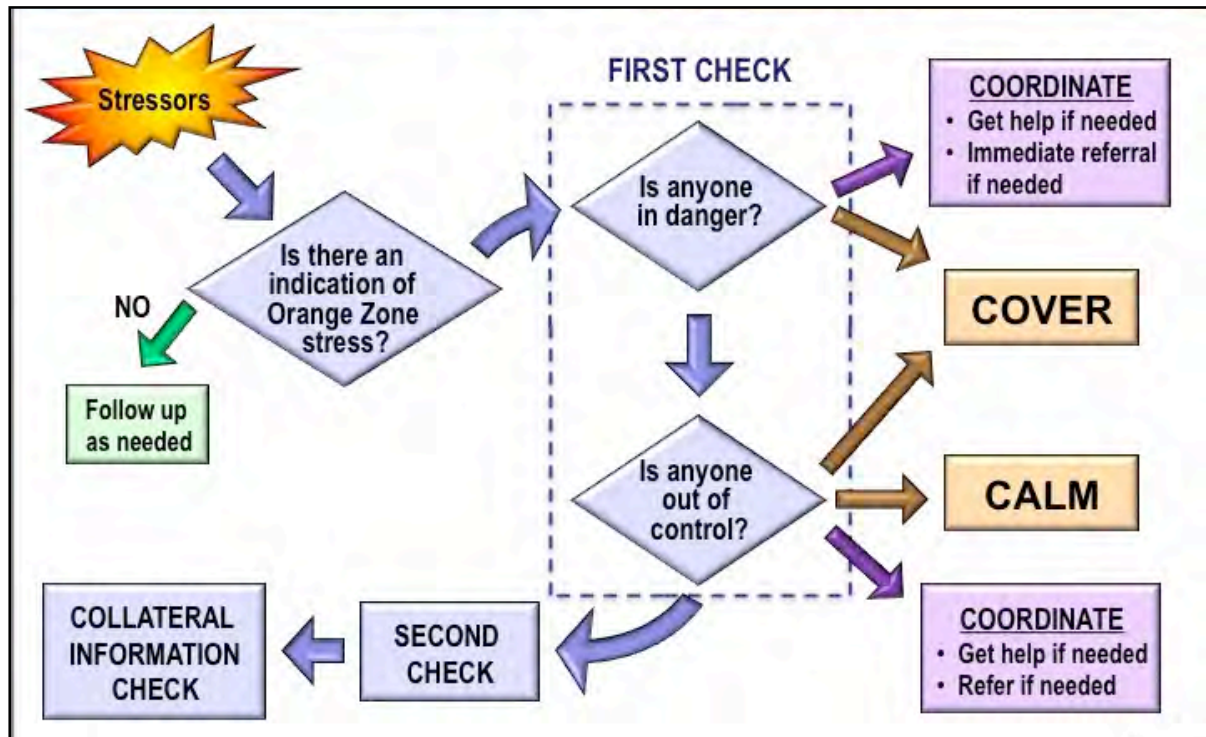
COVER

What Is It? *Figure 10* below shows a conceptual tree linking the major components of Cover as a COSFA function. Starting in the top right quadrant, the first and most basic component of Cover is to **make the stress-injured person safe** – 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 COSFA.

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 person's 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 harm's 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 COSFA 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 — 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 least to most 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 person's way with your own body.
- Pull or drag to safety; physical restraint.
- Take physical control of the person's 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 COSFA 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 person's 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 COSFA 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 COSFA.
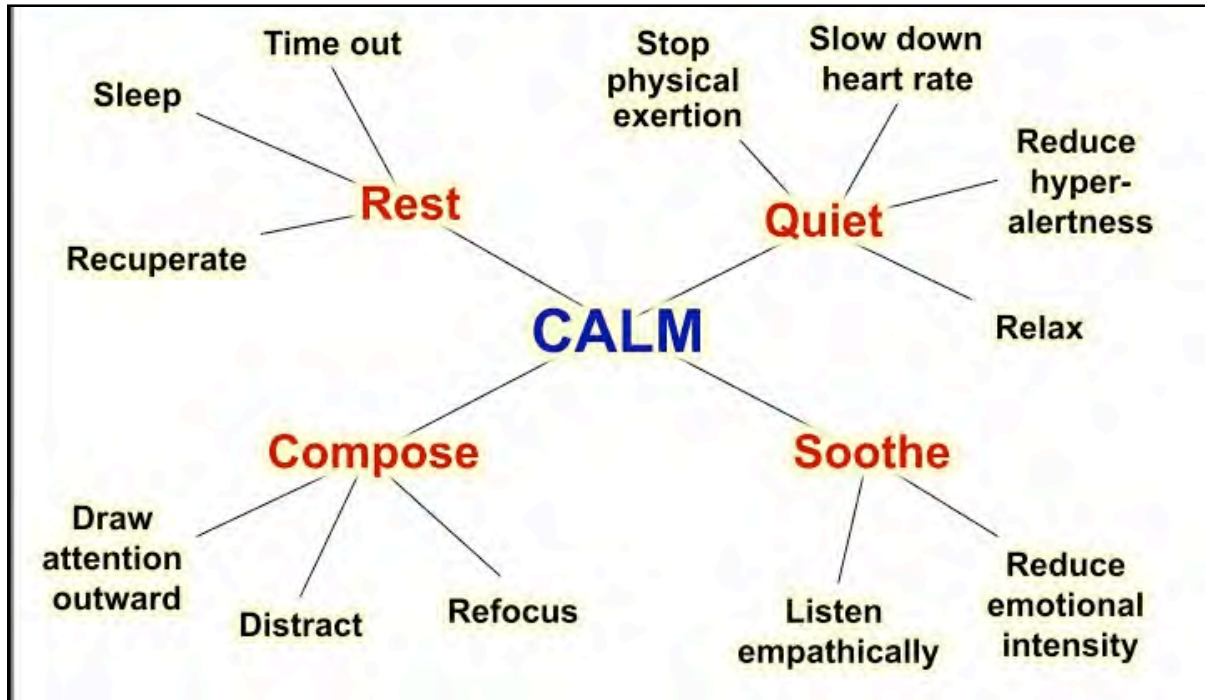
When Is It Needed? Calm is only needed when Orange Zone stress has interfered with the ability of individuals to reduce their own physiological activity level or emotional intensity. There are three main categories of situations that require Calm: (1) when physiological arousal level is stuck too high, (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 COSFA 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 COSFA 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 COSFA, 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 person's 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 now…" or "It's okay…"
- Reassurances of current safety and/or support, such as "You're safe now…" or "I'm here with you…"
- 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 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 COSFA 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 person's 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 military units — 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*** COSFA 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 COSFA 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.
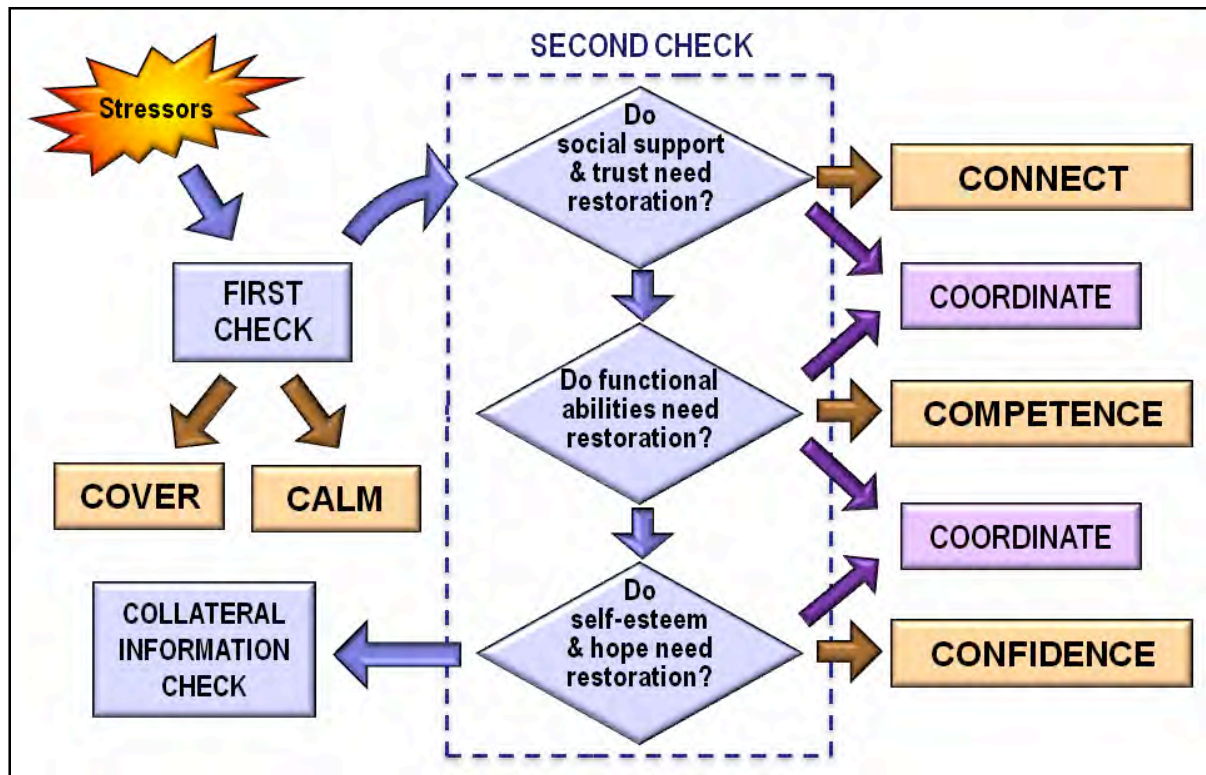
Just as the crisis responses of Primary Aid follow from the assessments and decision-making of the First Check, Secondary Aid is the result of the more detailed assessments of Second Check. The Second Check in COSFA answers the questions: (1) which stress zone is this person in right now? and (2) what 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 person's 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 COSFA 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 military units and families always functioned perfectly, there would never be a need for the COSFA Connect function, but individuals and units under severe stress do not always have optimal, or even adequate, social and spiritual functioning. Yellow Zone stress can create social friction in units and families, and Orange Zone stress can generate persistent alienation and loss of trust. The Connect function of COSFA 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 COSFA. 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 individual's 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 COSFA.
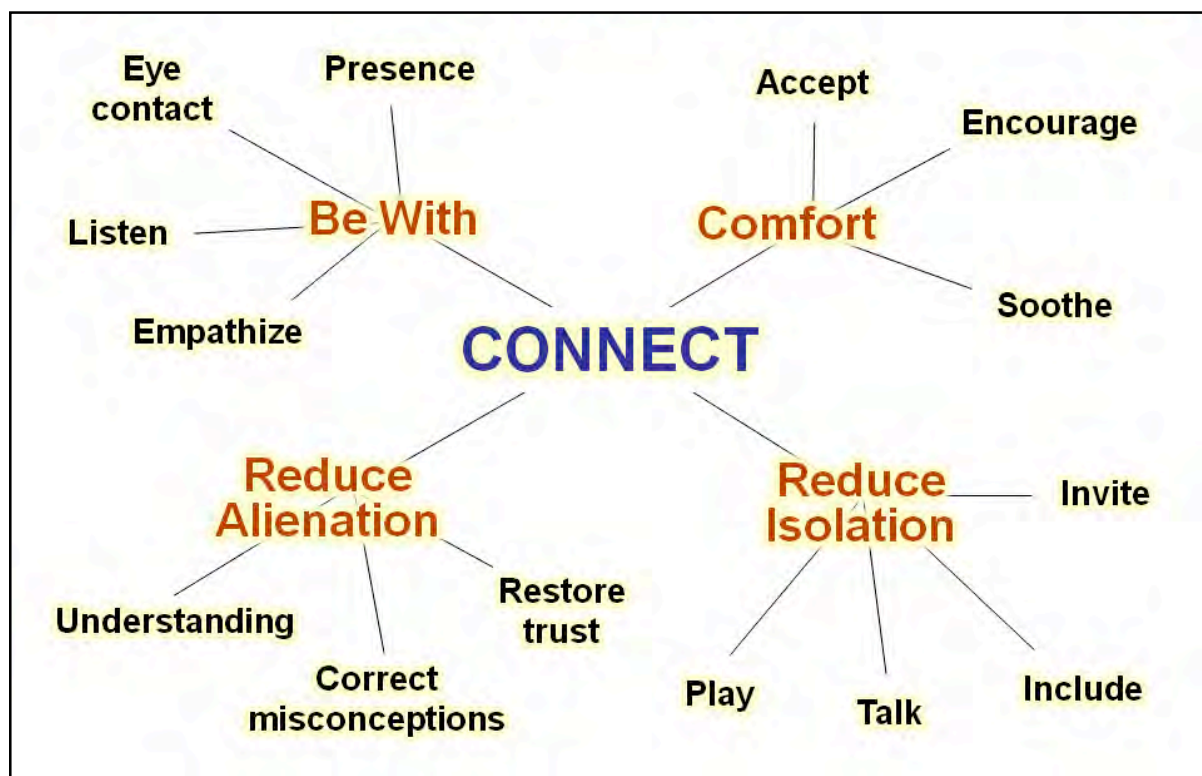
When Is It Needed? The Connect action of COSFA is closely related to **unit cohesion,** which is a state of mutual trust, respect, and communication within the unit. The Connect action of COSFA can be thought of as intentionally using unit cohesion for the benefit of one or more stress-injured Marines or Sailors in the unit, and repairing unit cohesion to the extent it is decremented by Orange Zone stress in the unit. Stress-injured Marines and Sailors 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 in a unit. The Connect action of COSFA is, therefore, **needed whenever Orange Zone stress causes a relative loss of cohesion in a unit**, 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 in the unit have lost trust in him or her.
- Cannot stop thinking about the vivid details of the death of another Marine, but is afraid to talk with others in the unit 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 Marines or another troubling event.
- Is blamed by other members of the unit for the death of another Marine 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 COSFA 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 COSFA 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 COSFA.

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. COSFA 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 COSFA 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 COSFA 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 COSFA, 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 COSFA 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 COSFA: (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 COSFA. 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 military 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 confidence in those abilities, through practicing them and demonstrating effectiveness. The critical role

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

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 COSFA.

When Is It Needed? The two important signals for the need for the Competence function of COSFA 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 COSFA 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 COSFA 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 COSFA.

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.

Competence Step	Specific Intent	How to Do It
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.

COSFA 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 COSFA 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 COSFA, 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 Sailors and Marines 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 God, and helping to remove those obstacles and/or build meaning.

Figure 15 below graphically depicts the four conceptual components of the Confidence function of COSFA: (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 — as an individual, and in relation to important others, institutions, and God.   More than any other function in COSFA, Confidence depends on a firm social and spiritual base to be effective.

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

When Is It Needed? Each of the six COSFA actions discussed up to this point addresses a potential need of individuals experiencing Orange Zone stress. Each of these needs addressed by COSFA 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 the military, that prize self-sufficiency and autonomy. The final COSFA function, Confidence, addresses these needs — 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. The Confidence function of COSFA is needed by everyone who has ever sustained a stress injury. 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 COSFA 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 COSFA 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 — 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 COSFA, 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 or military organizations, their symbols, and their ceremonies, can be tapped into by COSFA caregivers.

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

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

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.

Confidence Step	Specific Intent	How to Do It
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 military. • Address financial problems, family problems, military occupational problems, health problems, etc. • Identify obstacles and find solutions to overcome them.
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 heerself 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 COSFA. *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 COSFA 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.

Secondary Aid

50

COMMAND ASSESSMENT

Preserving the psychological health of service members and their families is one of the great challenges facing military leaders of today. The types of missions modern military organizations are called upon to perform can expose service members and their spouses and children to intense and prolonged stress. Modern psychological, medical, and spiritual frameworks offer military leaders the understanding and tools to help meet this challenge. Caregivers using stress continuum and COSFA knowledge are potential tools for the leaders. However, in the end, military leaders must shoulder this responsibility personally. Only commanders and the important links in their chains of command can perform the five core leader functions (Appendix F) of Combat and Operational Stress Control — STRENGTHEN, MITIGATE, IDENTIFY, TREAT, AND REINTEGRATE — essential for the prevention, identification, and care of adverse stress outcomes across the Combat and Operational Stress Continuum. Only military leaders can promote Green Zone wellness and return unit members to the Green Zone once they have experienced serious Yellow Zone stress reactions, Orange Zone stress injuries, or Red Zone stress illnesses.

Caregivers are a critical resource for commanders regarding individuals and the command as a whole. Effectiveness of caregivers in relation to command assessment depends not only on their knowledge of individuals and the command, but also of available resources in the current operational environment. Caregiver multidisciplinary collaboration and the ability to communicate effectively across roles regarding individual and command challenges are essential for effective COSFA interventions. In particular, the effectiveness of Secondary Aid depends on command leaders' ability to engage with resources that support connectedness, competence, and confidence. Often, leaders will turn to caregivers to assist in activating those resources. The COSFA model can be used to determine (Check) what type of resources would be most effective based on the assessed individual or command needs. The type and level of command assessment will be determined by the caregiver role. chaplains, corpsmen, Medical Officers, and Family Counselors are all guided by a professional code of conduct and policies. COSFA principles are applied within caregiver role-delineated boundaries for both individuals and commands as clients.

The use of COSFA for command assessment is initiated by the same factors that are used for individuals: observable changes in function, statements of distress, or known stress exposure. The COSFA framework of the five Cs – COVER, CALM, CONNECT, COMPETENCE, AND CONFIDENCE – forms the basis of conducting a command CHECK as well as systematically COORDINATING with leaders about individual service members and the command as a whole. In command assessment, the COSFA elements are transformed from a set of actions intended to be used with an individual into a framework for guiding caregiver communications about individual and command level stress-related behaviors and concerns (*Figure 16*).
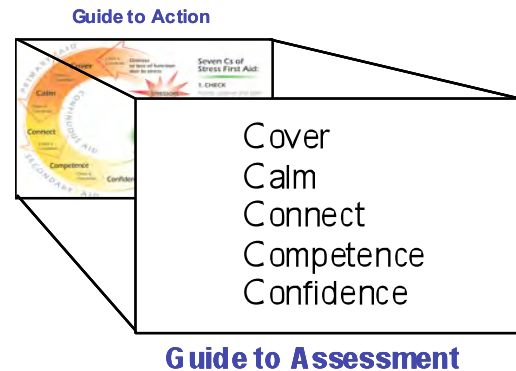
Figure 16. COSFA actions to assessment.

CHECK

Systematic assessment and synthesis of command stress concerns must occur before the caregiver can provide cogent command assessment. The command CHECK starts with understanding stress sources that are affecting command members – TRAUMA, LOSS, INNER CONFLICT, and WEAR AND TEAR. Any given stress injury source does not need to be experienced by every command member to influence the entire command. Unit cohesion is a protective factor against stress injury. Unit cohesion can also influence the shared experience and impact that events have among unit members (for example, personal events for one person can have a secondary impact on other unit members). The command CHECK starts with the identification of potentially impacting overt events and then moves toward inner events. It is important to remember that the sources of stress injury are not discrete or mutually exclusive and often have a co-morbid influence within the command. For example, the death of a command member may include a traumatic exposure, loss of a friend, and guilt about action or inaction, and be related to work load and operational tempo. Use the five core COSFA actions to assess potential stress injury sources on command members. Many factors determine the ways that stress injury sources will affect command members.

Figure 17. Command Assessment Matrix.

	Cover	Calm	Connect	Competence	Confidence
Life Threat/ Trauma					
Loss					
Inner Conflict					
Fatigue					

The command assessment and matrix (*Figure 17*) provides a useful grid for understanding the associations between stress injury sources and caregiver observations. The advantage of using the COSFA concepts for a command CHECK is that it allows the caregiver to identify strengths and limitations across the stress continuum for the whole command, and communicate those observations in behavioral terms. Once stated in

behavioral terms, command actions that support Cover, Calm, Connectedness, Competence, and Confidence can then be identified and applied.

> **Example:** A traumatic accidental death occurs on a ship related to an equipment safety failure. For this particular crew, the IMPACT of the traumatic death evokes a sense that the ship is an unsafe place to work. Crew members in the department of the deceased shipmate are agitated and angry, there is an increase in crew cohesion "to protect each other", there is no apparent impact on Competence, and there is a loss of Confidence in leaders' concern for the crew's safety. The LOSS associated with the accidental death stimulated increased Connection and support behaviors as well as expressed hope that the death will make the command pay more attention to safety. INNER CONFLICT is present in the crewmembers who saw the risk but did not take action, in the safety officers who felt a loss of competence in their ability to keep crewmembers safe, and in the leaders' confidence in the Navy's ability to get the ship necessary supplies and equipment. The WEAR AND TEAR of mission tempo compromised Cover because of "time-saving short-cuts" and Competence because impaired concentration reduced attention to detail.

Expression of Orange Zone strengths and limitations will vary just as the sources of stress injury can combine in many ways. Situational awareness of the command, personnel, mission requirements, and exposure over time is important. The advantage of embedded caregivers is that they know the command as a whole. The disadvantage of embedded caregivers is they share in the command experience. Using COSFA principles can help the caregiver maintain perspective and look past assumptions and rote interventions. As caregivers develop competency and proficiency in applying the COSFA model, they will develop an ability to assess the impact of sources of stress at individual, command, and mission-readiness levels.

COORDINATE

Once sufficient information has been collected to understand the major stress injury sources and their associated influence in the command, the next step is to formulate recommendations with the leaders. It is helpful for leaders when caregivers provide concrete recommendations that are consistent with core leader functions — STRENGTHEN, MITIGATE, IDENTIFY, TREAT, AND REINTEGRATE. By using the core leader functions as a framework rather than using a socio-medical framework, the range of potential solutions and resources for the leader are expanded. The command assessment process takes the information gathered in the CHECK process and adds the lens of the core leader functions (*Figure 18*) to help focus potential options for leaders, caregivers, and individuals. One of the most important features of this process is to help leaders identify and then activate resources or strategies that they think will best meet the needs of the command, the service member, and the mission.

Figure 18. Command Assessment and Consultation Matrix.

Figure 18, as a 4x5x5 assessment and consultation matrix, highlights the potential complexity that can occur within a command that has one or more individuals with Orange Zone stress injuries. The purpose of the assessment and consultation matrix is to help provide a systematic way to gather information and provide a common framework within which leaders and caregivers can discuss stress injury behaviors and develop mutually supported actions to conserve individuals and units that are temporarily non-mission ready because of stress injuries. The assessment and consultation matrix is a tool to enhance professional dialog and decision-making rather than provide a prescribed action plan.

Example: The caregiver within a Marine unit helps the leader to identify that there is a squad that shows issues related to CALM (high levels of expressed anger), CONNECT (individual infighting and split allegiance), and COMPETENCE (many new young Marines). The leader chooses to have the squad participate in a mixed martial arts training that includes calming techniques and team building. The training is led by an officer and senior enlisted team in another division and provides time for the leader to evaluate the best distribution of senior enlisted leaders within the company.

COSFA for Consultation

Suggest: Command assessment has different functions for advising in relation to the stress- injured individual versus the command as a whole. Fortunately, the COSFA model provides a framework for both forms of assessment. *Table 14* presents points of discussion to consider when the caregiver would provide command assessment.

For the individual, COSFA assessment can be used to communicate with the command leaders about the ability of the individual to continue in a duty status. Historically, individual assessment usually focused predominantly on the issue of potential for harm to self or others. The COSFA framework facilitates a broader discussion and acknowledges resources or other factors that are important when leaders, caregivers, and the service member must decide on the option that best meets the needs of the command and individual. It is critical for the caregiver to be clear on the goals for the assessment and whether it is for the sake of the individual or the command. Command assessment of an individual always needs to be done with the awareness, and preferably permission, of the individual. The strategies of motivational interviewing (Appendix C) and problem solving (Appendix D) can be used to develop a mutually agreed upon basis for engaging the command to support the individual.

For the command, COSFA core actions form the foundation of a systematic and ongoing assessment, intervention planning, and follow-up. A command level assessment is based on many observations of multiple command members within the context of mission requirements, operational tempo, and command leadership style. The most effective command COSFA assessment is based on the caregiver having a pre-established and legitimate caregiving role with the command. Caregivers get command information because of number of cases or a dominant theme. The COSFA themes are Cover, Calm, Connect, Competence, and Confidence. For example, if there is a command-level Cover issue, you might say, "Skipper, I'm concerned about the safety on this ship. We have people who are fatigued, sleep deprived, and at risk for making errors." This type of opening statement to the command is not based upon an individual, and by leveraging the COSFA model, a language and discourse can be created that is appropriate to leader decision-making.

Table 14. Individual and Command Factors for Command Assessment.

	Individual	Command
Cover	- Potential for harm to self and others - Safety Plan - Need for voluntary versus involuntary mental health assessment	- Attention to detail, sleep hygiene - Patterns of at-risk behaviors (high-risk drinking, driving, and peer challenges) - Mission risk profile
Calm	- Ability to self-regulate distress - Ability to choose and use positive calming strategies - Risk of functional impairment during missions or duties	- Intra-command behaviors that create or dissipate agitation and tension - Leader communication about mission requirements and expectations - Translation of communication down and up the chain of command

	Individual	Command
Connect	• Ability to connect with peers • Peer ability to connect with member • Quality of mentoring relationships • Quality of unit identity	• Esprit de corps, morale • Cohesion when under duress • Inter-unit relations • Quality of unit identity
Competence	• Skills and resources to manage role requirements and stressors • Problem-solving skills • Availability and quality of resources	• Crew readiness for mission • Congruence between training and mission demands • Adequacy of resources
Confidence	• Belief in self, mission, values, and faith • Balance of future expectations • Belief in ability to contribute to the mission	• Balance of future expectations • Belief in leadership • Belief in mission • Rules of engagement balance

Once the COSFA provider can determine which COSFA factors are predominantly present, a plan can be created with the leadership based not only on which factors are compromised at which levels (individual, command, or mission readiness), but on the resources that are available to the command. For instance, providing respite for the ship with Cover concerns will need to be determined by leadership based a multitude of factors, including the level of risk as well as the current op-tempo, staffing, and mission. A comprehensive plan may also include provisions for increasing Connectedness among command members, determining how to include training and mentoring to improve Competence in both job-related activities and management of stress reactions, and increasing the command's Confidence in leadership, mission, or personal values.

Command Requested COSFA Support

The command assessment process can also be used as a framework for providing external support upon command request. There are circumstances where caregivers who are not embedded in a command will be requested to provide COSFA support. Requests for external caregiver support usually occur when the circumstances of an event creates potential or actual disruption of mission capability, and internal command resources are either not sufficient to assess the whole command or are equally impacted. The result of the command COSFA assessment described above may be to recommend that additional or external resources are needed. When a caregiver or team of caregivers who are not embedded in a command are requested to provide COSFA support, they have some challenges to overcome, including: (1) they have limited knowledge about the organic and ongoing issues within the command, (2) they are external to the unit and have little, if any, trust and credibility with command members, and (3) they will not have a continued relationship that allows them to follow through with any interventions.

It is useful to think about the Requested COSFA Support as a process whereby COSFA actions are used repeatedly to provide the best assessment and recommendation to the commanding officer that can be achieved in a short period of time with limited resources. There are five phases in providing a requested COSFA support (*Table 15*). The first phase usually starts with command-initiated contact with external caregivers. The goal here is to develop caregivers' understanding of the events, concerns, and expectations of the command leaders. The Phase One assessment usually starts with a series of phone calls and finishes with an on-site meeting with command leaders. In Phase Two, the caregiver team then plans how they are going to conduct the command COSFA assessment. It is important for the team to identify the best-fit strategies for understanding the command members' experience and reactions, how often the team needs to meet, and an emergency contact plan. Phase Three is the assessment of command personnel within the context of their command and the event that stimulated the requested COSFA assessment. This phase uses strategies of motivational interviewing (Appendix C) to gather information and to facilitate discussion that support Connection, Competence, and Confidence. Phase Four is the provision of command personnel support that would normally flow from the Phase Three assessment. Often, Phase Three and Phase Four may occur within the same dialog with an individual or small group. The key point is that COSFA support is always preceded by a CHECK, and guided by assessment rather than assumptions. Phase Five is command consultation. Ultimate responsibility and authority for the health, safety, and mission capability resides with the commanding officer. The command consultation leverages the command assessment and advisement matrix to identify areas of concern, strengths, vulnerabilities, and potential actions of resources that are available to the commanding officer. The consultation offers maximal impact when it is succinct, organized, and utilizes specific, concrete examples to demonstrate key points.

Table 15: The Phases of Command Assessment and Consultation.

Phase 1: Command Leaders' Assessment
- Situation (What situation stimulated the request for assessment and consultation?)
    - o Known event facts
    - o Variables (consider both event and mission context)
        - ▪ Trauma Impact
        - ▪ Loss
        - ▪ Inner Conflict
        - ▪ Wear and Tear
- Leader Actions (What have the leaders already done or current status?)
    - o Strengthen
    - o Mitigate
    - o Identify
    - o Treat
    - o Reintegrate
- COSFA 5 Cs (Which of the five Cs have been met or are still in need, and how?)
    - o Cover
    - o Calm
    - o Connect
    - o Competence

Command Assessment

- o   Confidence
- Resources (What resources are available?)
    - o   Internal command resources (embedded caregivers, overall crew experience)
    - o   Local command resources (availability of other supports and agencies)
    - o   Individual resources (availability of family, community, and personal support)
    - o   Caregiver resources (availability for referral and follow-on care if needed)
- Clarify (Which factors need clarification to implement a plan of action?)
    - o   Command Expectations
    - o   Lines of communication
    - o   Team support
    - o   Frequency of command leader process feedback

Phase 2: Plan Command Assessment
- Strategies
    - o   Walk About
    - o   Group
    - o   Individual
- Schedule team meetings
- Emergency contact plan

Phase 3: Command Personnel Assessment
- COSFA 5 Cs (Invite Problem Solving: "What do you think would help or needs to happen next?")
    - o   Cover
    - o   Calm
    - o   Connect
    - o   Competence
    - o   Confidence
- Immediate Support and Information
    - o   Support Unit Cohesion
    - o   Forewarn about stress behaviors and thoughts
    - o   Support Buddy and Self care strategies

Phase 4: Command Personnel Support (elements of this phase may occur in conjunction with assessment) prioritized by COSFA 5 Cs
- Vulnerable groups or individuals
    - o   Scheduled group discussions with reacting teams
    - o   Identify private counseling resources
- Focused Crisis Intervention
- Systematic Training or Message
    - o   Support Unit Cohesion
    - o   Forewarn about stress behaviors and thoughts
    - o   Support Buddy and Self-care strategies

Phase 5: Command Consultation
- Describe process used by the team.
- Summarize findings using the command assessment and advisement matrix.
- Recommended leader actions using the 5 core leader actions.
- Provide access to care strategies for 72 hours, 14 days, 6 weeks.

In January 2010, the epicenter of a Caribbean earthquake decimated the island nation of Haiti. Within 76 hours of activation, the USNS Comfort was steaming to assist. Upon its arrival, the USNS Comfort became the highest echelon of care for the people of Haiti. The event was catastrophic for the people of Haiti and potentially overwhelming for rescuers and medical personal on the ground and on board ships.

Support for caregivers responding to the crisis in Haiti depended upon the level of prevention that was required. It is important to recognize that caregiver support is a function of good leaders using stress doctrine principles and not a function of a mental health team. The Navy-wide Operational Stress Control universal training had been ongoing for a year, and many caregivers who were deployed had participated in training at their parent commands. Selected prevention efforts were used by clinical leaders to prepare caregivers to address the core needs of safety, calm and effective communication, unit cohesion, clinical and social competence, and confidence that the mission has great meaning with a message of hope. The disaster support mission had many elements that caregivers associate with compassion satisfaction, including a clear and worthy mission, a cohesive team, a high potential for being a helpful support to those in need, and enough resources to make a difference. Compassion satisfaction buffers compassion fatigue and burnout risks. Initially, there was no evidence that the deployed caregivers need an indicated prevention intervention. A COSFA assessment was one of the strategies that leaders used to understand and address the needs of caregivers and responders. The following is an application of the COSFA command assessment to the USNS Comfort using publically available information provided by Jim Garamone (*USNS Comfort Crew Settles into Busy Reality,* American Forces Press Service), Robert Little (*Comfort's ability to help stretched to limit* and *Angel flights take Haiti's dead home,* Baltimore Sun) and John J. Kruzel (*5,000-Bed Hospital to Increase Haitian Medical Capacity*, American Forces Press Service). The example is not comprehensive and is used for illustrative purposes only.

COSFA Assessment Example

Sources of Stress Injury

Trauma/Life Threat: "Critical care overload by 20 patients per day," "shockingly severe injuries."

Loss: "Expected patient deaths,' (note: loss risk increases as patient length of stay increases; especially children).

Inner Conflict: Triage to capability: "Declined care to a brain-injured, paralyzed man", caregivers choosing between continued care and meeting their own food and rest needs, perceived reduced standard of care from CONUS MTF expectations, limited resources, concern about making serious medical error.

Fatigue: "Comfort reaching its breaking point," "space and supplies overtaxed," declining new admissions, "acceptable caseload is unmanageable," "more burn patients and premature infants than it can handle," OR's on 24-hours schedule, "busiest DoD medical facility in the world," "three USNS Comforts would not be enough."

Core Needs

Cover:
   Vulnerabilities: Crowd chaos at shore triage points, flight deck crew fatigue, sharps risk for caregivers.
   Strengths: Appears to be safe, insulated from mob pressure by water. 2.5:1 staff to patient ratio.

Calm:
   Vulnerabilities: Crowd chaos at shore triage points,
   Strengths: Reflective pause during 1MC calls for the chaplain or the liftoff of an "angel flight," reflective thinking about limited capabilities, "need to recalibrate what we consider good care," CO conducts evening discussion.

Connect:
   Vulnerabilities: New crew pulled from many different MTF's, limited resources
   Strengths: "We are family and we're with them", efforts to find relatives of the deceased.

Competence:
   Vulnerabilities: Limited resources, Space and supplies overtaxed, declining new admissions, fear of fatigue-induced medical errors
   Strengths: Mission success that so few have died, many caregivers have combat experience and have provided civilian care in Iraq and Afghanistan.

Confidence:
   Vulnerabilities: Multiple moral and ethical dilemmas around quality care and access, comparison to CONUS care, care demands exceeding resources.
   Strengths: "So few have died," significant meaning in work, honor, hope.

Table 16. USNS Comfort Example Command Assessment Matrix.

	Cover	Calm	Connect	Competence	Confidence
Trauma/ Life Threat	V- Shore based triage teams S- Sea buffer, UN security	V- Crowd control at transit sites S- Sea buffer, UN security	V- S-	V- Critical Care Overload S- Few deaths	V- Severe injuries S- Combat experience
Loss	V- S-	V- S-	V- Expect deaths S- "Angel flight"	V- S-	S- Visible chaplain role, expectation of dignity
Inner Conflict	V- S-	V- S-reflective pause for angel flight and evening prayer	V- Denial of care, applying US std of care S- "we are family," culture of dignity	V- Limited resources, triage to resources S- talking about moral dilemma	V- Refusal of care (by pt) S- CO AAR, DNS reframing care expectations, meaningful work
Fatigue	V- risk of sharps injury S-	V- S-CO and other leaders AAR	V- new crew for many MTF, declining new admissions S- move stable pt to shore asap	V- fear of medical error S-	V- reaching breaking point, limited resources S-

Information overload is one of the challenges facing unit commanders during high operational tempo or following significant stress events. Using the four sources of stress injury and the five essential needs that people have following disasters or trauma reduces the hundreds of possible stress variables into 20 decision points. Assessed vulnerabilities and strengths can be quickly distilled for guiding leader decisions and actions. This framework can be used repeatedly over time where there is sustained or ongoing operational stress. When used as part of medical intelligence, there is a need to be able to visualize vulnerabilities, strengths, and changes over time in a condensed format that can be used during command briefings and reports. A strategy that was used for the Operation Unified Response Joint Task Force included color-coding of the matrix. The color-coding schema is based on the judgment of the assessment team. The stress continuum model is the reference point for the colors. Green (Ready) is used to note where strengths exceed vulnerabilities, yellow (Reacting) when strengths appear to be sufficient to buffer the identified vulnerabilities, orange (Injured) indicates where vulnerabilities exceed strengths and need mitigation actions, and no color is used for those areas where there is no evidence of issues at the time of that particular assessment. *Table 17* is an example of applying the color coding to the USNS Comfort Example Matrix.

Table 16. USNS Comfort Example Command Assessment Matrix.

	Cover	Calm	Connect	Competence	Confidence
Trauma/ Life Threat	V- Shore based triage teams S- Sea buffer, UN security	V- Crowd control at transit sites S- Sea buffer, UN security	V- S-	V- Critical Care Overload S- Few deaths	V- Severe injuries S- Combat experience
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Inner Conflict	V- S-	V- S-reflective pause for angel flight and evening prayer	V- Denial of care, applying US std of care S- "we are family," culture of dignity	V- Limited resources, triage to resources S- talking about moral dilemma	V- Refusal of care (by pt) S- CO AAR, reframing care expectations, meaningful work
Fatigue	V- risk of sharps injury S-	V- S-CO and other leaders AAR	V- new crew for many MTF, declining new admissions S- move stable pt to shore asap	V- fear of medical error S-	V- reaching breaking point, limited resources S-

Potential Core Leader Actions

Strengthen: Effective and realistic pre-deployment training, enforce rest and restoration periods, shift and sleep hygiene, teach staff how to use COSFA to provide psychological support to the patients and each other, keep crew informed of changing deployment timeline, call attention to issues and outcomes that are associated with compassion satisfaction.

Identify: Know high-risk work areas, monitor long-stay patient and staff attachments, staff should know stress continuum and stress injury warning signs, watch for rumors that produce extremes of hope or pessimism, watch for compassion fatigue with triage teams.

Mitigate: Use regular After Action Reviews, team leaders to discuss 5 Cs after every shift, leaders to expect verbal reports about unit and work centers to address the five Cs, command expectation of shipmate care and breaking the code of silence, morale and recreation strategies, identify respite rotations (tasks that contribute to the mission but decrease or change exposure).

Treat: Identify command resources to address stress-injured staff, team leaders are expected to pull a staff member off line for short reset breaks, use leader-led After Action Reviews following high stress or critical events, consider team-level rest and reset.

Reintegrate: Be prepared to shift team members and support those who had diminished capacity and are ready to work back into a full pace.

The final step in command assessment and consultation is communication with command leaders. An open dialog with command leaders that reviews the process and finding is indicated if the assessment and consultation is related to a specific event or does not require repeated assessments over time. However, if an electronic slide is expected as part of the mission situational report, then *Figure 19* is a recommended format.

Figure 19. Sample COSFA Assessment Briefing Slide.

Summary

The use of COSFA for command assessment is initiated by observable changes in command function, statements of distress, or known stress exposure. The COSFA framework forms the basis of conducting a command CHECK as well as systematically COORDINATING with leaders about individual service members and the command as a whole. In command assessment, the COSFA elements are used as a framework for guiding caregiver communications about individual and command-level stress-related behaviors and concerns. Finally, in Command Requested COSFA Support, the COSFA framework is used by an external caregiver (or team of caregivers) to provide the best assessment and recommendation to the commanding officer that can be achieved in a short period of time with limited resources.

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APPENDICES

Appendices

Appendix A: Combat and Operational Stress First Aid (COSFA) Overview

	Goals	When It Is Used	How You Do It
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 unit 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.

COSFA TM v3.0

Appendix A

Appendix B: Major Concepts and Practices Underlying COSFA

Year	Concept or Practice	References
1996	Military line leaders bear primary responsibility for psychological health promotion in military units.	DoD IG Report 96-079 of 29 Feb 96 DoD Directive 6490.5 of 23 Feb 99
2002	Psychological debriefing is not an effective means to reduce acute posttraumatic distress or prevent PTSD.	Litz, B. T., Gray, MJ., Bryant, R. A., Adler, A. B. (2002). Early intervention for trauma: current status and future direction. *Clinical Psychology: Science and Practice, 9*:112-134 Department of Veterans Affairs, Department of Defense. (2004). VA/DoD Clinical Practice Guideline for the management of Post-Traumatic Stress. Available at: www.pdhealth.mil/clinicians/va-dod_cpg.asp
2006	*Psychological First Aid*: a modular approach to assisting individuals in the aftermath of disasters or terrorism, is based on five evidence-informed practices.	National Child Traumatic Stress Network, National Center for PTSD. (2006). Psychological First Aid: Field Operations Guide, 2nd Edition. Available on: www.ncptsd.va.gov 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.
2007	Exposure to intense or persistent stressors in military operations can cause literal stress injuries to brain and mind.	Nash, W. P. (2007). Combat/operational stress adaptations and injuries. In C. F. Figley & W. P. Nash, Combat Stress Injury: Theory, Research, and Management. New York: Routledge
2007	The Stress Continuum Model is adopted by the USMC as its overarching Combat and Operational Stress Control (COSC) framework.	Commanding Generals, I MEF, II MEF, & III MEF, letter of 12 Sep 07. Available at: www.mca-marines.org/Gazette/PDF/USMCLetterPP.pdf Marine Corps Bulletin 6490 of 18 Sep 08
2008	The Stress Continuum Model is adopted by the USN as its overarching Operational Stress Control (OSC) framework.	NAVADMIN 332/08 of 21 Nov 08 Also see: www-nehc.med.navy.mil/downloads/stress/osc_awareness_brief.pdf
2009	Five core leader functions for COSC and OSC: strengthen, mitigate, identify, treat, and reintegrate.	US Marine Corps, US Navy. (in draft). Combat and operational stress control, MCRP 6-11C/NTTP1-15M

Appendix B

Appendix C: Motivational Interviewing

Helping service members to be agents in their healing and recovery and building self-efficacy are core COSFA principles. However, caregivers will face service members 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 COSFA, the objective is to increase the likelihood that a service member will engage in steps towards being an active agent in a secondary aid plan to promote healing and recovery from combat and operational stress.

The key MI principle is that a service member is most likely to change his or her behavior when the need, the decision, and the plan for change <u>are generated by the individual</u>. MI is an approach that helps caregivers overcome their understandable inclination to tell service members what they need to do, and helps them shape the dialogue so that service members 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 <u>expected human experience</u>. In MI, the caregiver avoids confrontation and avoids telling service members what to do; rather, MI entails providing reflective feedback to the service member about his or her reluctance and ambivalence in a neutral but caring manner. It entails working <u>with</u> the ambivalence rather than against it. Sometimes this is called "meeting the service member where they are."

MI requires that the caregiver develop a nonjudgmental collaborative relationship with the service member. An important healing aspect of COSFA 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; judging, criticizing, or blaming; warning of negative consequences; seeking to persuade; interpreting or analyzing defensiveness; being authoritative; or using sarcasm.* MI entails helping the service member <u>self-identify</u> his or her wishes and intentions and to have them think about methods for positive change. The four key MI strategies are: (1) <u>expressing empathy</u>; (2) asking questions that help the service member <u>identify a discrepancy</u> between his or her current state and self-identified wishes, goals, and needs in the future; (3) *Rolling with* <u>resistance and avoiding argumentation</u>; and (4) <u>supporting self-efficacy</u>. For caregivers, the first and last strategy should come easily.

1) *Expressing 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 service member to articulate how his or her current state differs from his or her ideals and goals.   Discrepancies often emerge when service members 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 service members 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 service member 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 service member 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 service member 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 service member 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 COSFA strategies are often a part of the unit 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 service member generate ideas about the problem and what he or she needs to do to help solve it.

> **Example**: If the service member 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 Sailor or Marine, 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 service member 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 service member needs to do differently to reconnect, regain competence,

and bolster confidence. Caregivers might also help the service member clarify priorities, set 'milestones' on the way to achieving goals, help the service member 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 service member 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 service member 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 C

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 service members, 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 combat and 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. Service members 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 combat and 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 service members 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.
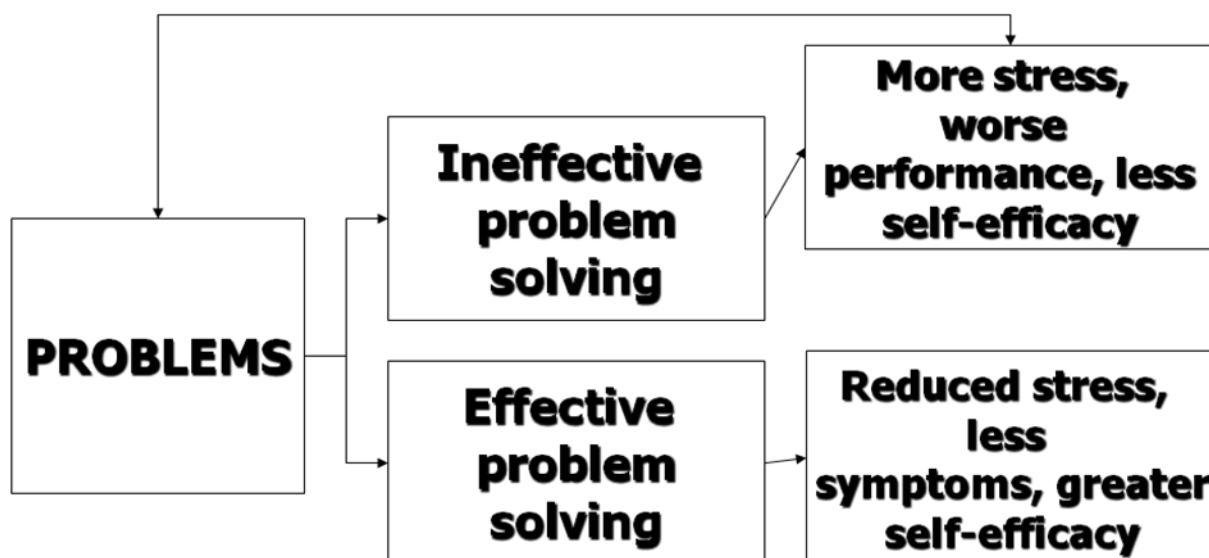
Problem-solving training is a simple yet useful tool for caregivers working with service members to accomplish secondary aid goals. These strategies stem from *Problem-Solving Therapy*, a cognitive-behavioral therapy approach that treats mental health problems by teaching patients how to systematically 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 COSFA provided by caregivers, problem solving will be useful to accomplish the three Secondary Aid goals, namely, *connect*, *competence,* and *confidence*. If the service member 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 service member, the service member will be in a mental state that will allow him or her to take advantage of a problem-solving intervention. Problem solving can help service members 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 service member 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 service member 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 service member to *break down large problems into smaller and more manageable parts*. They should also help the service member 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 service members 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, service members 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 service members 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 service member is asked to select a solution among all the brainstormed options. The process involves helping service members: Weigh advantages and disadvantages for each <u>viable</u> 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 service member to agree to try out a selected solution. *Encourage the service member to embrace the process and to be curious about whether the solution works.* The service member 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 service member 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. Service members 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 service member to *embrace and own the process.* Key questions are:

- What did the service member learn about the situation that he or she did not know for sure before?

- Exactly what happened when the service member 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 service member 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:

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Appendix D

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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

Service members are at risk for exposure to frequent and sustained combat and 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 service member 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 service members 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 combat and operational stress is an unfolding trajectory; what you see is not what you get over time. For example, some service members with Orange Zone Stress Injuries in theatre will recover and heal, and some will develop chronic Red Zone Illnesses, such as PTSD. In contrast, some service members 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 combat and operational stress injury, namely, *life-threat*, *loss*, *inner conflict*, and *wear and tear*. Even if service members 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, hypervigilance, 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 Navy–Marine Corps Combat and Operational Stress Continuum model provides a framework for understanding and recognizing combat and operational stress across its spectrum. The Marine Corps and Navy have established the following five core leader functions for COSC and OSC across the Stress Continuum:

- Strengthen
- Mitigate
- Identify
- Treat
- Reintegrate

Strengthen

Strengthening individuals, units, and families to enhance their resilience is the first core COSC and OSC function for military leaders. Individuals enter military 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 military organizations and decades of scientific research have demonstrated that commanders of military units can do much to enhance the resilience of unit members and their families, regardless of these pre-existing vulnerabilities. Activities available to commanders 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 service members' confidence in their ability as individuals and as members of units to cope with the challenges they will face, and inoculates them to the stressors they will encounter. One challenge for unit 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 combat and operational stress in both military units and families. Effective leaders know how to build cohesive units given enough time and unit stability, but a too-common challenge is to maintain unit cohesion in the face of rotations into and out of the unit, including late joins, casualties, and combat replacements. Individual augmentees and members of reserve or National Guard units may be particularly disadvantaged regarding this important ingredient to resilience. Another challenge for unit 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 unit than the active duty service members who deploy in cohesive units, 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 unit members and families. Unit 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 unit members is by providing a resource of courage and fortitude on which unit members can draw during times of challenge. The influence leaders have over their subordinates is a sword that can cut both ways — leaders who, themselves, are in the Yellow, Orange, or Red Zones may become detriments to their units unless the leaders' own stress is recognized and effectively managed.

Mitigate

Since no service member 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 units are exposed. Optimal mitigation of stress requires the balancing of competing priorities. On one side is the need to intentionally subject service members to stress in order to train and toughen them, and to accomplish assigned missions 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 unit 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 unit leaders to mitigate combat and 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 units, including their specific strengths and weaknesses, and the nature of the challenges they face, both in the unit and in their home lives. Leaders must recognize when individuals' confidence in themselves or their peers or leaders is shaken, or when units have lost cohesion because of casualties, changes in leadership, or challenges to the unit. Most important, every unit leader must know which stress zone each unit member is in at every moment, day to day. Service members 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 unit leaders to continually watch out for their subordinates, 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:

- Combat and Operational Stress First Aid (COSFA)
- Self aid or buddy aid
- Support from a small unit leader, chaplain, or corpsman
- Definitive medical or psychological treatment.

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

Regardless of what level or type of treatment is available and indicated for any given service member, the overall responsibility for ensuring that appropriate and timely care is delivered rests with unit leaders and their commanders. To increase the likelihood that needed care will be accepted by the individuals who need it, leaders must also attack stigma in their units 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 heal, 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 commanders face one final challenge in their management of service members 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 units, stigma must be continuously addressed, and the confidence of the stress-injured service member, their peers, and small unit 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 unit commanders is to assist service members as they transition to civilian life and VA care.

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Appendix G: Suicidal Ideation

Suicide is a preventable personnel loss that impacts unit 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 unit 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 unit effectiveness, and reduce risk of intentional self-harm. As such, preventing suicide begins with promotion of health and wellness consistent with keeping service members ready to accomplish the mission. The Navy and Marine Corps 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
- Intervention – ensuring timely access to needed services and having a plan of action for crisis response
- Response – assisting families, units, and service members 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: Military 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 military 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;

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[7] Defense Centers of Excellence. (2009). Military 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 battle injuries or combat-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, unit cohesion, caring leadership, and connection with fellow warriors)

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)?

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[8] *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)?

Command Advisement

Military 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 Navy and Marine Corps leaders use to guide decisions and actions. Leaders will use organic resources or consult with the nearest medical personnel, chaplains, or FFSC counselors to assess requirements for supportive interventions for units and affected service members. 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.militaryonesource.com
- www.militarymentalhealth.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

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Appendix H: Caregiver Occupational Stress

Background

The current demands and challenges that military medical personnel face today are dramatically different from the challenges of only a few years ago. Caregivers rarely deploy as a cohesive unit and do not have the protective factors associated with intensive realistic team training. The restorative dwell time between deployments that is so critical to combat units is not part of the caregiver culture. The skills, knowledge, and role expectations that caregivers use in a combat 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 service members, 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 both the civilian and Navy 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 COSFA 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 COSC 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 warrior-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 unit.

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 units 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 commands and became part of a cohesive unit. They leave the cohesive unit and return to their parent command, where they must become part of a new unit. 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

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Appendix H

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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 service member's susceptibility varies over time due to the accumulation of stress from other causes. No one knows how common traumatic stress injuries are among service members 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 service members include:

- Like other stress injuries, they are invisible, so they can easily be overlooked by leaders.
- Like other stress injuries, they can provoke feelings of shame in service members, 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 service members 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 service members at risk for traumatic stress injuries. These situations vary in their toxic effect on service members, and each service member's vulnerability to various PTEs is unique. PTEs in current operations include:

- Multi-casualty events, such as IEDs, SVBIEDs, and ambushes.
- Friendly-fire casualties.
- Death or maiming of women and children.

- 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.
- Being helpless to defend or counterattack.
- 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 deployments. 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 tough training and even tougher operational deployments. 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 post-deployment, 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 service members — and yourself. In contrast to traumatic stress injuries, to which younger service members are often most vulnerable, older service members 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 service member 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 service member 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 combat environment for more than 6 continuous months
- High casualty rates in the unit
- The loss of sustaining friendships in the unit 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 homefront worries, such as relationship, health, or money problems
- Prolonged boredom
- The lack of opportunities for occasional recreation and enjoyment

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 unit
- 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 homefront 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 service members receive adequate sleep, rest, and recreation while deployed. Once service members 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 service member take a break from operational challenges for 24-72 hours, if at all possible.
- Recreate - have the service member engage in sports or games with others in the unit, if at all possible.
- Ensure that the service member is engaging in daily physical exercise, including aerobic endurance training, to help restore depleted resources.
- Reassure the service member that his or her symptoms and behaviors will be temporary.
- Keep the service member connected with his or her unit, if at all possible.

Assess the need for professional care

- Indications for *immediate* professional care include:

- Service member cannot get to sleep or stay asleep for at least 6 hours every days.
- Service member threatens harm to self or others in the unit.
- Service member's behavior or speech is confused, irrational, or disorganized.
- Service member's anger or fearfulness disrupts unit 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 service member about the stress injury symptoms listed above, and *listen* to his or her answers.
- If symptoms resolve without professional care, monitor the service member carefully for persistent but unreported symptoms.
- If professional evaluation and treatment are indicated, encourage your service member to receive and comply with such treatment.
- Do not allow your service member 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 service member gradually back to full duty.
- Encourage counseling with the unit chaplain, if desired by the service member.
- 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 service member and other unit members of him or her remaining in the unit, balanced against the risk to the service member and other unit members of him or her leaving the unit
- 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 service member (It is natural to feel frustrated with someone who seems not to be coping as well as expected, especially in a combat or operational situation, but expressing anger or frustration *never* helps.)
- Trying to convince a stress-injured service member 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 service member for being "weak" - everyone has his or her breaking point, including you.
- Not giving the service member 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 service members 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 Service members who experience a fatigue stress injury will recover if given adequate sleep, rest, and recuperation.
- Most (more than 95%) will remain with the unit to complete the operational deployment.
- Many will require no professional medical or mental health help other than counseling with the unit 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 service members receive, and of how they respond to treatment.
- Of those few service members 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 service members in your unit to ask for help when they need it, more of your service members may ask for help. That is good for your unit, your service members, and their families.

Troubleshooting Suggestions for Leaders

A Service member 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 service members 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 service member with stress problems to admit to them if you disclose stress problems that you, yourself, or that other respected service members have experienced. Remind the service member 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 service members. If a service member with fatigue stress injury symptoms refuses to talk about them or to consider getting help, honor that decision unless the service member's potential risk to himself or herself or to others requires the service member to submit to a mental health evaluation in accordance with DoDD 6490.1.

A Service member 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 – a violation of the UCMJ. However, malingering of operational stress problems, such as depression, anxiety, or other fatigue stress symptoms, is exceedingly rare. Most service members or veterans 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 service member getting away with deception is an injustice, so also is a service member being denied help for a real stress injury. Resist the urge to jump to conclusions, but always refer such service members 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 service member 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 service member 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 service members recover from traumatic stress injuries, not all helping professionals are equally trained and experienced in providing such help. Since the last time our country was in a sustained conflict, PTSD did not yet exist as a diagnostic entity. There is a great deal about combat-related stress injuries that has only recently been learned or developed. If one of your service members 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 service member 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 J

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 combat and other military operations, losses can result from casualties within the unit, or from a death or relationship break-up back home. The physical and mental components of grief have, in the past, usually been considered normal 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 which 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 combat and other military 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, such as a "battle buddy"
- The death of a valued leader or mentor
- The death of someone with whom the service member closely identified
- The death of someone for whom the service member 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 unit affect *everyone* in the unit, although service members closest to the lost unit member (closest to the center of impact of the loss) will likely be more deeply wounded by the loss. Furthermore, normal processes of healing from grief are almost always shared by the community impacted by the loss. 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 unit as a whole. Leader actions for grief include: (1) applying psychological first aid for individuals, (2) applying psychological first aid for units, (3) assessing the need for professional care, and (4) mentoring back to full duty and function.

Individual Actions

- If the service member loses control, keep positive physical control of the service member until his or her internal controls return.
- Calm, soothe, and support emotionally - be gentle but firm.
- Keep the service member occupied and productive, but away from combat or other 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 service member if he or she wishes to talk about the loss.
- Keep the service member connected to peers and other leaders.

Unit Actions

Unit-level interventions after losses are the responsibility of unit leadership, at all levels — including unit chaplains and medical personnel — with assistance and support of mental health personnel outside the unit as needed. Routine psychological debriefing in units, such as Critical Incident Stress Debriefing (CISD), is not encouraged because it is not believed to be helpful, and it may be harmful for certain individuals. The following are COSFA interventions for units affected by losses:

- Get the unit to safety as soon as possible.
- Rest the unit for 24-72 hours, if at all possible.
- Encourage discussions in squad-sized After Action Reviews of what happened, why it happened, what will be done to prevent it from happening again (if possible), and what purpose was served by the sacrifice.
- Reinforce the rules of engagement and Law of War, and remind your service members that revenge not only dishonors the Corps and those who have sacrificed, but it also is self-defeating in a counterinsurgency conflict.
- Honor the fallen through memorial services, physical memorials, and other celebrations.

Assess the need for professional care

It is unusual for service members 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 service members 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 service members).
- Remember that you are the leader of your service members *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 service members 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 service member to receive and comply with such treatment.
- Do not allow your service members to be criticized or punished for receiving counseling or other treatment – getting help is *not* a sign of moral weakness.
- Encourage counseling with the unit chaplain, if desired by the service member.

What to Avoid

- Trivializing the loss or its impact on your service members
- Expecting everyone in the unit to react the same way to a loss, especially in the middle of an operational deployment, when it is normal for many service members to be emotionally numb to losses, while others will feel grief more acutely
- Blaming any service member 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 service members 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 unit members so they know what really happened and why.)

- Not holding memorial services because of operational demands

- Delegating to your unit chaplain the entire responsibility for grief leadership in your unit; leading your service members 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 service members heal quickly and well from grief.

- Very few service members will have long-term mental health problems from unhealed grief.

- The most common problem experienced by service members 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 service members from acting on their wishes for revenge.

Troubleshooting

A Service member 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 service members 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 service member with stress problems to admit to him or her if you disclose stress problems that you, yourself, or that other respected service members have experienced. Remind the service member 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 service members. If a service member with stress injury symptoms refuses to talk about them or to consider getting help, honor that decision unless the service member's potential risk to himself or herself or to others requires the service member to submit to a mental health evaluation in accordance with DoDD 6490.1.

You send a service member 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 service members 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 service members 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 service member through another of the many available portals of care (listed elsewhere in this guide). Third, contact one of the leaders of a helping professional community or service for further assistance and guidance.

Appendix K

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 service members 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 military culture and context (for example, with family or after retirement), some service members 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 service member'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 service member feels remorse about various behaviors, he or she will experience guilt; if the service member 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 service members will be convinced and confident that not only their actions, but they are unforgiveable. In other words, service members will fail to forgive themselves and experience self-condemnation. If the service member experiences betrayal, his or her confidence in leaders and mission readiness can be compromised as well.

Orange Zone Signs of Moral injury:

Service members 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. Service members 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 service members repair and renew. For many service members, repair and renewal require an initial dialogue about the moral transgression(s), its meaning and significance, and the implication for the service member moving forward in his or her life. Because of shame, guilt, and the expectation of condemnation and rejection, the service member needs to share and disclose what haunts him or her. Service members need to articulate their thoughts about what the event means about who they are now, their role in the military, their role in their families, and so forth.

Then, the caregiver needs to help the service member think about what might happen if he or she sticks to these judgments, moving forward in his or her life.
Service members need support and guidance to consider an alternative repair and renewal plan over time, which will entail exposure to corrective experience within the military and outside the military (for example, with family).
The service member 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.

Unit Actions

Unit-level interventions are the responsibility of unit leadership at all levels - including unit chaplains and medical personnel - with assistance and support of mental health personnel outside the unit as needed. In the case of moral injury, service members 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 service member 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 service members 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 parasuicidal 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 service members 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 service members
- Blaming any service member 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 in combat or other 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 world view.
- Look for signs where the service member uses the moral transgression experience to mentor and teach others.
- Watch for signs of self-handicapping behavior or the member being shunned by the unit. Sometimes the member can begin to work through the moral transgression while members of the unit are trying to reconcile their own roles and expectations around the events.

Troubleshooting

 A service member 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 service members 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 service member with stress problems to admit to him or her if you disclose stress problems that you, yourself, or that other respected service members have experienced. Remind the service member 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 service members. If a service member with stress injury symptoms refuses to talk about them or to consider getting help, honor that decision unless the service member's potential risk to himself or herself, or to

Appendix L

others requires the service member to submit to a mental health evaluation in accordance with DoDD 6490.1.

Appendix M: Group-Administered COSFA

The model for applying COSFA 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 psychoeducation 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. Additionally, two randomized controlled trials (RCTs) of CISD have reported a higher incidence of negative outcomes in those who received CISD when compared with those who did not receive an intervention (for recent reviews, see Bisson, 2003; Litz et al., 2002; McNally et al., 2003).

Three recent 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. In another RCT, Sijbrandij, Olff, Reitsma, Carlier, and Gersons (2006) assigned adult survivors of a recent traumatic event (civilians) to individual emotional ventilation debriefing, individual educational debriefing, or no debriefing (control condition). The study found no evidence for the usefulness of psychological debriefing in reducing symptoms of PTSD, anxiety, and depression after psychological trauma, and Sijbranij et al. reported that participants in the emotional debriefing group with high baseline hyperarousal scores had significantly more PTSD symptoms at 6 weeks than control participants. In a third RCT, this one with armed robber victims, Marchand et al. (2006) also reported no differences between a CISD intervention and control group in preventing PTSD or attenuating posttraumatic symptoms.

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. In the meantime, numerous reviews of the best-controlled studies conclude that CISD cannot currently be endorsed as an intervention that prevents long-term distress or psychopathology (Litz & Maguen, 2007; McNally et al., 2003; Rose, Bisson, & Wessely, 2003). Given the negative findings associated with CISD as well as preliminary evidence that increased arousal in the immediate phases post-trauma is linked to long-term pathology, experts are concerned that any intervention that focuses on emotional processing during this immediate period may be contraindicated. 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 opportunities 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 COSFA, 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 COSFA 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 COSFA in a group setting (see table below). First, providing information about different COSFA actions after a critical event is more efficient in a group format. When individual COSFA 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 service members. Second, social support is an important aspect of coping with combat and 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 service member, in that other persons are seen to be coping with similar difficulties. Group-administered COSFA should ideally differ from After Action Reviews in that it provides education about the COSFA 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.

Appendix M

POTENTIAL ADVANTAGES OF COSFA OFFERED IN GROUP FORMAT	POTENTIAL DISADVANTAGES OF COSFA IN GROUP FORMAT	COSFA 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 service members.
▪ 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 service member, in that other persons are seen to be coping with similar difficulties.
▪ A COSFA 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 COSFA 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 COSFA OFFERED IN GROUP FORMAT	POTENTIAL DISADVANTAGES OF COSFA IN GROUP FORMAT	COSFA 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 service 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 service members cope with combat and 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
- Not wanting to burden others
- Wanting to avoid thinking or feeling about the event
- Feeling embarrassed or "weak"
- Doubting it will be helpful or that others won't understand
- Feeling that others will be disappointed or judgmental
- Feeling they will lose control
- Having tried to get help and felt that it was not there before
- Not knowing where to get help

Good Things to Do When Giving Support

- Show interest, attention, and care.
- Show respect for individuals' reactions and ways of coping.
- Talk about expectable reactions to traumatic stress, and healthy coping.
- Find an uninterrupted time and place to talk.
- Acknowledge that this type of stress can take time to resolve.
- Believe that the person is capable of recovery.
- Be free of expectations or judgments.
- Help brainstorm positive ways to deal with their reactions.
- 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"
- Acting like someone is weak or exaggerating because he or she is not coping as well as you are
- Discussing your own personal experiences without listening to the other person's story
- Giving advice without listening to the person's concerns or asking the person what works for him or her
- Stopping the person from talking about what is bothering them
- 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're 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:	• "No wonder you feel…" • "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…"
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 combat and operational stress, a person's view of the world and himself or herself may change. For example, service members 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 service members change their perspective in a way that helps them to gain insight, reduce distress, and move forward more effectively.

Caregivers can help service members 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 buddy/family member, what would you say to him/her?"

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Appendix O

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 buddies.	• 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

Military 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.

- 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 corpsman is tending to a wounded Marine, if the Marine can hold a weapon, he has the task to protect the corpsman while he is being treated. This keeps the Marine focused on having a job to do to continue the mission. Along with distracting and focusing, this strategy has 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 combat readiness 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 mission elements/tasks need immediate attention.

Check and Repeat:
Check to see if the service member 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. Trauma/Impact Case Exemplar

This exemplar vignette is designed to provide one possible scenario out of many variations on a theme that is intended to enhance understanding of COSFA principles and caregivers are encouraged to think about your own professional skills and personal style within the context of the vignette.

Back Story:
HM1 Radiology Tech assigned to a deployed LHA off the coast of Iraq. One of HM1 Rentgen's primary duties is to identify and sort blast-exposed body parts. HM1 Rentgen has been performing the duties for about 4 months and is known as a serious and focused petty officer who is considered highly competitive for promotion to E-7. HM1 Rentgen is married with two sons. The elder son is in the Army and currently deployed to Iraq. HM1 Rentgen used emotional distancing and thought of the work as a form of forensic puzzle. The current task was to sort and identify the parts of three soldiers from a vehicle that flipped and burned due to an IED blast. A quick glance at a hand struck HM1 Rentgen as being familiar. A sense of dread and panic started to increase upon closer inspection the hand. HM1 Rentgen then checked the names of the three deceased soldiers. The first name of one of the deceased soldiers was the same as HM1 Rentgen's deployed son.

Cycle 1

HN Jones, another X-ray tech, observes that the current exam is taking longer than usual and stops in to see if the HM1 Rentgen needs assistance with the task. HN Jones sees HM1 Rentgen sitting on the deck next to the radiology table, legs crossed, head held in hands, slumped over, breathing rapidly, with arms shaking.

1. Check
   a. Check 1: Look for danger, quick assess of environment, ABCs (Airway, Breathing, Circulation). Observes burnt body parts, strong odor in the room, constant noise from ventilation system, a folder on the floor near HM1 Rentgen.
      i.   Assessment: Not a medical emergency and HM1 not in immediate danger

   b. Check 2: HN Jones approaches HM1, kneels down on one knee and asks, "Are you hurt? What's wrong?" Observes that HM1 Rentgen is slow to respond to HN Jones, low verbal repetition of son's name.
      i.   Assessment: Appears to be some type of stress response, appears safe but is not responding well to calming interventions. Orange Zone Distress: minimal response, need more data.

2. Coordinate:
   a. What can I do?
      i.   Cover: Do not leave him alone.
      ii.   Calm
   b. Do I need more help?
      i.   Yes, go to door and ask for help.

    c. Who else needs to know?
       i. Other first responders

3. Cover
    a. Presence, Letting him know that the HN is with him

4. Calm
    a. HN Jones tries three times to get HM1 Rentgen to respond. First, calm voice asking if HM1 Is okay. Second, tried to get HM1 to follow along with two cycles of deep breathing. HM1 Rentgen started to slow breathing and HN Jones asked if HM1 Rentgen wanted to sit on a chair rather than the deck. HM1 nodded yes and began to rise. HM1 Rentgen is just sitting in the chair as another corpsman and an HMC enter the room.

Cycle 2
     HMC Jackson enters the room and sees HM1 Rentgen sitting on a chair with HN Jones kneeling in front of the HM1, talking in a low calm voice.

HMC Jackson:
1. Check
    a. Check 1. Observe for immediate dangerousness.
       i. Assessment: Not in danger
    b. Check 2: "HMC Jackson asks, "What is going on." HN Jones pauses to let HM1 Rentgen answer. HM1 Rentgen says, "Nothing, I'll be okay, the smell must have gotten to me." HMC Jackson turns to HN Jones and states, "Why did you call for help?" HN Jones replies, "I stopped in to see if HM1 needed any help. HM1 was sitting on the floor by the table, was breathing fast, arms were shaking, and it took awhile to get off the floor and move to the chair.
       i. Assessment: Appears to be some type of stress response, appears safe but is slow to respond and shows a definite change from behaviors a few hours earlier at morning quarters. Orange Zone Distress: need more data.

2. Coordinate:
    b. What can I do?
       i. I can go to a private spot and assess further.
    c. Do I need more help?
       i. Not yet
    d. Who else needs to know?
       i. No one else right now

3. Cover
    a. Move HM1 Rentgen away from potential triggers in the radiology room to the Chief's office. HMC Jackson instructs HN Jones to secure the radiology room until HM1 can return to the work. While walking with HM1, the Chief observes for non-verbal and verbal behaviors looking in particular for slowed motor response, hypervigilance, or a return to baseline.

4. Calm
   a. HMC closes the office door and sits down next to HM1 Rentgen and states in a calm and reassuring tone, "I don't know what happened in there this morning and I hope that you will be able to tell me. I do know that you have been very dedicated, you are one of the most professional petty officer's in sickbay, and you have been doing a job that is very difficult.

   b. Check1: not dangerous, in more control, able to talk

   c. Check 2: "Help me understand what happened." HM1 Rentgen states that the day started like any other day and that the work today was going to be a challenge because at least three bodies arrived in only two bags. While sorting the recognizable parts there was a hand that looked familiar, and images of HM1 Rentgen's son started to intrude into HM1's thoughts. HM1 Rentgen stated, "I saw a ring on a hand and thought it was my son who is deployed. I quickly checked the names of the deceased and I saw my son's first name. I lost my breath, my heart started racing, and I sat on the floor. That's when I noticed that the last name was different and it was not my son. Next thing I remember was Jonesie telling me to move to a chair and then you showed up. I still feel shaken up." While talking, HM1 Rentgen became more animated and appeared to startle to noises in the passageway outside the Chief's office.

      i. Stressor Events: Ring on hand reminded of son, first name of remains was son's name
      ii. Distress: First: panic, "This is my son".   Second, Relief that it was not and feeling overwhelmed. Now: feeling dazed.
      iii. Change in Function: "Went blank." Heart rate, could not catch breath, pulse still up, HM1 startles to noise in passageway. Behaviors remain different from baseline. "Still shaken up"
      iv. Decision: Orange Zone injured as evidenced by change in function, statements of distress, and an identified stressor event of thinking of son's death.

5. Connect
   a. Observed Behavior
      i. Minimized need for help.
      ii. Occupational isolation (others do not talk with him about the work)
   b. Vulnerabilities
      i. Isolation
      ii. No one else shared the experience
      iii. Feeling vulnerable
      iv. Potential Shame (self-stigma)
      v. Expectation of stigma (peer stigma)
      vi. Loss of intimacy (trust in other)
      vii. Numbness

    c. Resources
        i.   Trusted Friends
        ii.   Social skills
        iii.   Peer acceptance
        iv.   Spirituality
        v.   Family
    d. Obstacles
        i.   Language of thought and emotions
        ii.   Peer or command conflict or disunity
        iii.   Morale
    e. Needs
        i.   To be understood
        ii.   Meaning making
        iii.   Unburdened
        iv.   Comforted
        v.   Guidance

6. Competence,
    a. Observed Behavior
        i.   Collapsed to floor
        ii.   Temporarily non-mission ready
    b. Vulnerabilities
        i.   Ability to detach
        ii.   Phobic avoidance
        iii.   Ability to modulate physiological arousal
        iv.   Loss of control physiologic, cognitive, emotional
        v.   Constricted
        vi.   Numbness
        vii.   Resilience to social challenge
        viii.   Concern about future sleep management
    c. Resources
        i.   Work Skills
        ii.   Social skills
        iii.   Problem solving skills
        iv.   Alternative skills
        v.   Good peer supports
        vi.   Cohesive milieu
        vii.   Good leaders
    d. Obstacles
        i.   Operational impatience
        ii.   Denial
        iii.   Self-stigma
        iv.   Self-blaming
        v.   Loss of meaning and purpose
        vi.   Peer or command conflict or disunity
        vii.   Morale

e. Needs
   i. Retraining
   ii. Mentoring back to competence
   iii. May need augmented skills
   iv. Stress and affect management
   v. Education
   vi. Accurate expectations
   vii. Preparation
   viii. Skills training
   ix. Anticipate short-term challenges
   x. Psychoeducation
   xi. Self-care routines

7. Confidence
   a. Observed Behavior
      i. HM1 Rentgen stated a readiness to return to the radiology room to finish the current task. HMC Jackson is concerned but does not want to undermine HM1's confidence. HMC tells HM1 to take a break and get some fresh air. HMC also states that he realized that there has not been enough cross-training in sickbay and that he wants HM1 Rentgen to mentor both HN Jones and HM3 Hardesty as assistants.
      ii. To be determined, needs follow-up Check
   b. Vulnerabilities
      i. Lost trust in abilities
      ii. Lost trust in value of the mission
      iii. Demoralized
      iv. Existential uncertainty
      v. Questions about war
      vi. Self-condemnation
      vii. I will never be the same (tainted)
      viii. Tarnished belief in God
      ix. Negative career impact expectations
   c. Resources
      i. Supportive supervisor
      ii. Others in sickbay who could do the task or assist
      iii. HMC sees HM1 as a mentor
   d. Obstacles
      i. Guilt about under-functioning
      ii. Shame about loss of control
      iii. Hopelessness
      iv. Distorted thinking: Overgeneralizing
      v. Mission uncertainty
      vi. Immaturity
      vii. Prior unhealed trauma
      viii. Prior failure experiences

    e. Needs
- i.   Predictability and control
- ii.   Restoring hope
- iii.   Acceptance
  - Humanity
  - Changes
- iv.   Meaning
  - Contextualizing (understand the reasons this happened)
  - Restoring self-worth
- v.   Success experiences
  - Occupational
  - Symptom management
  - Social connection
    1. Being understood
    2. Comfort
    3. Acceptance
    4. Love

8. Secondary Aid Plan:
   a. Validate experience
   b. Reassure
   c. Model acceptance of humanity
   d. Educate
      - i. Provide guidance
      - ii. Review incident and impact
      - iii. Nature of stress injury
      - iv. Accurate expectations
   e. Collaborative contract about a recovery plan
      - i. Getting on the same page
      - ii. Solicit agreement
   f. Plan for rest and restoration
      - i. Plan for wellness and sleep
      - ii. Arousal reduction
        - Deep slow breathing
        - Distraction
        - Self-talk
   g. Social resource replenishment
      - i. Family contact
      - ii. Encourage disclosure with close peer?
      - iii. Garner support of trusted others (on behalf of the service member)?
   h. Plan for reintegration into work center
      - i. Processing with others
      - ii. Rebuild trust
   i. Plan for building competence and confidence
      - i. Reassignment?
      - ii. Create opportunity for success experiences

       iii. Gradual exposure back to full duty
  j. Plan for follow-up and follow-through
       i. Check for distorted thinking
- Disputation
- Is there another way of looking at this?

       ii. Check for sleep and wellness routines (eating, leisure, play, hygiene)
       iii. Check for quality of social connection
       iv. Check for lessons learned, constructions, narrative, etc. (transcendence)
       v. Recheck the plan

9. Coordinate:
  b. What can I do?
       i. Provide calm reassurance
       ii. Communicate faith in HM1 abilities
       iii. Get more people cross trained to duties
       iv. Develop a rotation to decrease exposure of any individual corpsman
  c. I need more help:
       i. Medical officer evaluation because of finding HM1 on the floor and the rapid breathing with elevated heart rate. Need to make sure that dehydration or other physiological issues did not contribute to HM1's response.
       ii. Trusted others (garner social supports)
       iii. Offer Chaplain support to HM1
       iv. Confer with trusted other (for HMC Jackson) about plan
  d. Who else needs to know?
       i. Senior Medical Officer
       ii. Senior Enlisted Leader for medical

10. Continue to Check and Coordinate

Appendix Q

Appendix R. Loss Case Exemplar

This exemplar vignette is designed to provide one possible scenario out of many variations on a theme that is intended to enhance understanding of COSFA principles, and caregivers are encouraged to think about your own professional skills and personal style within the context of the vignette.

Back Story:
In theatre, in Afghanistan.

Chaplain Marks is walking around Camp ____ wanting to be available because two days earlier a unit was patrolling _____ during the night and snipers fired on the patrol and a Marine Sgt. Lewis was killed. Chaplain Marks conducted the memorial service a day earlier.

Chaplain Marks notices that Marine Cpl. Curran is sitting alone on the ground behind the mess tent, while other Marines are eating and conversing nearby. Cpl. Curran appears dejected and has a pained but very reserved look on his face. Chaplain Marks approaches Cpl. Curran. The Chaplain shares his observations with Cpl. Curran and asks him if he is willing to talk about what might be going on for him.

Cpl. Curran tears up slightly and is flushed. He is anxious and dazed and shares that he has to go. Noticing that Cpl. Curran is in pain, Chaplain Marks gently grasps his shoulder and asks him to stay a bit longer so they can talk. Cpl. Curran wants to leave and does not want to talk; he is very uncomfortable, scans his surroundings to avoid eye-contact, and then stares at the ground. He clenches and unclenches his fists repeatedly. Chaplain Marks allows a few minutes of silence before he asks Cpl. Curran if he might be willing to share what is bothering him. Cpl. Curran reasserts that he would rather not talk and asks if he can go. His speech is staccato. The first thing Cpl. Curran shares is how angry he is – he feels like he could blow. Even thought he stated he wanted to go, Cpl. Curran talks about how he cannot wait to go outside the wire; he is desperate to get some payback for Lewis. He is extremely bitter. Chaplain Marks asks Cpl. Curran to describe his relationship with Lewis.

Chaplain Marks learns that Lewis was Cpl. Curran's mentor and he looked up to him like a big brother. Lewis was stern but always fair and liked practical jokes. Most important, Lewis made him feel safe, almost invulnerable because he was so decisive and clear about what needs to be done in any situation. It is clear that Cpl. Curran had a deep love and bond with Lewis, and his loss is unimaginable and has shaken him to the core. He feels that a part of him died with Lewis. When asked about how he has been functioning since the loss, Cpl. Curran shares that he is isolating himself and is unable to trust anyone. He feels pangs of rage and pangs of deep sorrow that he tries to avoid at all costs. Cpl. Curran has not been taking care of himself; he eats little and his sleep is spotty because images of Lewis and the patrol haunt him, especially at night.

Cycle 1 (First Responder Scenario)

1. Check

    a. Chaplain Marks approaches Cpl. Curren because he is isolated and looks dejected and numb. He first determines that Cpl. Curran is not in any immediate danger of hurting himself or others.
        i. Assessment: Not a medical emergency and Cpl. Curran not in immediate danger

    b. Check 2:
        i. In the initial second check, Chaplain Marks determines that Cpl. Curran is in the Orange Zone and is initially most concerned about the level of anger and the need for revenge. Because Chaplain Marks is aware of the recent loss, he knows to inquire about Cpl. Curran's response to the loss and his relationship with Sgt. Lewis. He knows to look past the anger to see if a loss injury is the core problem.

2. Coordinate:
    a. Chaplain Marks is confident that at this point, he can have this conversation with Cpl. Curran, alone. He is also aware that if he needed help, he would go to ____.
        i. Cover is not necessary at this time.
        ii. Calm: Chaplain Marks feels that the best course of action is to establish a trusting conversation so that Cpl. Curran can share what is bothering him.
    b. Do I need more help?
        i. No, not at this point.
    c. Who else needs to know?
        i.. Chaplain Marks is mindful that he will eventually need to engage others.

3. Cover
    a. Chaplain Marks is clear that he needs to stay with Cpl. Curran and try to find out the source of his pain, to determine the next steps.

4. Calm
    a. Chaplain Marks feels that although Cpl. Curran is expressing strong feelings and is very tense, he determines that calming strategies would detract from the connection he is trying to make. His main goal is to provide a safe space to further assess what is going on in terms of the source and form of his Orange Zone injury.

Cycle 2

1. Check
a. Check 1. Because Cpl. Curran expressed rage initially and a need for revenge, Chaplain Marks knows to Check for dangerousness (e.g., poor judgment and control). Observe for immediate dangerousness.
        i. Assessment: Cpl. Curran's anger is not directed at peers but his need for revenge may be a problem that will need to be addressed. Chaplain Marks makes a mental note to return to this issue.
b. Check 2: Chaplain Marks asks questions to assess the nature of a potential loss injury.

i.   Assessment: Chaplain Marks determines that Cpl. Curran is suffering from a loss injury.

2. Coordinate:
    a. What can I do?
        i.   Chaplain Marks does not want to interrupt the flow of the dialogue and he determines that the level of privacy is necessary and sufficient for a conversation about the loss at this point.
    b. Do I need more help?
        i.   Not yet
    c. Who else needs to know?
        i.   No one else right now

3. Cover
    a. Chaplain Marks provides cover by being present and engaged.

4. Calm
    a. Chaplain Marks' goal is to get Cpl. Curran to share his experience. He wants to assess his experience and allow him to unburden his anguish and sorrow at least to the extent that will make the experience worthwhile and clarifying for Cpl. Curran.

    b. Check1: not dangerous, in more control, able to talk

    c. Check 2: Chaplain Marks asks a serious of questions to determine the following:
        i.   Stressor Events: see above
        ii.   Distress: see above
        iii. Change in Function: see above
        iv.   Decision: Orange Zone injured as evidenced by an unequivocal loss event, statements of distress and observations of distress, and reports of changes in function.

5. Connect
    a. Observed Behavior
        i.   Cpl. Curran is isolating himself and has trouble trusting his peers.
        ii.   He wants revenge and is very angry and bitter about the loss of Sgt. Lewis
    b. Vulnerabilities
        i.   Isolation
        ii.   No one could understand his relationship with Lewis and he feels shame about being so close and caring.
        iii. Feeling intensely vulnerable and generally unsafe now that Lewis is not there for him
        iv.   Is likely to focus on rage and revenge as a way of avoiding vulnerability and sorrow about the loss of Lewis. So, sadness is likely to produce shame (self-stigma).
        v.   Expectation that he could not be understood and he thinks that he is the only one so strongly affected by Lewis (peer stigma).

      vi.   There is a general loss of trust in others and an avoidance of peers.
      vii.   Cpl. Curran shifts from numbness and disengagement, to anger, to brief sadness
   c. Resources
      i.   Cpl. Curran has a great relationship with his wife and he has two young children whom he loves very much.
      ii.   Prior to the loss, Cpl. Curren would hang out and have fun with peers during down time.
      iii.   Cpl. Curran is a Catholic and it helps that Chaplain Marks is a Catholic in this instance.
   d. Obstacles
      i.   Because of the loss of Sgt. Lewis, there is a leadership vacuum.
      ii.   Morale is low because of the loss.
   e. Needs
      i.   Cpl. Curran needs to unburden his sadness and disappointment about the loss. He needs to be understood and accepted, especially in terms of the leadership vacuum left after Lewis' loss.
      ii.   Cpl. Curran needs to mourn in a more focused manner. His avoidance and use of anger to get away from vulnerability is making it difficult for him to heal from the loss injury.
      iii.   Cpl. needs positive experience connecting with peers and leaders.
      iv.   Cpl. Curran's awareness of the grief expressed by other unit members during the memorial ceremony and currently, may be masked by his own distress.

6. Competence
   a. Observed Behavior
      i.   Isolating behaviors
      ii.   Reported need for revenge
   b. Vulnerabilities
      i.   Cpl. Curran is at risk for making bad decisions and acting out his rage.
   c. Resources
      i.   Cpl. Curran had worked well in his squad. The expectation is that he can regain full competence, if he sufficiently grieves the loss of Lewis and establishes trust with peers and especially a new leader
      ii.   Squad leader, corpsman, chaplain
      iii.   Leader and other behaviors that Cpl. Curran learned from Sgt. Lewis
   d. Obstacles
      i.   It is unclear who Lewis' replacement will be, who will lead the unit.
      ii.   Other Marines are hurting from the loss and may also want to avoid talking about it or sharing their vulnerability.
   e. Needs
      i.   Reconnection and reattachment with others
      ii.   Because Cpl. Curran is not taking care of himself (not eating well, not sleeping well), he needs to talk to a doctor and he needs help to ensure proper self-care.
      iii.   Because Cpl. Curran is numb and disengaged, he needs support and encouragement to reclaim leisure activities with peers.

      iv.   Cpl. Curran may be the symptom bearer within the squad and others may be having difficulty in addressing their grief within the squad.

      v.   Cpl. Curran may be rejecting the positive role model behavior that he has internalized from Sgt. Lewis because of his grief and may need to overtly discuss how the principles and skills taught to him by Sgt. Lewis now live one through Cpl. Curran.

7. Confidence
   a. Observed Behavior
      i. Cpl. Curran has lost self-efficacy and is at risk for feeling especially vulnerable in his role because Lewis is gone .
   b. Vulnerabilities
      i. Because the loss was only two days ago, other vulnerabilities related to competence and confidence are likely to be manifest over time.
      ii. Loss created a leadership vacuum that forced other squad leaders to adjust their roles.
   c. Resources
      i. Family
      ii. Peers, if given the chance, may be empathic because they lost Lewis as well.
      iii. Marine Corps rituals and practices around loss and honor
   d. Obstacles
      i. Cpl. Curran feels raw and exposed and does not want to talk about his loss. He understandably expects that it will make things worse.
      ii. He feels shame about any loss of control and vulnerability.
   e. Needs
      i. Reconnection, support, mentoring
      ii. Restoring positive connection and self-care
      iii. Acceptance of the loss and the ability to reconnect and trust others again

8. Secondary Aid Plan:
   a. Chaplain Marks believes that Cpl. Curran needs to do focused processing/sharing of the loss of Lewis, especially in terms of the implication of the experience moving forward. Further mourning of the loss will allow Cpl. Curran to be more accepting of his experience, will help him realize that he can come out of the other end of sadness, feeling intact and open to reestablishing meaningful connections with peers and leaders.
   b. Chaplain Marks shares his feedback about what he has learned and provides hope and reassurance that Cpl. Curran can find a healing path.
   c. Chaplain Marks educates Cpl. Curran by:
      i. Reviewing the loss and its impact.
      ii. Sharing the nature of a loss injury.
      iii. Providing accurate expectations about what will be useful in the days and weeks ahead (meeting with him a few times to further the dialogue about the loss, soliciting the help and support of family, peers, and leaders, and reestablishing wellness routines).

        iv. Sharing observations about statements made by squad members at the memorial service and pointing out that he has seen that other squad members are struggling to make sense of their loss with Sgt. Lewis as well.

        v. Encourage the recognition of strengths and positive traits that Cpl. Curran learned from Sgt. Lewis. (For some, the fear of dishonoring what a revered leader stood for can act as a catalyst to reduce revenge seeking).

e. Chaplain Marks establishes a collaborative contract about a recovery plan with Cpl. Curran.

        i. Getting on the same page about the need for wellness, regaining connection with peers and leaders, and getting guidance from others

        ii. He asks Cpl. Curran if he agrees with the plan.

f. Plan for restoration of wellness

        i. Meeting with Cpl. Curran, squad corpsman, and a doctor to discuss sleep problems

g. Social resource replenishment: Plan for restoration of trusting connection with others

        i. Family contact

        ii. Encourage disclosure with close peers

        iii. Garner support of leaders (on behalf of the service member)

h. Plan for reintegration into unit role

        i. Discuss a plan to manage anger and need for revenge with Chaplain and leaders

i. Plan for building competence and confidence

        i. Create opportunity for success experiences in terms of reconnection and reengagement into unit/leisure activities

j. Plan for follow-up and follow-through

        i. Check for distorted thinking.

        ii. Recheck the plan.

9. Coordinate:

a. What can I do?

        i. Because of the positive initial primary aid conversation, Chaplain Marks feels like he is well prepared to meet with Cpl. Curran to discuss the meaning and implication of the loss.

b. I need more help:

        i. Talk with unit members and leaders about the impact of the loss of Lewis and assess what would be helpful for Lewis to regain connection and to reengage.

        ii. Talk with leaders about their need to assess Curran's anger and revenge needs.

c. Who else needs to know?

        i. Senior Medical Officer

        ii. Senior Enlisted Leader

10. Continue to Check and Coordinate.